2016

Impact Survey on IEC/SBCC Activities Implemented by the Information, Education & Motivation Unit (IEM) of DGFP

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স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

পরিবার পরিকল্পনা অধিদপ্তর

Impact Survey
on
IEC/SBCC Activities Implemented by the Information, Education & Motivation Unit (IEM) of DGFP

Submitted To

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Submitted By

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স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

পরিবার পরিকল্পনা অধিদপ্তর

Foreword

I am very delighted to know that the Impact Survey on IEC/SBCC Activities implemented by IEM Unit, DGFP and conducted by Department of Population Sciences, University of Dhaka during February-May 2016 focuses the importance of different IEC activities on FP-MCH issues. The major objective of this Impact Survey on IEC/SBCC activities by IEM Unit was to identify the success of the program as well as its limitations, implementation challenges and lessons learned.

IEC OP caters the provision of conducting two Impact Study in every five year plan to assess the impact of different packages IEM Unit conducts every year. This survey is the second of its kind while the first one was conducted in 2013.I am optimistic the findings of this study will be food for thought in forecasting various priority activities of the forthcoming Five Year Plan (2016-21) for the key actors of DGFP as well as Ministry of Health and Family Welfare.

I extend my sincere thanks to Department of Population Sciences, University of Dhaka for their relentless endeavor in materializing the research a success. As the esteemed academic body in Population study, inclusion of Department of Population Sciences will surely impregnate more values and trust of this study among the stakeholders.

I believe this study will not only help the IEC OP but also guide other OPs of DGFP in formulating their key activities addressing the FP-MCH issues for the next sector program. Last but not the least; special thanks go to the respondents who extended immense cooperation giving their valuable time. The study would have been impossible without their cooperation. I am also thankful to all other who provided necessary inputs in the study.

Mohammad Wahid Hossain, *ndc*
Additional Secretary
&
Director General
Directorate General of Family Planning

July 2016

Preface

The Impact Survey on IEC/SBCC Activities is glossary of the findings of different IEC related programs implemented by IEM Unit, DGFP. This survey unveils the strength as well as weaknesses of the ongoing IEC activities of IEM Unit, i.e. family planning, maternal and child health, reproductive health related activities.

This study, I believe, will surely foreshadow some lights on assessing the IEC/SBCC activities of the recently finished last five year (2011-2016) sector plan. At the same time, it will cater some thoughts in shaping the forthcoming five year (2016-2021) Plan of MOHFW.

Department of Population Sciences, University of Dhaka experiences unendurable labor in embroiling the study in shape. I gratefully acknowledge the contributions of the professionals of DGFP, Ministry of Health and Family Welfare (MOHFW) and those who are in Technical Review Committee in assisting Department of Population Sciences, University of Dhaka for designing and conducting the study.

Special thanks and gratitude goes to Secretary, MOHFW for guiding the study in the right way by his valuable suggestions despite his rigid official engagements. DG, DGFP also rendered his inputs in steering the study to its destination. Without their contribution this study would not have been possible.

I will be happy if the study leaves commendable impressions among the demographers, researchers, professionals in the population sector along with the DGFP/MOHFW officials.

Md. Ferdous Alam
Joint Secretary, MOHFW
Director (IEM) & Line Director, IEC
Directorate General of Family Planning

July 2016

Acknowledgement

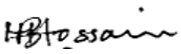
I am very pleased to submit the Impact Survey Report on IEC/SBCC Activities, Package No. IEC-R-S-28. This survey was conducted among married couples (aged 15-49 years), unmarried adolescent girls (13-19 years), community leaders, service providers (frontline workers, facility level providers, program managers of both GOB and NGOs); Local Government representatives; p*olicy makers, development partners working in HPN sector; and print and electronic media personnel.* Particular emphasis was given on collecting data from different categories of women such as high parity women, low parity women, newly married women, currently pregnant women, lactating mothers and non-users of family planning methods.

I express my sincere gratitude to the professionals of the Directorate General of Family Planning (DGFP), Ministry of Health and Family Welfare (MOHFW) and oterh experts who provided technical support to the Department of Population Sciences for final design and conducting the study.

I am grateful to Mr. Mohammad Wahid Hossain, Director of General Directorate General of Family Planning for providing thoughtful guidance on conducting the study. I would like to thank Mr. Md. Ferdous Alam, Director (IEM) & Line Director (IEC), Directorate General of Family Planning for his excellent cooperation in conducting the survey within the given timeframe.

I am especially thankful to Ms. Zakia Akhter, Deputy Director (Programme Monitoring); Md. Mahbub-Ul Alam, Program Manager, Family Planning Field Services Delivery; and Khandaker Mahbubur Rahman, Deputy Program Manager, IEM Unit of DFGP for their exceptional guidance and cooperation in completion of this project.

I would like to extend my thanks to the survey team members including supervisors, data collectors, and data entry operators for their time and efforts in successful completion of the study. I also express my thanks to GOB officials in District and Upazila levels for providing excellent support and information in conducting the survey.



July 2016

Mohammad Bellal Hossain
Team Leader & Associate Professor
Department of Population Sciences
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LIST OF ABBREVIATIONS

ANC	Antenatal Care
BBS	Bangladesh Bureau of Statistics
BTV	Bangladesh Television
CPR	Contraceptive Prevalence Rate
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health
DHS	Demographic and Health Surveys
EPI	Expanded Programme on Immunization
FGD	Focus Group Discussion
FP	Family Planning
FP-MCH	Family Planning-Maternal and Child Health
FWA	Family Welfare Assistant
FWC	Family Welafre Centres
FWV	Family Welfare Visitor
HNPSDP	Health, Nutrition and Population Sector Development Programme
HNPSP	Health, Nutrition and Population Sector Programme
HPSP	Health and Population Sector Programme
ICPD	International Conference on Population and Development
IEC/SBCC	Information, Education and Communication/Social Behaviour Change Communication
IEM	Information, Education and Motivation
IMR	Infant Mortality Rate
IUD	Intra Uterine Device
JHU	Johns Hopkins University
KII	Key Informant Information
LAPM	Long Acting Permanent Methods
MCH	Maternal and Child Health
MCWC	Mother and Child Welfare Center
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
NGO	Non-Government Orgamization
NIPORT	National Institute of Population Research and Training
NSV	No-Scalpel Vasectomy
PNC	Postnatal Care
PPD	Partners in Population and Development
TFR	Total Fertility Rate
UFPO	Upazila Family Planning Officer
UH&FWC	Union Health and Family Welfare Centers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Directorate General of Family Planning (DGFP) has been providing family planning, maternal health and child health services nationwide aiming to ensure healthy, happy and prosperous Bangladesh by population control and development. The Information, Education and Motivation (IEM) unit of the DGFP has been playing the key role in implementing IEC/SBCC activities through awareness building campaign; orientation workshop; motivational meeting; display of IEC materials through different media including TV, radio to raise awareness towards behaviour change and thereby to create demand for FP-MCH services leading to increased CPR, reduced TFR, MMR and IMR. This impact survey on IEC/BCC activities was implemented by the IEM Unit under IEC Operational Plan to identify the success of the program as well as its limitations, implementation bottlenecks and lessons learned.

This impact survey was conductedbyfollowing mixed method approach: quantitative (face-to-face interview) and qualitative (FGD and KII). Quantitative data were collected from 5747 women aged 15-49 from seven divisions and qualitative data were collected from men through focus group discussion (FGDs) and from program managers, service providers, community leaders, local government representatives and policy makers through Key Informant Interview during April to June, 2016. Major findings of the survey are as follows:

- Majority women have exposure to television (89.8%) followed by radio (63.7%) and newspaper (34.3%). Overall, women living in slums and hard-to-reach areas have lower exposure to media than women living in rural and urban areas. The exposure to internet among women is less than five percent (4.6%).

- A vast majority of the women who have exposure to television know that health and family planning programmes are broadcasted in radio and television. However, this knowledge is lower among women living in slum and hard-to-reach areas. More than two-third women follow health and family planning programmes in their personal life. More than half of the women watch Star Jalsha channel (58.2%) followed by BTV (19.1%), Zee Bangla (6.6%), Channel I (3.0%) and Star Plus (1.8%).

- Most women have very good knowledge about negative consequences of child marriage. Despite this awareness overall prevalence of child marriage among women aged 15-49 was about 70.0 percent with the highest prevalence rate in hard-to-reach area (74.0%) and the lowest rate prevailing in urban areas (66.5%). IEC/SBCC activities broadcasted in electronic media, print media and through outdoor activities have played important role in dissemination of knowledge related to child marriage.

- Age at first birth is much lower among high parity women (around 17 years) on the other hand low parity women have highest age at first birth compared to other categories of respondents. On the other hand, under-five mortality is highest among high parity women. Increasing age at first birth and decreasing under-five mortality will have positive impact in reducing fertility rates which is one of the goals of IEC/SBCC activities.

- Almost all respondents (98.7%) know about availability of health care centers in their locality. About half of the total respondents mentioned the availability of services in the UH & FWC followed by satellite clinic/EPI Centre, community clinics, Upazila Health Complex, NGO clinic, district hospital, private clinic, MCWC, private hospital, and medical college hospital. They have also learntabout various services provided by the health and family planning centers from activities of IEC/SBCC.

- Most women are very much aware about importance of antenatal check-up during pregnancy and many of them know required number of check-up during pregnancy. At least one check-up among low parity women (have only one child) is 85.4% followed by 60 percent among high parity women (have three or more children) and 60 percent among non-users of family planning. However, at least one antenatal check-up and 4+ check-up are much lower in slums compared to other areas.

- Women also have good knowledge about various types of care that are needed during pregnancy such as taking adequate rest, eating extra food, not allowing heavy work, taking iron tablets when needed, monitoring weight regularly, taking vaccine, and Vitamin A capsule. Major sources of gettinginformationon care of pregnant mothers include various activities of IEC/SBCC such as workshop, seminars, yard meeting, polligan and street drama.

- Facility delivery among low parity women is 44.6% compared to 19.8% among high parity women. Among non-users of family planning facility delivery is 36.3%. Higher rate of facility delivery among low parity women than high parity women suggests that there is an increasing awareness about facility delivery among women in Bangladesh which can largely be attributed to various activities of IEC/SBCC.

- Postnatal check-up within 42 days after delivery among low parity women is the highest (73.7%) which is followed by lactating mothers (73.3%), high parity women (56.6%) and non-users of family planning (51.2%). Majority high parity Women had taken PNC within 42 days of giving birth from satellite clinics (37.7%) followed by UH & FWC (12.9%), private clinics (12.5%), community clinics (12.0%), NGO clinics (11.3%), MCWC (8.5%), upazila health complex (7.3%), district hospital (7.0%), private hospital (5.8%) and medical college hospital (6.9%).

- Majority women have good knowledge about taking various care of mother during post natal period such as giving nutritious food, extra good, taking adequate rest, not allowing heavy work, giving liquid food and taking iron tablets when needed. They have learnt about those information from various activities of IEC/SBCC.

- Most of the women have good knowledge about necessity of taking care of newborn and children. They know the importance of colostrum for the newborn, exclusive breastfeeding till six months after birth, breastfeeding with supplemetary foods after six months, giving vaccination, giving vitamin A capsule, and checking weights regularly.

- Among low parity women 91.8% have given vaccination to their children which is followed by high parity women (86.2%), lactating mothers (85.9%), and FP nonusers (83.1%). Similarly, 72.1% low parity women have provided vitamin A capsule to their children which is followed by high parity women (67.6%), FP nonusers (33.2%), and lactating mothers (23.4%).

- Majority women have good knowledge about causes and treatment of diarrhea and pneumonia. Most of the women have knowledge about foods that contain nutrition such as vitamins A. Women have learnt about newborn care, child care and nutrition from IEC/SBCC activities.

- All women know about family planning methods and the sources of contraceptives. The contraceptive use rate is highest among high parity women (78.0%), followed by low parity women (72.6%), and lactating mothers (67.6%). There has been slower progress in increasing long acting and permanent method users of family planning partly due to several

misconceptions about these methods, lack of quality services, inadequate wage compensation for adopting these methods, and to a smaller extent sociocultural factors including religion.

- Majority men are also aware about negative consequences of child marriage. They know about most of the health and family planning centers in their locality and about various services provided by these centers. However, they want quality services from these health and family planning centers particualry in heard-to-reach areas. Majority men are not in favour of using permanent method of family planning (NSV) due to several misconceptions such as risk of reducedsex power, side effects and negative attitude of family and society.

- Majority program managers and service providers are aware about various activities of IEC/SBCC. However, in some cases they do not have adequate capability to deliver quality services to achieve the desired goals of IEC/SBCC activities. They also have limited Interpersonal Communication with the target group of IEC/SBCC interventions. On the brighter side, program managers and service providers have strong willingness to deliver quality services given that adequate logistic supports and professional development trainings are provided.

SECTION ONE

1.1 Background

Bangladesh is one of the most densely populated countries in the world. With a current population of 159.8 million and total fertility rate (TFR) of 2.3 children per woman, the total population of Bangladesh is projected to reach 223.4 million by 2061 under medium variant, a scenario most likely to happen (BBS, 2015). Family planning programmes received inordinate attention in Bangladesh since 1950s due to the large number of population, high fertility and high prevalence of poverty (Cleland Amin and Kamal, 1994). The Family Planning Programme in Bangladesh has undergone a number of transitional phases. For instance, the Government emphasized on Integrated Health & Family Planning Program (1972-74), Maternal and Child Health (MCH)-based Multi-sectoral Program (1975-80), Functionally Integrated Program (1980-85), Intensive Family Planning Programme (1985-90), Reduction of rapid growth of population through intensive service delivery and community participation (1990-95), Health and Population Sector Programme (HPSP) (1998-2003), Health, Nutrition and Population Sector Programme (HNPSP) (2003-2011), Health, Nutrition and Population Sector Development Programme (HNPSDP) (2011-2016) (Randal, 2012; DGFP, 2011).

The Perspective Plan of Bangladesh 2010-2021 (Vision 2021) set the goal of reducing poverty rate to 15%, providing standard nutritional food to 85% of the population, ensuring a minimum of 2122 kilo calories of food for poor people, eliminating all kinds of contagious diseases, increasing longevity to 70 years, reducing infant mortality to 15 per thousand, reducing maternal death rate to 1.5%, and increasing birth control method to 80%. In consistent with the Vision 2021 of the Government of Bangladesh, the 7th Five-year Plan set the targets: population growth rate - 1.0%; MMR -105 (per 100,000 livebirths); Neonatal Mortality Rate-13(per 1000 livebirths); IMR-20 (per 1000 livebirths); under-five mortality rate-37 (per 1000 live births); Total Fertility Rate (TFR)-2;, CPR=75%;, unmet need for family planning=10%; iscontinuation rate of FP methods-20%;, 65% of births attended by skilled personnel; 50% facility delivery; 70% ANC coverage; 50% PNC coverage (mother) by a medically trained provider; 95% of children fully vaccinated by 12 months; and 75% of babies to be exclusive breastfed. To achieve these goals, 7th Five-year plan recommended several interventions including promote delay in marriage and child bearing, use of post-partum Family Planning (FP) and FP for appropriate segments of population; strengthen FP awareness building efforts through Information, Education and Communication (IEC) activities with special emphasis on mass communication and considering local specificities; use different service delivery approaches (including domiciliary services) for different geographical regions and segments of population having low CPRs; register eligible couples with particular emphasis on urban areas to establish effective communication and counselling; compensation for lost wages for long acting and permanent method contraceptive performance; strengthen FP services especially post-partum and post abortion FP and demand generation through effective coordination of services with DGHS; and strengthen advocacy for male participation in permanent and other methods of contraception (Bangladesh Planning Commission, 2015).

Directorate General of Family Planning has been providing family planning, maternal health and child health services nationwide aiming to ensure healthy, happy and prosperous Bangladesh by population control and development (MoHFW, 2012). While ICPD principles are the foundation for FP programme in Bangladesh, population policy, five year plan and Health Population and Nutrition Sector Development Program (HPNSDP) are the guiding documents.

International Conference on Population and Development (ICPD) ratified the importance of IEC for family planning programmes (United Nations, 1995); based on this ratification national population policy has identified Behaviour Change Communication (BCC) as one of the strategies to achieve the vision of making a prosperous country. HPNSDP has identified one of the drivers of health sector

programme as “addressing population growth with vigorous, fully integrated family planning services, and cross cutting, multi-sectoral interventions. Focus is on LAPM including the unmet need with participation of related different stakeholders, both in urban and rural areas.” Moreover, HPNSDP priority interventions include mass communication, IEC activities considering local specifications along with public information, motivation and counselling campaign as cross cutting issue (MoHFW, 2011).

In Bangladesh the provision of IEC on selected health, family planning and nutrition issues has been one of the key interventions for more than three decades in these programmes. Communication activities have resulted in increased awareness and have contributed to a greater use of key health; family planning and nutrition services in the country. Since its inception, the Information, Education and Motivation (IEM) unit of the Directorate of Family Planning has been playing the key role in implementing the IEC programmes throughout the country. A number of multi-sectoral ministries were also involved in the BCC/IEC activities.

While DGFP activities are divided into service delivery and demand generation, diversified IEC interventions have been identified and implemented by the IEC operational plan. General objective of the IEC operational plan is to raise awareness towards behavior change and thereby to create demand for FP-MCH services leading to increased CPR, reduced TFR, MMR and IMR (DGFP, 2015). Major activities of IEC operational plan are: awareness building campaign; orientation workshop; motivational meeting; display of IEC materials through different media including TV, radio. Target group for those interventions include eligible couples, adolescents, school/Madrasah teachers, local government representatives, journalists etc. (DGFP, 2015).

The IEM Unit of the DGFP implemented an impact survey in 2011 to assess the effectiveness of different population programmes broadcasted by BTV and Bangladesh Betar under population cell. A total of 1500 respondents of radio programme and 3500 respondents of TV programme were successfully interviewed. It was found that about 74 percent respondents listen to radio programme and 73.2 percent watch TV programmes. Among radio listeners, 91.2 percent listen programme on family planning, maternal and child health and other health issues within three months prior to the study and similarly, 90.6 percent of the TV programme viewers watch relevant TV programmes broadcasted. Overall, the findings of this impact survey suggest that communication had a positive impact on ongoing interventions for achieving high levels of knowledge and practicing FP methods. Based on the findings it was recommended that population programmes in radio and TV should be more attractive and time convenient so that listeners/viewers become interested in listening/watching the programs. However, this impact *survey did not focus on Various aspects of FP-MCH including Motivation, Behaviour and Practice;* Maternal and newborn health; Delivery Care; Family Planning Knowledge and Practice; Immunization/Vaccination, EPI and Diseases; IEC Support-Knowledge and Awareness; and awareness and status of listening and watching of health and FP programme in radio and TV by the managers and service providers.

Moreover, the IEM Unit of the DGFP implemented the “Impact Survey on IEC activities by IEM, DGFP” in 2013 addressing the above mentioned limitation of the 2011 impact survey. The objective of the 2013 impact survey was to assess the impact of messages through mass media campaign for target populations in order to strengthen the onward program. The impact survey revealed an improvement on respondents’ awareness, motivation and practices of ANC including attendance of skilled service providers during delivery and availing PNC. Irrespective of respondents’ categories, majority were aware and knowledgeable on FP-MCH related services including exclusive breastfeeding practices but still a good section of sampled women remained to be aware with the same. The study also identified oral pill as the most popular method among different contraceptives and the government sector remained major provider of contraceptive methods. More attention was

recommended to increase the permanent FP method through intensifying IPC particularly through counselling. Electronic and print media along with IPC were the main source of information on health, FP, maternal and child health. Most of the respondents learned and attempted to adopt messages on FP-MCH through radio/TV but a few had seen BCC materials. Regarding IEC materials both managers and service providers were fully aware on its importance, but those materials were inadequate for mass campaign.

1.2 Rationale of the Impact Survey:

IEM Unit of DGFP under the Ministry of Health and Family Welfare (MOHFW) implements IEC/BCC activities throughout the country using multiple channels beginning from July 2011. The current sector program (HPNSDP) will end in June 2016. Like other Operational Plans (OP) under MOHFW, IEM Unit has been actively involved in the development of IEC-OP for next sector program (July 2016 – June 2021). To head on with the new sector program, IEM Unit need critical analysis of the IEC/BCC intervention implemented under the current IEC-OP (2011-2016) to see what did work well and what did not. For this reason, an impact survey on IEC/BCC activities was implemented by IEM Unit under IEC Operational Plan to identify the success of the program as well as its limitations, implementation bottlenecks and lessons learned.

1.3 Target Audiences:

1.3.1 Primary:

a) Married couples (women aged 15-49 years) including lactating mothers
b) Newly wed couples (married in the last 2 years of the survey) with special emphasis on 15-20 age group
c) Adolescent girls (13-19 years);

1.3.2 Secondary:

a) Family members, community leaders, service providers (frontline workers, facility level providers, program managers of both GOB and NGOs);
b) School and Madrasah teachers especially female teachers;
c) Local Government representatives (chairmen, members, female members, vice-chairmen);

1.3.3 Tertiary:

a) Policy makers, development partners working in HPN sector;
b) Print and electronic media personnel;

Geographical Locations: The impact assessment covered all over Bangladesh with special focus on low-performing regions, hard to reach areas including slums.

1.4 Objective of the Impact Survey:

The overall objective of the impact survey was to investigate the effectiveness of different IEC/BCC interventions implemented by IEM Unit under IEC-OP particularly what did work well and what did not and why.

Specific Objectives are:

a) To investigate the effectiveness of IEC/BCC messages and materials (both printed and enter-educative) developed by IEM Unit of DGFP;
b) To find out the impact of different training, orientation, workshops on the target audiences implemented by IEM throughout the country/low-performing regions;
c) To investigate the impact of Bangladesh Betar and BTV population cell programs;

d) To examine the impact of the audio-visual programs implemented by IEM Unit through 26 zones;
e) To identify what IEC/BCC interventions did work well and what did not (lessons learned).

1.5 Methodology

1.5.1 Methods of data collection and types of respondents

For this study data were collected both from primary and secondary sources. The primary data were collected following mixed method approach: combination of quantitative and qualitative approaches. The quantitative data were collected from various categories of household level respondents (newlywed couples, currently pregnant, lactating mothers, low-parity, high-parity couples aged 15-49, non-users of FP, and adolescent girls) through face-to-face interview using structured questionnaire.

The qualitative data were collected through Focus Group Discussion (FGDs) and Key Informant Interviews (KIIs). The Focus Group Discussions were conducted in all seven divisions among husbands. The KIIs were conducted in all seven divisions among program managers (divisional director, deputy director-FP, UFPO & MO-MCH-FP), service providers (FWVs, FPI, and FWA), elected representatives (UP Chairman, and women members), community and religious leaders, and school and Madrasah teachers. In addition, KIIs were conducted at national level among policy makers, development partners working in HPN sector (USAID, UNFPA, JHU and PPD), print media, electronic media, and NGO representatives and Bangladesh Betar Listening Club (adolescent).

The secondary data were collected from the Demographic and Health Surveys (DHS), Maternal Mortality Surveys, Urban Health Surveys in Bangladesh, and Utilizations of Essential Services Delivery Surveys. In addition, annual Reports of relevant ministries, planning documents and Five-year plans of the Government of Bangladesh were reviewed as part of the secondary analysis.

The face-to-face interview was conducted to investigate the effectiveness of different IEC/BCC interventions on the following aspects:

- Motivation, Behaviour and Practice on timing of pregnancy
- Maternal and newborn health
- Delivery Care
- Knowledge, Awareness and Perception of household about FP-MCH, ANC
- Family Planning Knowledge and Practice
- Contraceptive choice
- Immunization/Vaccination, EPI and Diseases
- IEC Support-Knowledge and Awareness
- Media Knowledge and Preference

1.5.2 Study Area and Sample Size

The study used multistage random sampling to get representative samples from seven divisions of Bangladesh: Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur and Sylhet. Three areas were selected from each division: urban, rural, and hard to reach areas. The target population for face-to-face interviews were newlywed couples married in last 12 months), currently pregnant, lactating mothers, low-parity (had one child), high-parity couples (had three or more children), adolescent girls and non-users of FP aged 15-49. Sample size should be determined with the goal of assessing the impact of the effectiveness of different IEC/BCC interventions (awareness building campaign; orientation workshop; motivational meeting; display of IEC materials through different media including TV, radio) on various aspects of FP-MCH. To attain the goal we calculated sample size using

"the proportion of couples watching family planning messages/programmes in television in the last six months". The 2011 Bangladesh Demographic and Health Survey show that the proportion is 48.6 percent. Using 5% of margin of error with 2.0 design effect, household response rate of 97.9%, couple's response rate of 96.8%, the total sample size of eligible women aged 15-49 for the proposed impact survey were 5,700 following the formula shown below:

$$n = \frac{(1.96)^2 \times p(1-p) \times (deff)}{e^2 \times rr}$$

Where, n= total sample size

p= the proportion of couples watching family planning programmes in television
deff= Design effect
e2 = Margin of error
rr = Response rate

1.5.3 Sampling Strategy for Quantitative Survey

Bangladesh Demographic and Health Surveys conducted by NIPORT contain wide range of information on maternal and child health. For selecting the sample size latest available data of BDHSs was used. According to BDHS 2011, 44% women had three or more children ever born (High Parity) while 31% had one or no child (Low parity). Moreover, 7% women were married within two years before the survey (Newlywed); 6% were pregnant at the time of survey (Currently pregnant); 25% were lactating mother. The non-users of family planning methods were found to be 39%. Lastly, according to sample census survey (BBS, 2011) 20% of the female respondents were between 10 to 19 (Adolescent girls) years of age. These proportions were used to distribute the 5,700 respondents into the above mentioned categories. From each division equal numbers of respondents were interviewed across three categories: urban, rural, and hard-to-reach. FWA registers, which contain unit wise population data, were used as sample frame. Total number of respondents interviewed was 5747.

Table 1.1 : DGFP Impact Survey on IEC BCC/Activities: Final Sample Interviewed

Respondent Category		Division							Total
		Barisal	Chittagong	Dhaka	Khulna	Rajshahi	Rangpur	Sylhet	
Low Parity	Rural	19	44	85	39	47	40	19	293
	Urban	19	43	88	40	53	40	19	302
	Slum	0	44	87	0	0	0	0	131
	Hard to Reach	18	44	86	41	46	41	19	295
	Total	**56**	**175**	**346**	**120**	**146**	**121**	**57**	**1021**
High Parity	Rural	27	64	126	57	68	59	27	428
	Urban	28	65	125	56	68	59	27	428
	Slum	0	65	123	0	0	0	0	188
	Hard to Reach	28	66	123	55	69	58	27	426
	Total	**83**	**260**	**497**	**168**	**205**	**176**	**81**	**1470**
Currently Pregnant	Rural	4	9	17	8	10	8	4	60
	Urban	4	9	17	8	10	8	4	60
	Slum	0	10	17	0	0	0	0	27
	Hard to	4	9	17	8	9	8	4	59

Table 1.1 : DGFP Impact Survey on IEC BCC/Activities: Final Sample Interviewed									
Respondent Category		**Division**							**Total**
		Barisal	**Chittagong**	**Dhaka**	**Khulna**	**Rajshahi**	**Rangpur**	**Sylhet**	
	Reach								
	Total	**12**	**37**	**68**	**24**	**29**	**24**	**12**	**206**
Lactating Mother	Rural	16	37	70	33	40	34	16	246
	Urban	16	37	72	33	39	33	16	246
	Slum	0	37	72	0	0	0	0	109
	Hard to Reach	16	37	71	33	39	33	16	245
	Total	**48**	**148**	**285**	**99**	**118**	**100**	**48**	**846**
Non User	Rural	25	56	110	50	60	51	24	376
	Urban	25	56	109	50	60	51	24	375
	Slum	0	56	109	0	0	0	0	165
	Hard to Reach	25	56	109	50	60	51	24	375
	Total	**75**	**224**	**437**	**150**	**180**	**153**	**72**	**1291**
Newly Wed	Rural	5	10	17	9	11	9	4	65
	Urban	5	10	24	9	11	9	4	72
	Slum	0	18	20	0	0	0	0	38
	Hard to Reach	5	10	20	9	11	9	4	68
	Total	**15**	**48**	**81**	**27**	**33**	**27**	**12**	**243**
Adolescent	Rural	13	29	55	26	29	27	12	191
	Urban	13	29	59	26	33	26	12	198
	Slum	0	30	57	0	0	0	0	87
	Hard to Reach	13	29	56	26	33	25	12	194
	Total	**39**	**117**	**227**	**78**	**95**	**78**	**36**	**670**
All Type	**Total**	**328**	**1009**	**1941**	**666**	**806**	**679**	**318**	**5747**

1.5.4 Qualitative Data Collection

For collection of qualitative data, two FGDs were conducted from each division among husbands. Thus the total numbers of FGDs were 14 for the proposed impact survey. Furthermore, KIIs were carried out to collect information from program managers, service providers, elected representatives, community and religious leaders, school and madrasah teachers, policy makers, development partners working in HPN sector, and print and electronic media, NGO representatives, and Bangladesh Betar Listening Club (adolescent). Detail distributions of these KIIs are shown below.

Table 1.2: Distribution of qualitative samples

Distribution of qualitative samples	
Respondents	**Number of KIIs in each division**
Program Managers[Divisional director (FP), Deputy director (FP), UFPO & MO (MCH-FP)]	3
Service Providers[FWVs, FPI and FWA]	3
Elected Representatives (UP Chairman and women members)	1
Community & religious leaders	1
School & Madrasah teachers	1
Total KIIs in 7 Divisions	**63**
Respondents	**Addition KIIs (national)**
Policy Makers	3
Development Partners (USAID, UNFPA, JHU, PPD) working in HPN Sector	1
Print Media	1
Electronic Media	1
NGO representatives	5
Total KIIs (National)	**11**
Total KIIs (divisional + national)	**74 (63+11)**
FGDs with Husbands (2 in each division)	**14**

1.6 Impact measurement and analytical approach

The effectiveness of different IEC/BCC intervention were measured through collecting information on motivation, behaviour and practice (attitude towards ideal age at marriage, pregnancy of newlywed women, desired age of pregnancy by newlywed women; birth spacing,); maternal and new-born health; delivery care; Family Planning Knowledge and Practice Media Knowledge and Preference (awareness and listening of Radio/TV transmitted health and FP related messages, respondents learning from IEC materials by residence, wealth, reasons for not seeing IEC materials, attempt to adopt Radio/TV messages).The collected data were analysed using a combination of quantitative and qualitative techniques. In quantitative analysis, univariate and bivariate analysis were conducted disaggregated by socio-demographic characteristics of the respondents. In bivariate analaysis chi-square test was used to assess the significance of the variables. Appropriate graphic presentation was given wherever needed.

SECTION TWO

2.1 Findings of the Survey

In this section, demographic and socioeconomic characteristics of the study population, their media exposure, and their knowledge and perception about child marriage, availability of health and family planning centers in the locality and services provided by these centers are presented. These aspects are common to all women interviewed for this study. Hence, their findings are presented together instead of presenting across each of the sub-groups of women.

2.1.1 Sample characteristics of the respondents

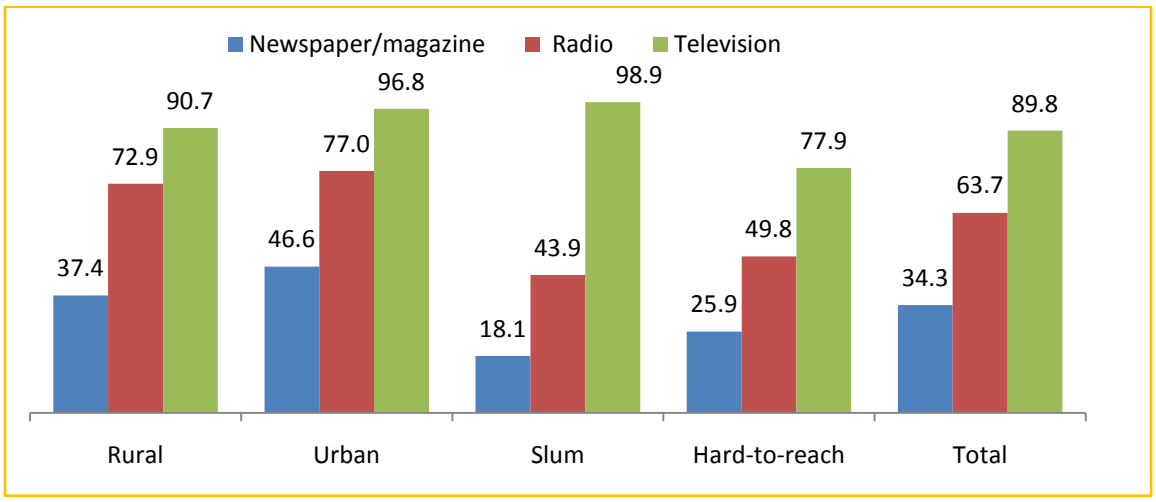
Among the selected women for this study high parity women have the highest average age (36.0 years) followed by non-users of family planning (31.2%), low parity women (24.1 years), currently pregnant women (23.6 years), newly wed (21.8 years), and adolescents (15.4 years). High parity women have the highest proportion of no education (42.9%) followed by non-users of family planning methods (29.9%), low parity women (11.9%), currently pregnant (10.7%), newly wed (6.6%) and adolescent (0.6%). The percentages of employed women range between seven to eight percent among all women except for currently pregnant women (2.9%). The mean age at first marriage among high parity women is 15.1 years, 17.0 years among low parity women and 18.3 years among high parity women. More than 84.0 percent women in all categories are Muslims Annex Table 1).

Child mortality among high parity women is the highest (21.1%) which is 13.9 percent among non-users and 6.3 percent among low parity women. There are differences in age at first birth among women; however, there is no substantial difference in age at second and third births among women. For instance, the average age at first birth among high parity women is 17.6 years which is 18.3 years among non-users and 19.9 years among low parity women. The distribution of women across wealth index is almost evenly distributed ranging from 19-20% in each categories of wealth index (Annex Table 1).

2.1.2 Media Exposure among all women

A vast majority of the women have exposure to television (89.8%) followed by radio (63.7%) and newspaper (34.3%). Overall, women living in slums and hard-to-reach areas have lower exposure to media than women living in rural and urban areas (Figure 1). Among those who have exposure to media, more than half of the women (56.3%) watch television everyday whereas only around five percent women read newspaper and listen to radio every day. The exposure to internet among women is less than five percent (4.6%), and slightly higher than one-third of them uses internet everyday. The average duration of listening radio per day is 163 minutes with slum and hard-to-reach areas having higher duration than rural and urban areas. On the other hand, the average time of watching television is 120 minutes with slums and hard-to-reach areas having higher duration of watching television than women living in urban area.

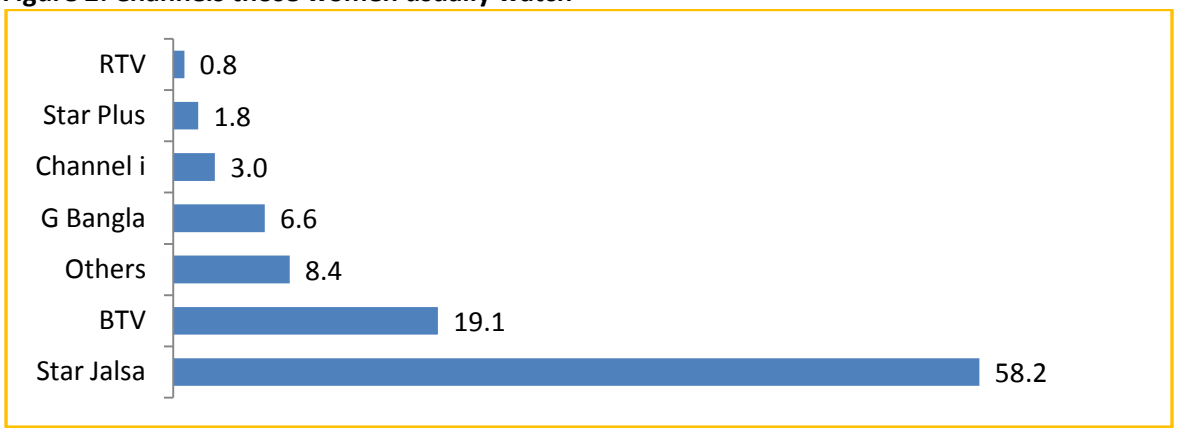
Figure 1: Exposure to media: Television, Radio, and Newspaper/magazine among women



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

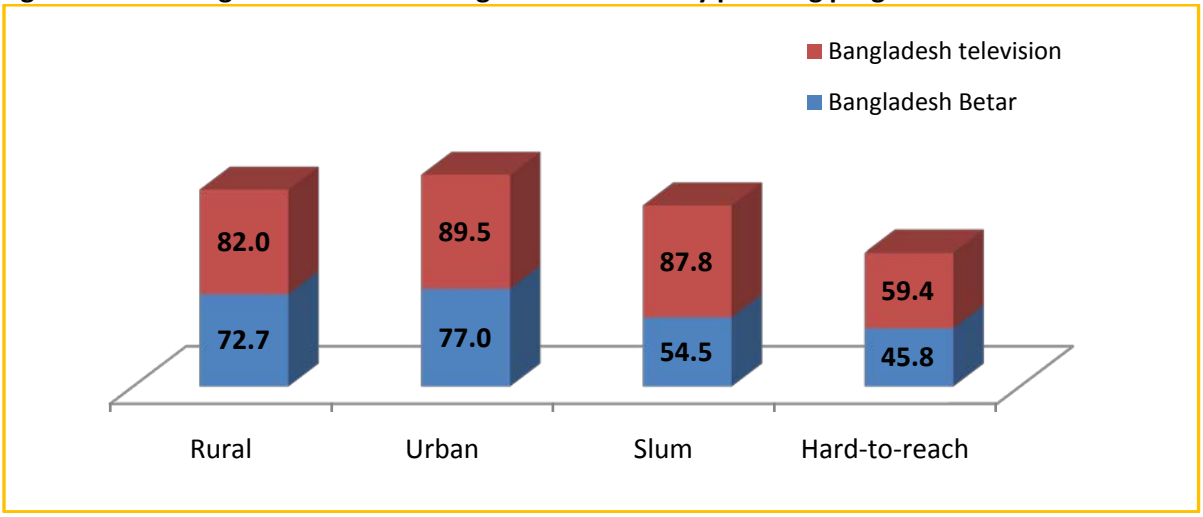
Concerning the timing of watching listening radio and watching television, majority women listen to radio at noon (34.4%) while most of the women watch television at night (70.5%). More than half of the women watch Star Jalsha channel (58.2%) followed by BTV (19.1%), Zee Bangla (6.6%), Channel I (3.0%) and Star Plus (1.8%) (Figure 2).A vast majority of the women who have exposure to television know that health and family planning programmes are broadcasted in radio and television. However, the rate of knowledge about broadcasting health and family planning programmes are slightly lower among women living in slum and hard-to-reach areas (Figure 3). More than two-third of the women mentioned that they followed health and family planning programmes in their personal life.

Figure 2: Channels those women usually watch



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Figure 3: Knowledge about broadcasting health and family planning programmes in media

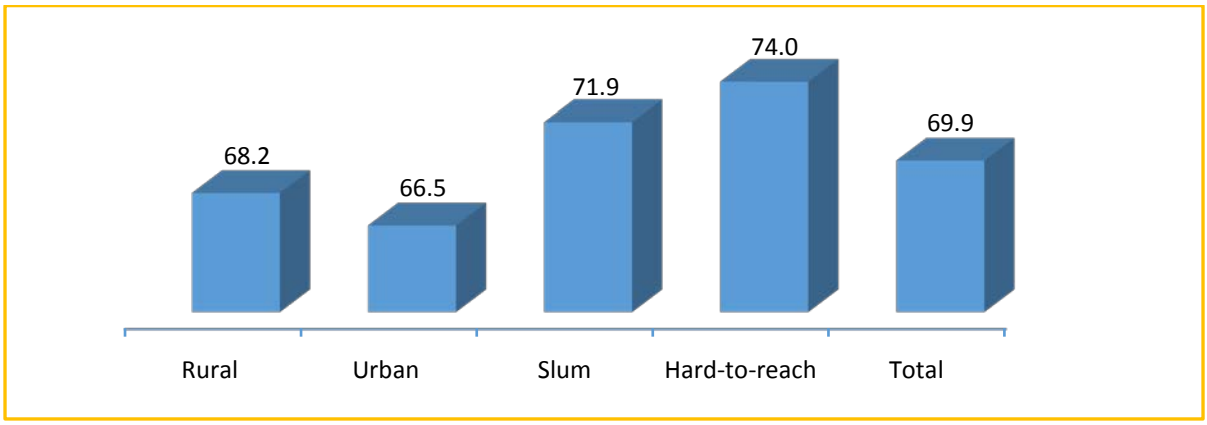


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.1.3 *Child Marriage among all women*

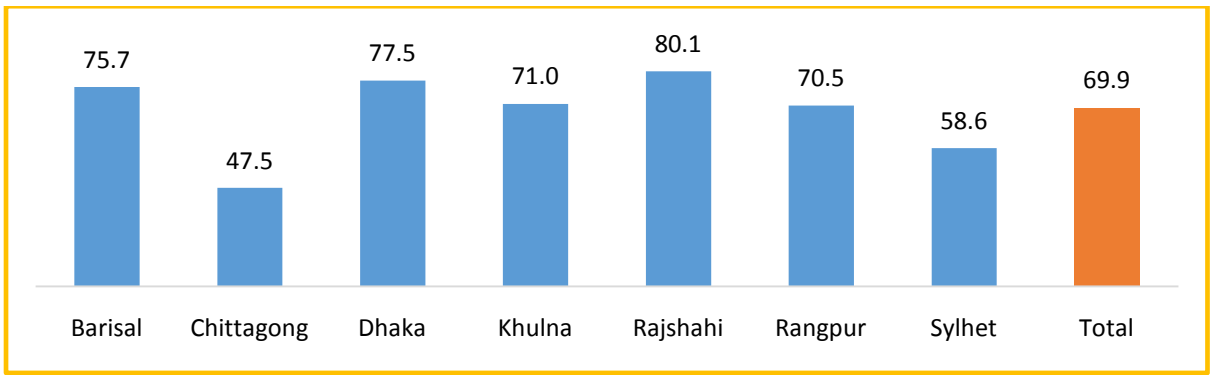
Among married women the prevalence of child marriage was about 70.0 percent with the highest prevalence rate in hard-to-reach area (74.0%) flowed by slums (71.9%), rural (68.2%) and urban (66.5%) areas (Figure 4). Prevalence of child marriage across division shows that Rajshahi division has the highest rate of child marriage (80.1%) while Chittagong division has the lowest rate of child marriage (47.5%) in Bangladesh (Figure 5).

Figure 4: Prevalence of child marriage among married women by study area



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

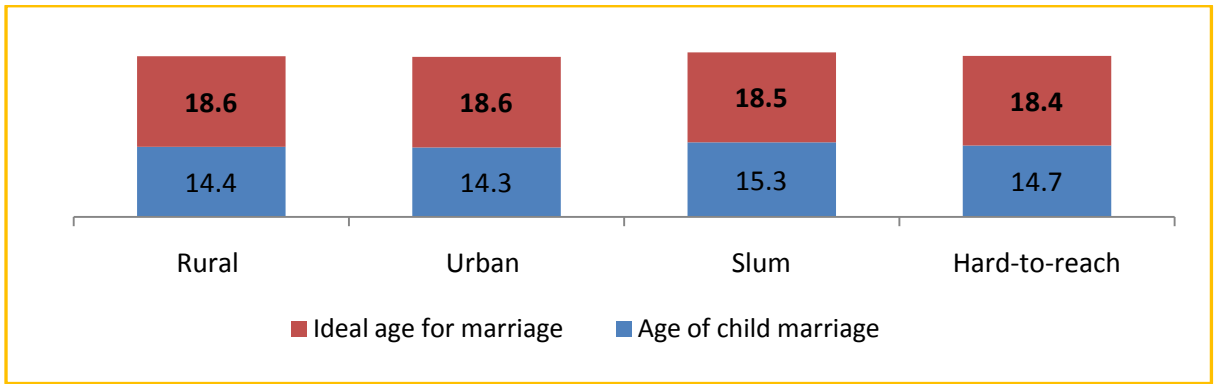
Figure 5: Prevalence of child marriage among married women by division



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

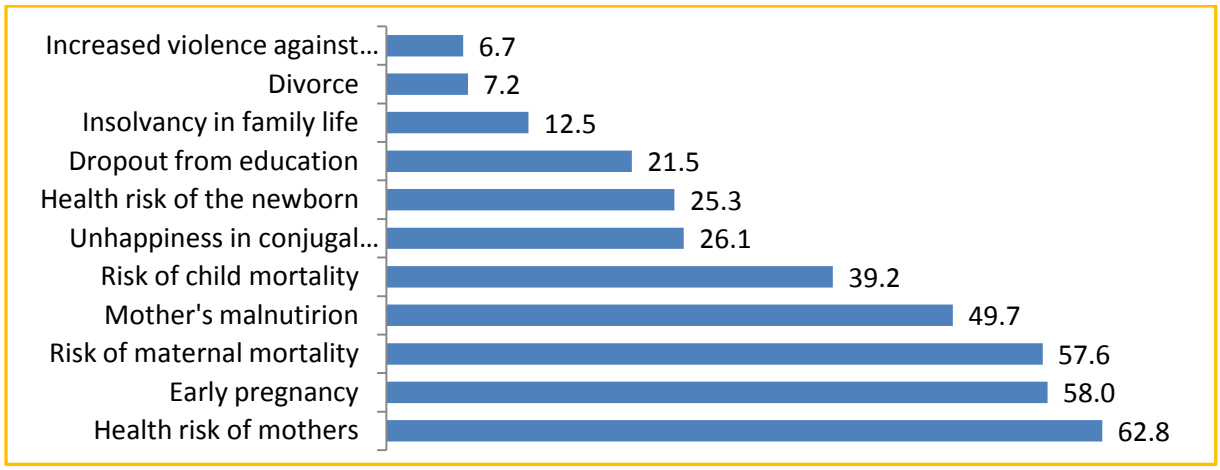
The perception of women about age at child marriage is that of below 15 years in rural, urban and hard-to-reach areas. However, women living in slums reported slightly higher age for child marriage (15.3 years). The average ideal age for girls to get married as mentioned by the respondents is above 18 years in all areas of the study (Figure 6).

Figure 6: Perception among women about age at child marriage and ideal age of marriage for girls



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

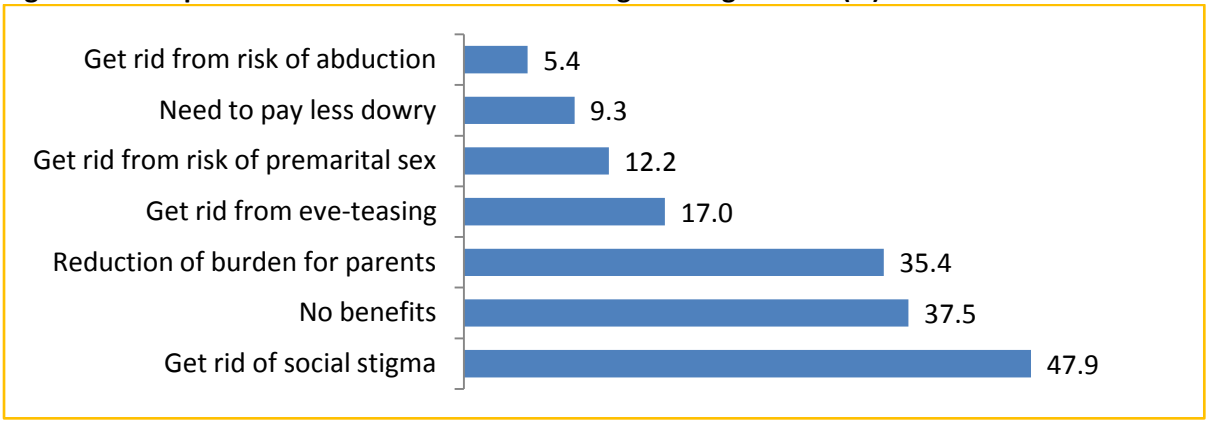
Figure 7: Knowledge among women about consequences of child marriage (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Concerning women's knowledge about the consequences of child marriage it was found that majority women mentioned health risk of mothers (62.8%) followed by early pregnancy, risk of maternal mortality, mothers malnutrition, unhappiness in conjugal life, health risk of the newborn, dropout from education, insolvancy in family life, higher risk of divorce and increased violence against women (Figure 7). In connection with this, women's perception about benefit of child marriage includes getting rid of social stigma (47.9%), reduction of burden for parents (35.4%), get tid of eve-teasing (17.0%), get rid ofrisk of premarital sex (12.2%), need to pay less dowry (9.3%), and get rid fom risk of abduction (5.4%). However, more than one-third women foresee no benefits of child marriage (Figure 8).

Figure 8: Perception about benefits of child marriage among women (%)

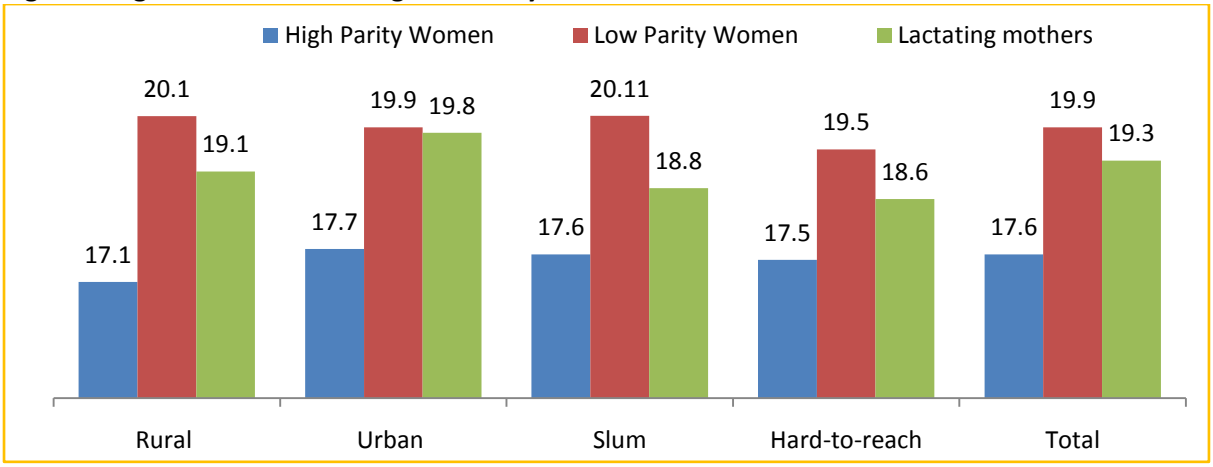


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.1.4 *Fertility Related Measures among all Women*

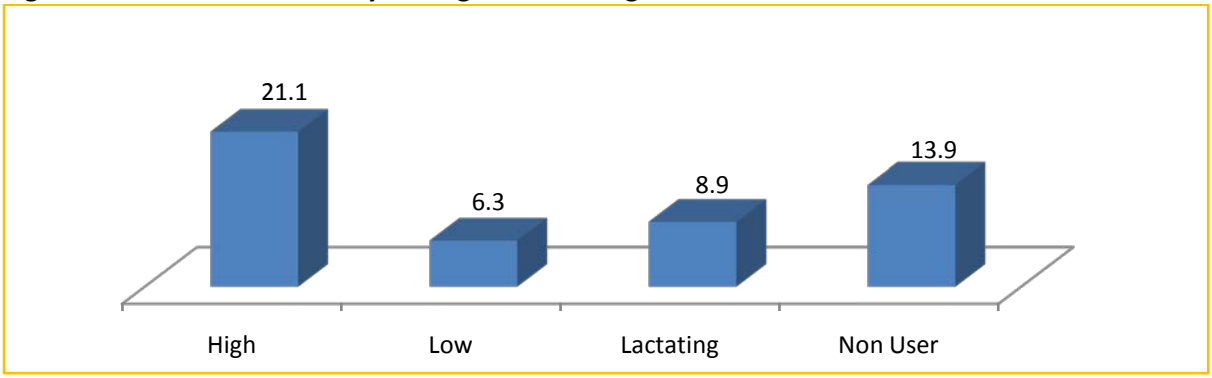
Age at first birth and under-five mortality are two important indicators of mortality. Previous research shows that increasing age at first birth and lower rate of under-five mortality depress fertility rate in a society. Figure 9 shows that age at first birth is much lower among high parity women (around 17 years) on the other hand low parity women have highest age at first birth compared to other categories of respondents. On the other hand, under-five mortality is the highest among high parity women (Figure 10).

Figure 9: Age at first birth among women by residence



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Figure 10: Under-five mortality among various categories of women

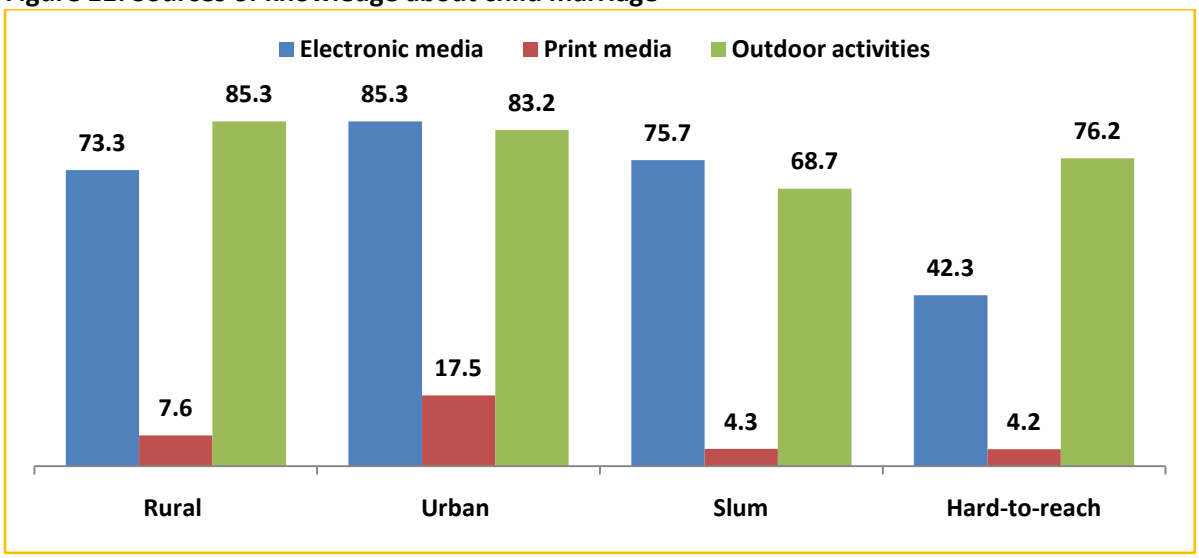


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.1.5 Sources of knowledge about child marriage among all women

The above findings suggest that most women are aware about various negative consequences of child marriage in our society. Concerning the impact of IEC/BCC activities on child marriage, it was found that about seventy percent women got message onchild marriage from electronic media (68.2%), about ten percent women knew from print media, and 80.0 percent women were informed about child marriage from outdoor activities which includes family planning workers, NGO workers, billboards, folksong, workshop/seminar, courtyard meeting, satisfied clients, and fromstreet drama. The use of IEC/BCC activities across study area shows that majority women in rural areas reported using outdoor activities compared to print and electronic media; in urban and slum areas majority women reported using electronic media; on the other hand, most women in hard-to-reach areas mentioned use of outdoor activities. Comparing IEC/BCC activities across four types of study areas shows that slums had the lowest rate of using outdoor activities compared to rural, urban and hard-to-reach areas (Annex Table 2).

Figure 11: Sources of knowledge about child marriage

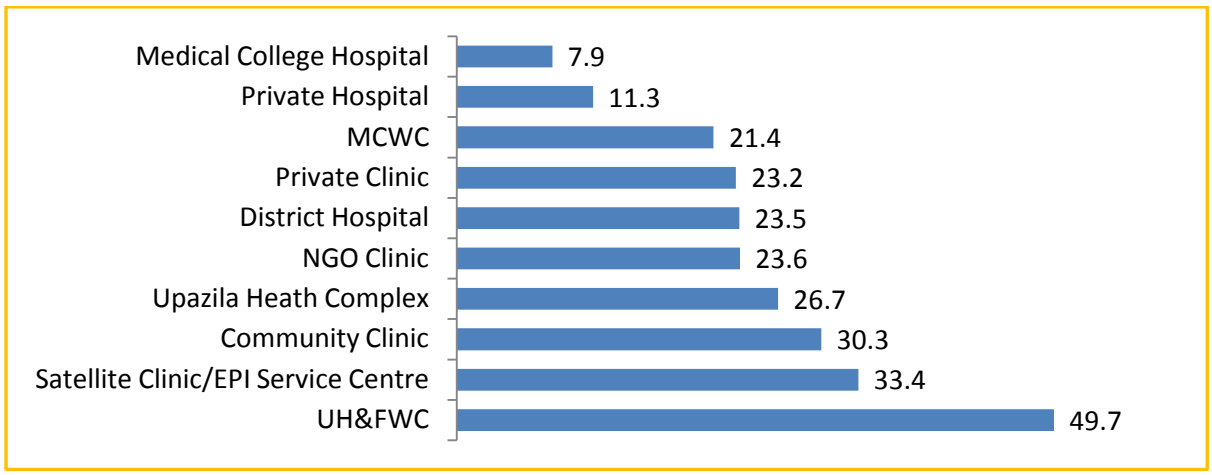


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.1.6 Knowledge about Family Planning Centers and Services

Almost all respondents (98.7%) know about availability of health care centers in their locality except in the case of slum areas where the percentage is slightly lower (96.7%). About half of the total respondents mentioned the availability of UH & FWC (49.7%), followed by satellite clinic/EPI Centre (33.4), community clinics (30.4%), Upazila Health Complex (26.7%), NGO clinic (23.6%), district hospital (23.5%), private clinic (23.2%), MCWC (21.4%), private hospital (11.3%), and medical college hospital (7.9%) (Figure 12).

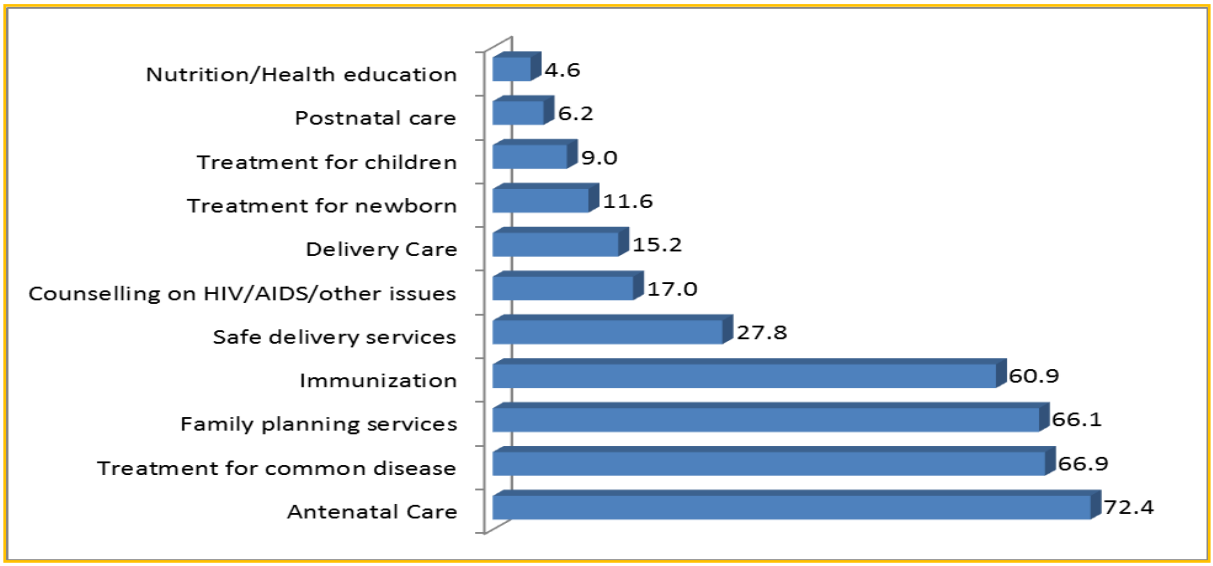
Figure 12: Knowledge about availability of any health centre in locality among women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Concerning knowledge about services provided by the UH&FWCs all women are aware about some services such as antenatal care (72.4%), treatment for common diseases (66.9%), family planning services (66.1%), immunization (60.9%), safe delivery services (27.8%), counselling (17.0%), delivery care (15.2%), treatment for newborn (11.6%), treatment for children (9.0%), postnatal care (6.2%), and nutrition and health education (4.6%) (Figure13). The proportion of respondents regarding the knowledge on various health and family planning services are slightly lower in rural areas than urban areas. In addition, women living in slums also have lower percentage in reporting various services provided by the UH&FWCs.

Figure 13: Women's knowledge about services provided by health and family planning centers (%)

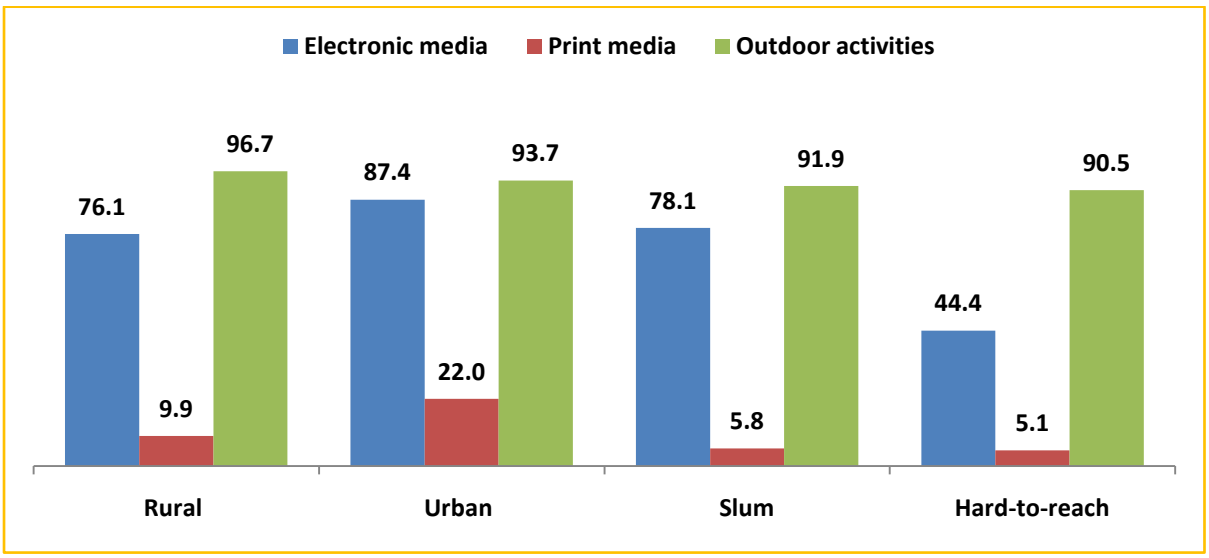


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.1.7 *Sources of information on health and family planning services*

Majority women (93.4%) got information about health and family planning services from outdoor activities of IEC/BCC followed by electronic media (70.5%) and print media (11.5%). Women living in hard-to-reach areas have much lower exposure to print and electronic media. However, women living in rural areas had the highest exposure to outdoor activities of IEC/BCC followed by urban, slum and hard-to-reach areas (Annex Table 2).

Figure 14: Sources of knowledge about health and family planning services



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

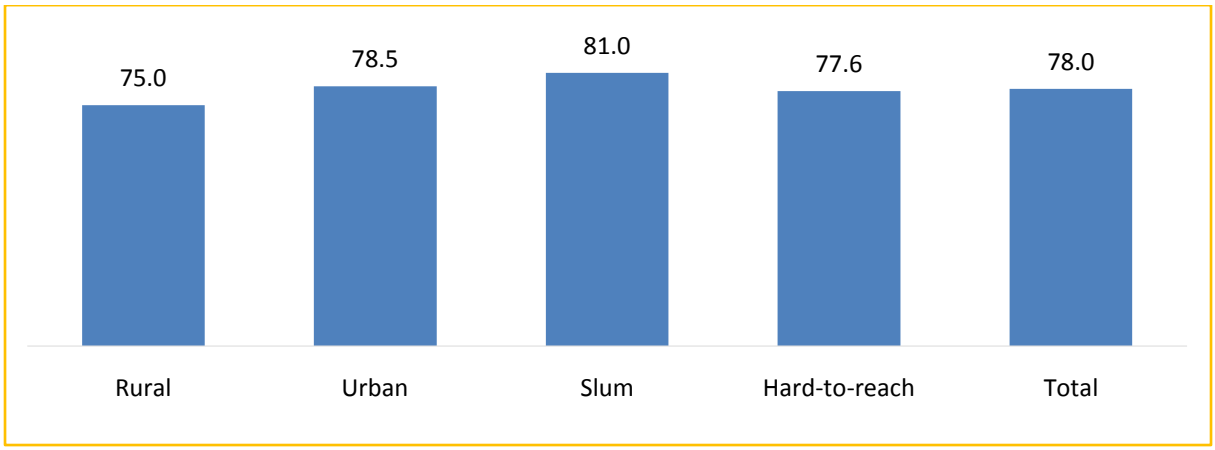
2.2 Findings of High Parity Women

This section presents knowledge and practices of high parity women in the areas of antenatal care, delivery care, postnatal care, newborn and child care, and family planning. As mentioned earlier, high parity women are those who had three or more children at the time of the survey.

2.2.1 Knowledge and practice of family planning practice among High Parity Women

Among high parity women 78.0 percent use family planning method. The contraceptive use rate in rural area is 75.0 percent, 78.5 percent in urban area, 81.0 percent in slums and 77.6 percent in hard-to-reach areas (Figure 15). More than one-third of the users of family planning use pill (38.5%) which is followed by injectable (20.6%), tubectomy (17.0%), implant (7.5%), condom (6.8%), calendar method (3.8%), NSV (3.2%), IUD (1.6%), and abstinence (1.1%). Government field worker/FWV is the major source of getting family planning methods (42.6%) among high parity women. Other sources of family planning methods include pharmacy (25.9%), UH & FWC (18.9%), upazila health complex (13.4%), community clinic (10.5%), NGO clinic/worker (7.7%), MCWC and hospital (6.1%).

Figure 15: Currently using any family planning method among high parity women (%)

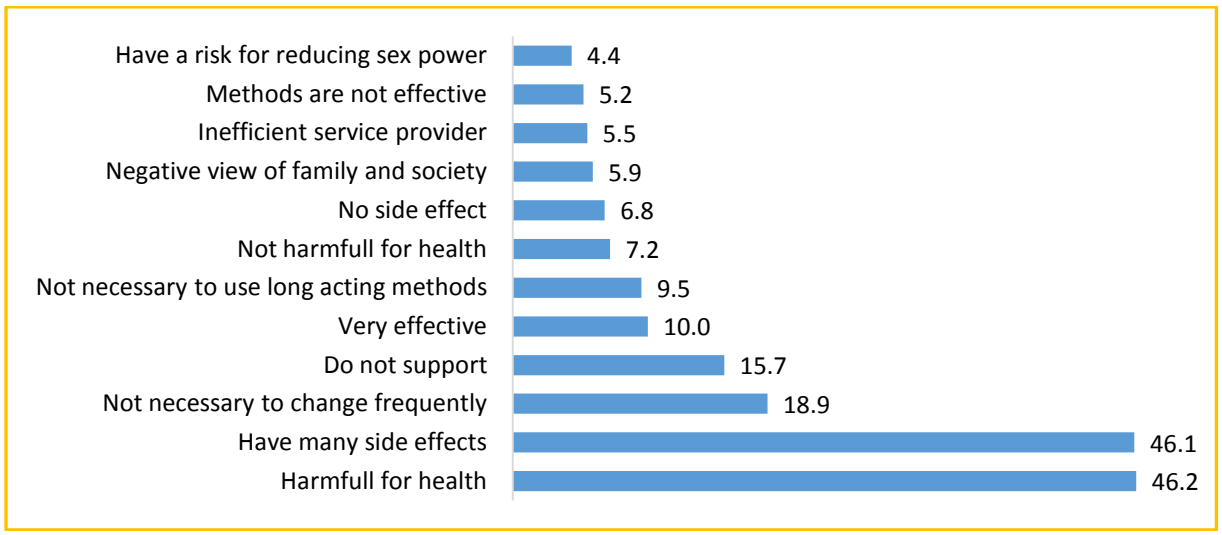


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.2.2 Attitude towards long acting family planning methods among High Parity Women

While most of the high parity women mentioned many negative aspects of long acting methods of family planning, some of them mentioned positive aspects as well. For example, about half of the high parity women mentioned that long acting methods were harmful for health and had many side effects. In addition, 15.7 percent high parity women even do not support long acting methods. Other negative aspects mentioned by high parity women include negative view of family and society (5.9%), inefficient service providers (5.5%), methods are not effective (5.2%), and have risk for reducing sex power (4.4%). On the other hand, many high parity women expressed positive attitude towards long acting methods of family planning such as not necessary to change frequently, very effctive, and not harmful for health (Figure 16).

Figure 16: Attitudes towards long acting methods among high parity women (%)

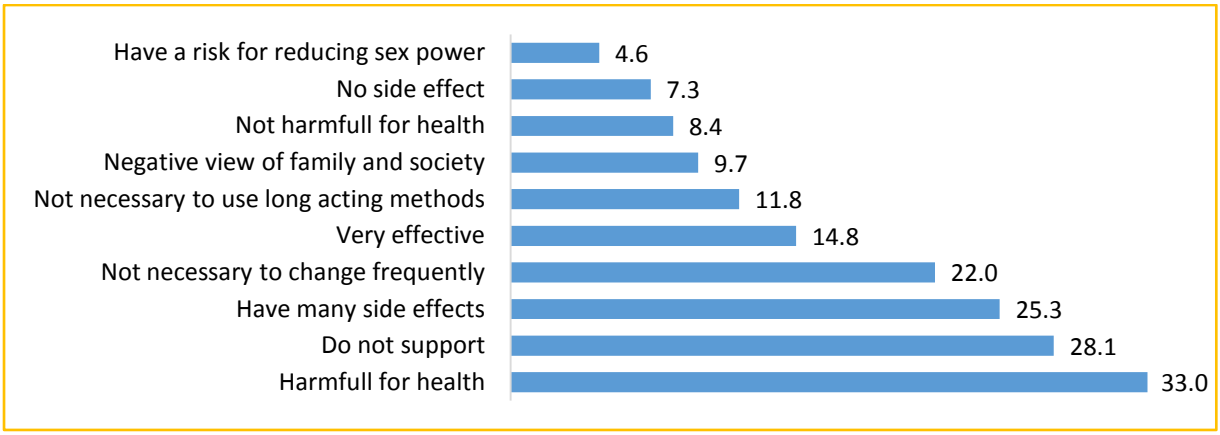


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.2.3 *Attitudes towards permanent methods among High Parity Women*

Similar to the attitude towards long acting method among high parity women, the attitude towards permanent methods were both positive and negative. About one-third women mentioned that permanent methods are harmful for health which is followed by do not support (28.1%), had many side effects (25.3%), negative view of family and society (9.7%) and had risk for reducing sex power (4.6%). On the contrary, positive attitudes expressed by high parity women includes not necessary to change frequently, very effective, not harmful for health, and no side effects (Figure 17).

Figure 17: Attitudes towards permanent methods among high parity women (%)



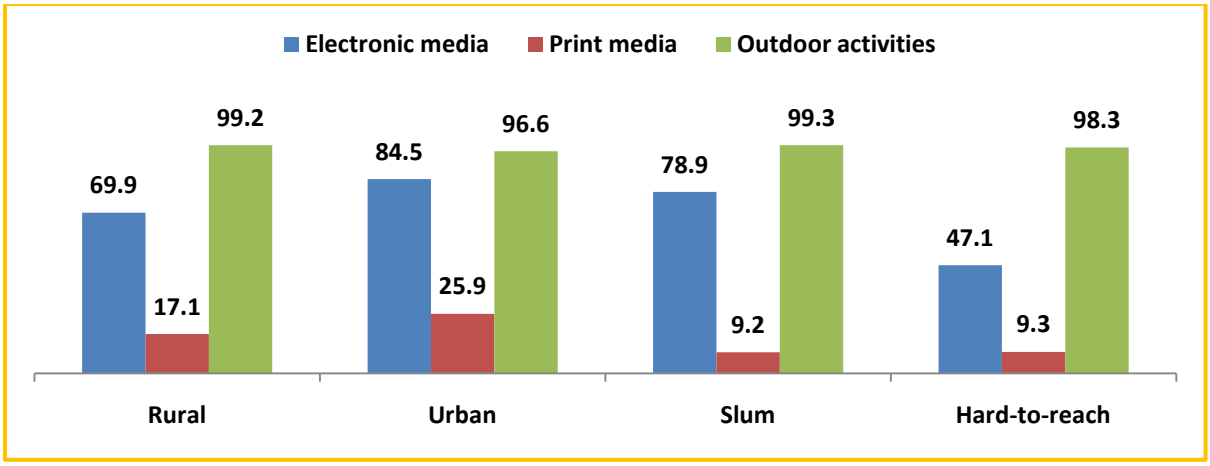
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

More than half of the women (52.7%) believe that STD and HIV/AIDS can be prevented by using condom. However, this knowledge of presenting STD and HIV/AIDS is the lowest in slum areas (37.2%) compared to rural, urban and heard-to-reach areas. Concerning the perception about taking more children all high parity women mentioned some negative consequences. For instance, more than two-third high parity women mentioned that having more children leads to health risk of mother which is followed by family insolvency (66.1%), malnutrition of mother (59.0%), malnutrition of newborn (34.5%), increased child mortality (19.2%), and future insecurity of family (13.9%).

2.2.4 *Sources of knowledge about family planningamong high parity women*

A vast majority high parity women were informed about family planning by the outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiary, folksong and street drama (98.3%). In addition, about half of high parity women mentioned that they learned about family planning from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Table 4).

Figure 18: Sources of knowledge about family planning among High Parity Women (%)

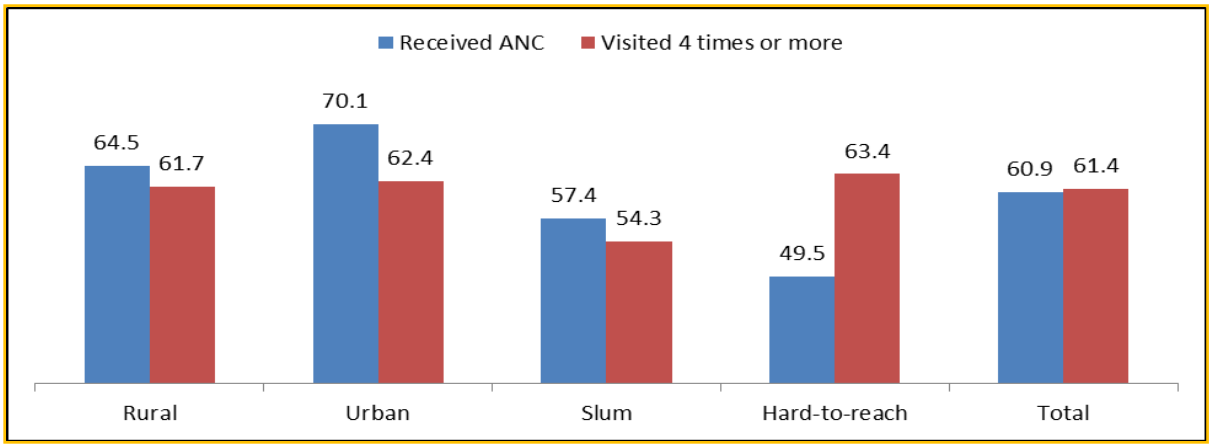


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.2.5 *Status of antenatal care among High Parity Women*

Majority high parity women (60.9%) had ANC during their last pregnancy. The rate of ANC during last pregnancy is 64.5 percent in rural areas, 70.1 percent in urban areas, 57.4 percent in slums and 45.5 percent in hard-to-reach areas (Figure 19). Majority high parity women receive checkup during pregnancy from UH & FWC, private clinic, NGO clinic, satellite clinic/EPI centre, district hospital, upazila health complex and community clinics. It was found that overall 61.4 percent high parity women had more than four ANCsduring pregnancy. However, women in urban area have the lowest rate of four plus ANCduring pregnancy (Figure 19).

Figure 19: Percentage of high parity women who did checkup during pregnancy



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

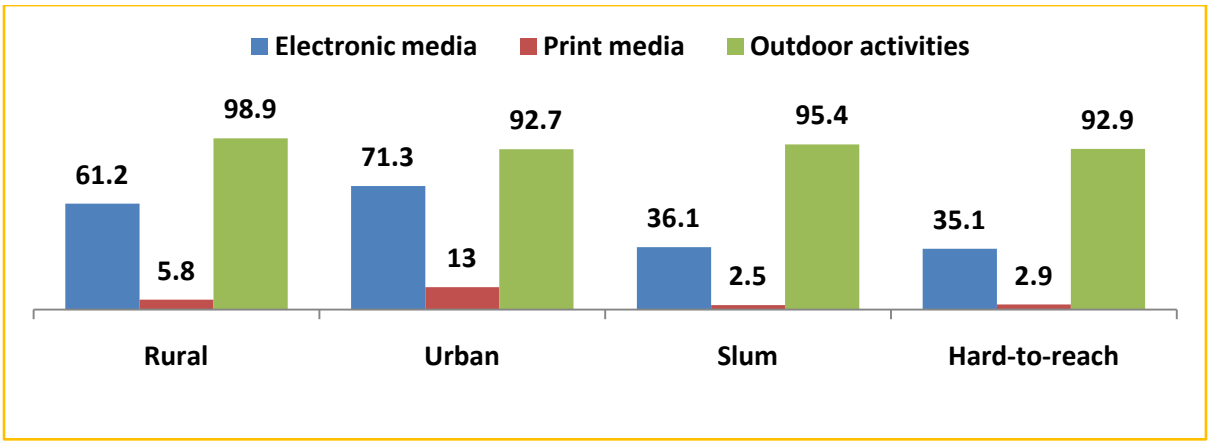
More than half of the high parity women (56.5%) received TT vaccination during pregnancy. The rate of taking vaccination is the highest in rural areas (63.3%) followed by slum (59.0%), hard-to-reach (53.1%) and urban areas (51.9%). It should be mentioned that the rate of TT vaccination during pregnancy is slightly lower because some women already have taken required number of TT vaccine before their last pregnancy.

All high parity women have some kind of knowledge about the necessity of care during pregnancy. For instance, 82.5 percent high parity women mentioned the necessity of providing extra food during pregnancy which is followed by not allowing to do heavy work, monitoring weight, taking iron tablets if needed and taking vaccination and vitamin A whenever needed.

2.2.6 *Sources of knowledge about antenatal care among High Parity Women*

Majority high parity women had been informed about antenatal care by the outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiary, folksong and street drama (93.8%). In addition, more than one third of high parity women mentioned that they learned about checkup during pregnancy from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Table 3).

Figure 20: Sources of knowledge about antenatal care among High Parity Women (%)

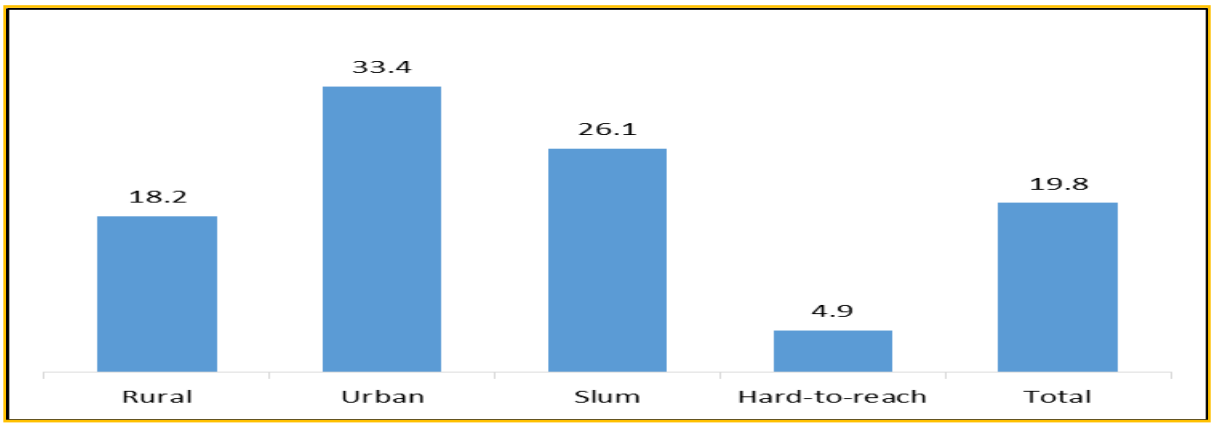


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.2.7 *Status and source of knowledge about delivery care among High Parity Women*

Among high parity women 19.8 percent age birth at facility. The rate of giving birth at facility is the highest in urban (33.4%) which is followed by slum (26.1%), rural (18.2%), and hard-to-reach areas (4.9%) (Figure 21).

Figure 21: Facility delivery of last birth among high parity women (%)

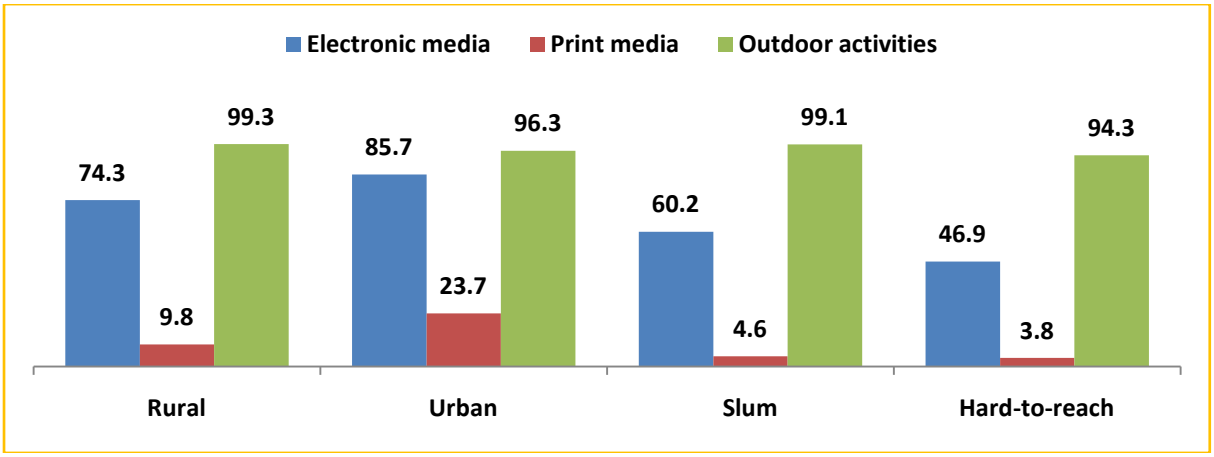


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.2.8 *Sources of knowledge about delivery care among High Parity Women*

Various outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiary, folksong and street drama are the major source of knowledge about delivery care among high parity women. Moreover, high parity women mentioned that they learned about delivery care during pregnancy from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Figure 22 &Annex Table 3). This pattern of gathering knowledge from IEC/BCC activities is also true in the case of women's sources of knowledge about caring for pregnant motherand place of delivery (Annex Table 3).

Figure 22: Sources of knowledge about delivery care among High Parity Women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.2.9 *Status of postnatal care among High Parity Women*

More than half of the high parity women (56.6%) have taken treatment/checkup within 42 days after delivery. The rate of PNC is highest in slums followed by hard-to-reach, rural and urban areas (Figure 19). More than one third of the high parity women who had taken treatment/checkup within 42 days of giving birth went to satellite clinics for the services followed by UH & FWC (12.9%), private clinics (12.5%), community clinics (12.0%), NGO clinics (11.3%), MCWC (8.5%), upazila health complex (7.3%), district hospital (7.0%), private hospital (5.8%) and medical college hospital (6.9%).

Figure 23: Treatment/checkup within 42 days after delivery among high parity women (%)

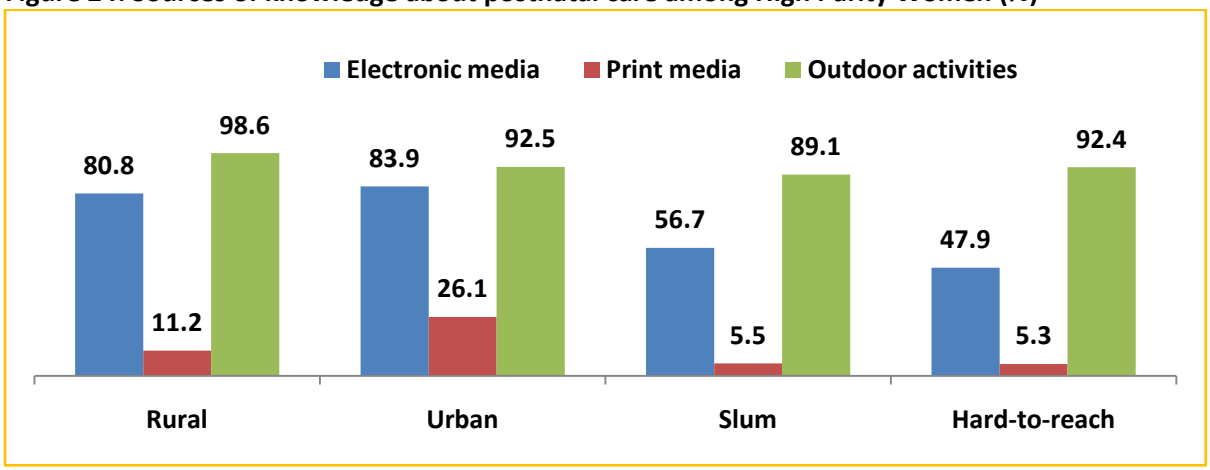
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Concerning knowledge about care for mother after delivery all high parity women have good knowledge. For example, 72.1 percent high parity women know about giving nutritious food which is followed by giving extra food (58.5%), taking adequate rest (57.0%), not allowing heavy work (56.4%), giving liquid food (21.4%), vaccination/Vitamin A (11.7%), and taking iron tablets when needed (10.3%).

2.2.10 Sources of knowledge about postnatal careamong High Parity Women

Majority high parity women had information aboutthe placesof treatment/checkup after delivery from outdoor IEC/BCC activities (95.1%). In addition, about half of high parity women mentioned that they learned about the placesof treatment/checkup after delivery from various activities of IEC/BCC broadcasted in electronic media. A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media. This pattern of getting knowledge from IEC/BCC activities is also true in the case of knowledge about caring for a mother after delivery (Annex Table 4).

Figure 24: Sources of knowledge about postnatal care among High Parity Women (%)



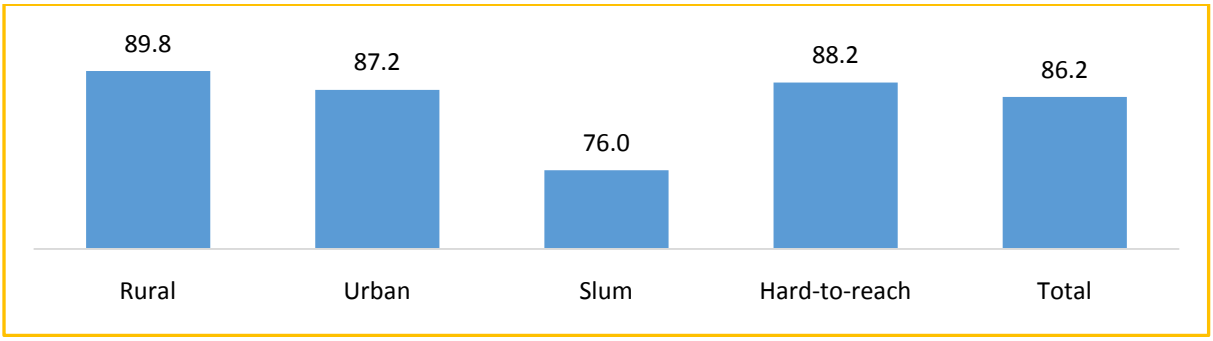
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.2.11 Newborn and child health among High Parity Women

All high parity women have some knowledge about necessity of taking care of newborn. For example, 78.9 percent high parity women mentioned the importance of feeding colostrum to newborns which is followed by exclusive breastfeeding till six months after birth (59.0%), breastfeeding with supplementary foods after six months (42.8%), giving vaccination (27.1%), giving vitamin A capsule (13.2%), and checking weights regularly (10.2%).

Concerning vaccination of last child it was found that Overall 86.2 percent high parity women gave vaccination, however, the rate of vaccination was the lowest in slums (76.0%) compared to rural, urban and hard-to-reach areas (Figure 25).

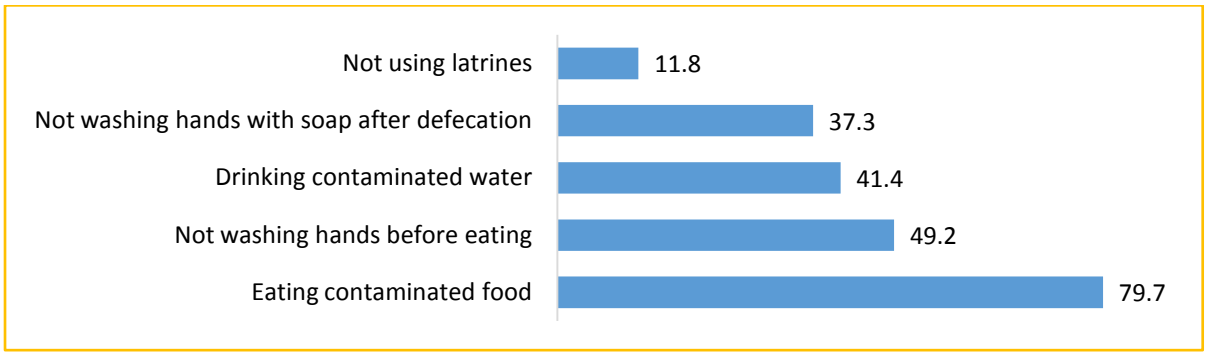
Figure 25: Vaccination of last child among high parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

More than two-third of the high parity women have given vitamin A capsule to their children. However, the rates of giving vitamin A capsule to children is the lowest in slums (59.0%) compared to rural (62.8%), urban (69.9%) and even in the hard-to-reach areas (73.8%). All high parity women have some sort of knowledge about various causes of diarrhea. For example, about eighty percent high parity women mentioned cause of eating contaminated food. Among other reasons mentioned by high parity women as causes of diarrhea were not washing hands before eating, drinking contaminated water, not washing hands with soap after defection, and not using latrines (Figure 26).

Figure 26: Knowledge about Causes of Diarrhea among high parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

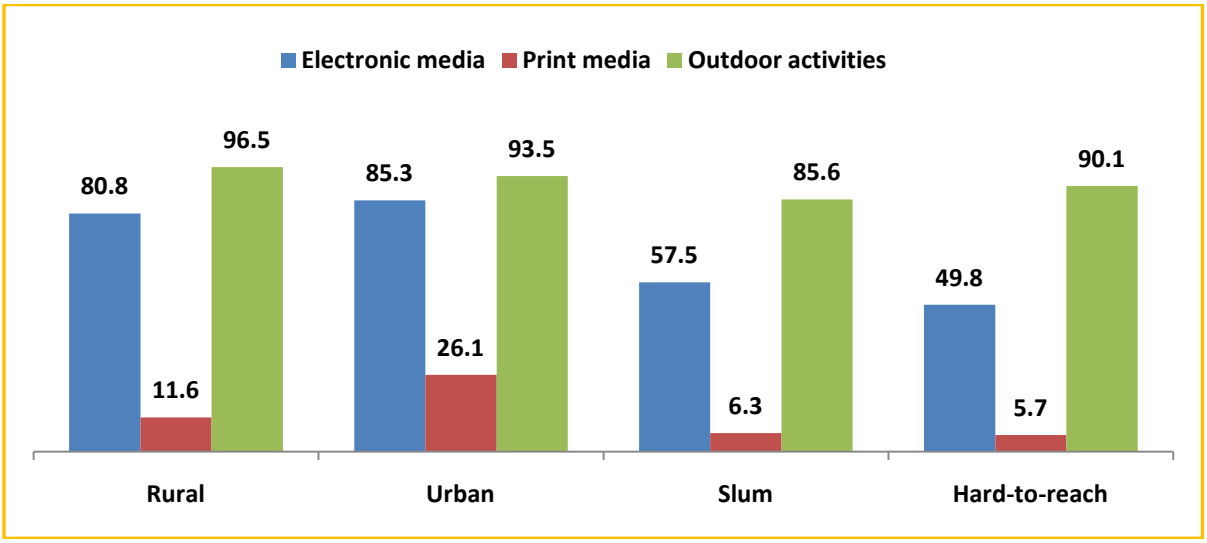
In addition to the knowledge among high parity women on Vitamin and diarrhea, they also have some knowledge about symptoms of Pneumonia of their children. For instance, 73.5 percent high parity women mentioned the symptom of quick breathing which was followed by cough and cold (72.5%), cough in the chest (39.9%), fever (30.7%), and unable to carryout breastfeeding (25.9%).

2.2.12 Sources of information about newborn and child care among High Parity Women

High parity women were highly benefitted from various activities of IEC/BCC regarding newborn and child health. For example, a vast majority high parity women got information about necessity of taking care of newborn, child immunization, giving Vitamin A capsule, taking care of diarrhea and Pneumonia affected children from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiary, folksong and street drama. Moreover, about half of the high parity women mentioned that they learned about taking care of newborn, child immunization, giving Vitamin A capsule, taking

care of diarrhea and Pneumonia affected children from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, Billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Tables 4).

Figure 27: Sources of knowledge about newborn and child care among High Parity Women (%)



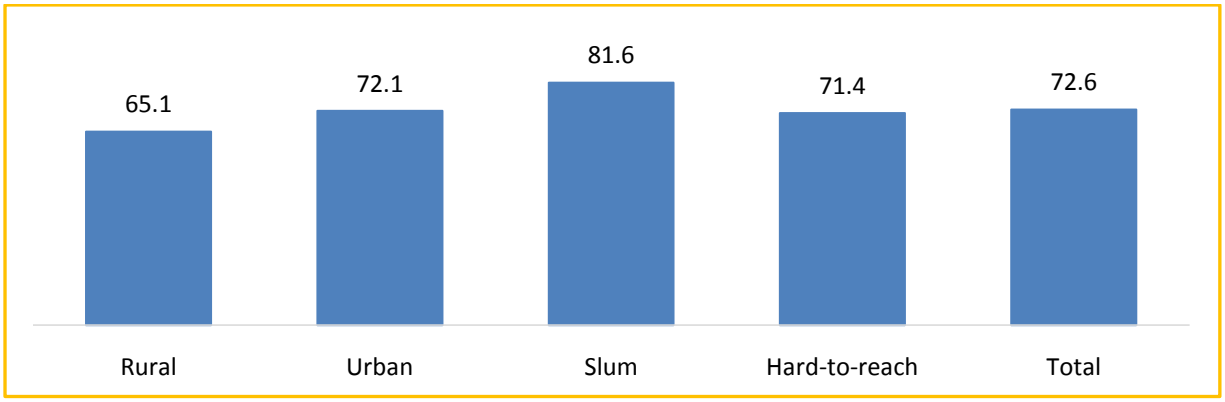
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.3 Findings of Low Parity Women

2.3.1 *Knowledge and practice of family planning among low parity women*

Among low parity women 72.6 percent are using any method of family planning. The contraceptive use rate is 65.1 percent in rural areas, 72.1 percent in urban areas. 81.6 percent in slums and 71.4 percent in hard-to-reach areas (Figure 28). The top five contraceptive methods used by low parity women are pill (57.7%), injectable (19.7%), condom (12.7%), implant (4.5%), and calendar method (3.0%). Majority of the contraceptive users collect family planning methods from Government field workers/FWV (43.4%), which is followed by pharmacy (41.6%), UH & FWC (15.2%), community clinics (11.9%), upazila health complex (5.9%), and MCWC (4.0%).

Figure 28: Currently using any family planning method among low parity women (%)

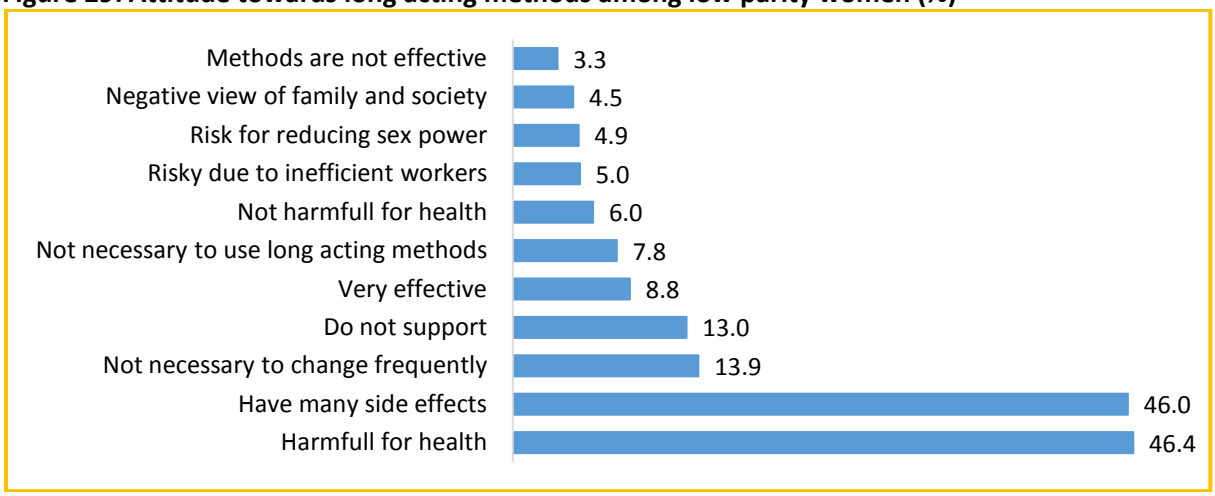


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.3.2 *Attitude towards long acting and permanent methods among low parity women*

Majority of the low parity women mentioned several negative consequences of long acting and permanent methods. For example, long acting methods are harmful for health, have many side effects, do not support, risky due to inefficient service providers, risk ofreduced sex power, negative views of family and society (Figure 29). These negative attitudes were also reported by low parity women in case of permanent methods of family planning. However, some of the low parity women also mentioned several positive aspects of both long acting and permanent methods of family planning such as not necessary to change frequently, very effective, not harmful for health, and no side effect.

Figure 29: Attitude towards long acting methods among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

More than half of the low parity women (62.4%) know that STD and HIV/AIDS can be prevented by using condoms. However, this percentage is much lower in slums (42.0%) and hard-to-reach areas (46.1%) compared to rural and urban areas. Most of the low parity women are aware about the negative consequences of having more children. For example, 73.3 percent mentioned that having more children is risky for mothers which is followed by family insolvency (66.4%), manlnutrition of mothers (57.8%), increased child mortality (19.9%), future insecurity of families (15.9%).

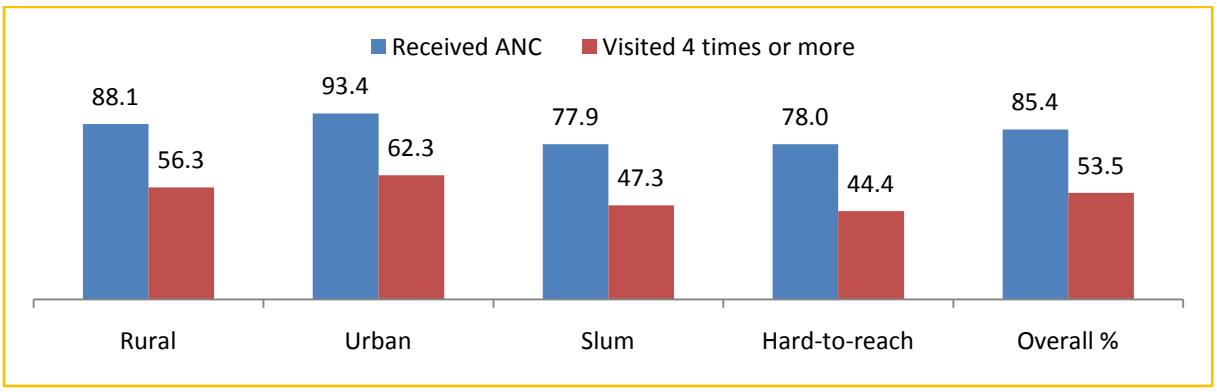
2.3.3 Sources of knowledge about family planning methods among low parity women

More than 95.0 percent low parity women were informed about family planning, knowledge about preventing STD and HIV/AIDS, and negative consequences of having children from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiaries, folksong and street drama. In addition, more than half of low parity women mentioned that they learned about family planning, knowledge about preventing STD and HIV/AIDS, and negative consequences of having children from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). Furthermore they were benefitted from IEC/BBC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Table 6).

2.3.4 Status of antenatal care (ANC) among low parity women

As mentioned earlier, in this study low parity women are those who have only one child at the time of the survey. Among low parity women 85.4 percent have done checkup during pregnancy. However, women living in slum and hard-to-reach areas have lower rate of ANC compared to rural and urban areas. On average, more than half of the low parity women had the required number of four and above ANC which is followed by rural, urban and slum areas. Although on average 13.1 percentage low parity women had one checkup during pregnancy, the rate is just half in urban areas (Figure 28).

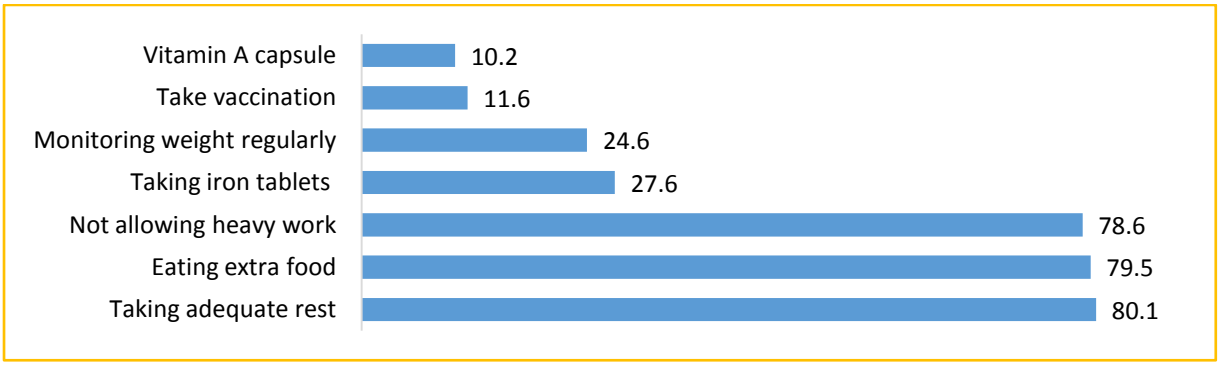
Figure 30: Getting checkup during pregnancy among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Among low parity women, 71.2 percent have taken TT vaccination during their last pregnancy. However, the rate of taking TT vaccination during pregnancy is higher in rural areas (72.0%) than urban areas (64.9%); and lower in hard-to-reach areas (72.5%) than slum areas (80.9%). Figure 31 shows that all low-parity women have some knowledge about necessity of care during pregnancy. For instance, about eighty percent low parity women mentioned the need for taking adequate rest and eating extra food. They also reported the need for not allowing heavy work, taking iron tablets when needed, monitoring weight regularly, taking vaccination, and Vitamin A capsule (Figure 31).

Figure 31: Knowledge about necessity of care during pregnancy among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

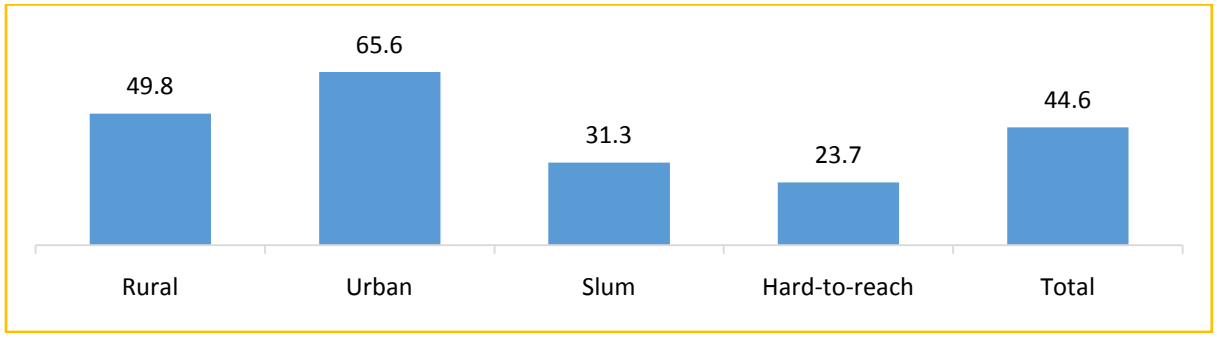
2.3.5 Sources of knowledge about antenatal care among low parity women

More than ninety percent low parity women received message about ANC and necessity of care during pregnancy from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiary, folksong and street drama. Moreover, more than half of low parity women mentioned that they learned about ANC and necessity of care during pregnancy from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, Billboard, poster, leaflet, brochure, flier, booklet and festoon. However, women living in slums and hard-to-reach areas had lower percentage of information on ANC from IEC/BCC activities from all three sources (Annex Table 5).

2.3.6 *Status of delivery careamong low parity women*

Among low parity women 44.6 percent gave birth in the facilities. The rate of facility delivery was highest in urban (65.6%) followed by rural (49.8%), slum (31.3%), and hard-to-reach (23.7%) areas (Figure 32). More than 96.0 percent low parity women learned about facility delivery from outdoor IEC/BCC activities, and more than half of the low parity women mentioned electronic media as their source of knowledge. It should be mentioned that the rate of using print and electronic media in gettingknowledge about place of delivery was lower in slum and hard-to-reach areas compared to rural and urban areas (Annex Table 5).

Figure 32: Rate of facility delivery of last child among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

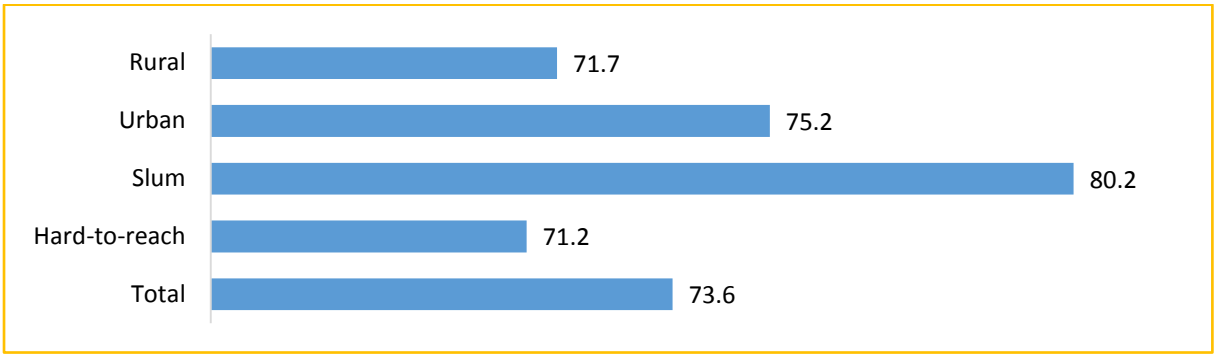
2.3.7 *Sources of knowledge about delivery care among low parity women*

Majority low parity women gathered knowledge about delivery care from outdoor IEC/SBCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiaries, folksong and street drama (95%). In addition, more than two third of low parity women mentioned that they learned about delivery care from various activities of IEC/SBCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of low parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Table 5).

2.3.8 *Status of postnatal care among low parity women*

Almost three in every four low parity women received treatment/checkup within 42 days of giving birth with slightly lower rate in rural and hard-to-reach areas compared to urban and slum areas (Figure 33). However, the rates of receiving checkup within seven days after giving birth are higher in rural and urban areas (41.9% and 53.3% respectively) than slum and hard-to-reach areas (about 30.0% in both cases). In rural areas, five major sources of receiving PNC within 42 days of delivery is satellite clinics, UH & FWC, private clinics, upazila health complex and district hospitals. This pattern is also consistent in other areas except for slums where one-fourth low parity women mentioned the name of NGO clinics.

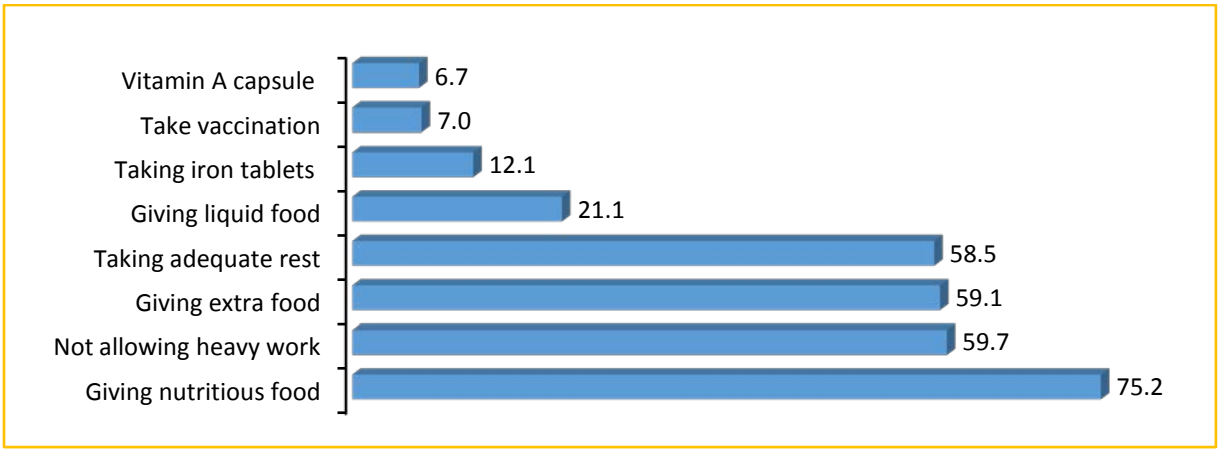
Figure 33: Treatment/checkup within 42 days after delivery among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Concerning knowledge about care for a mother after delivery it was found that 75.2 percent low parity women mentioned the importance ofnutritious food during post natal period which is flowed by not allowing heavy work, giving additionalfood, taking adequate rest, giving liquid food, taking iron tablets, taking vaccination, and Vitamin A capsule (Figure 34). Majority of the low parity women learned about PNC from outdoor IEC/BCC activities. Moreover, more than half of low parity women mentioned that they have been informed about PNC from various IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Table 5).

Figure 34: Knowledge about care for a mother after delivery among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

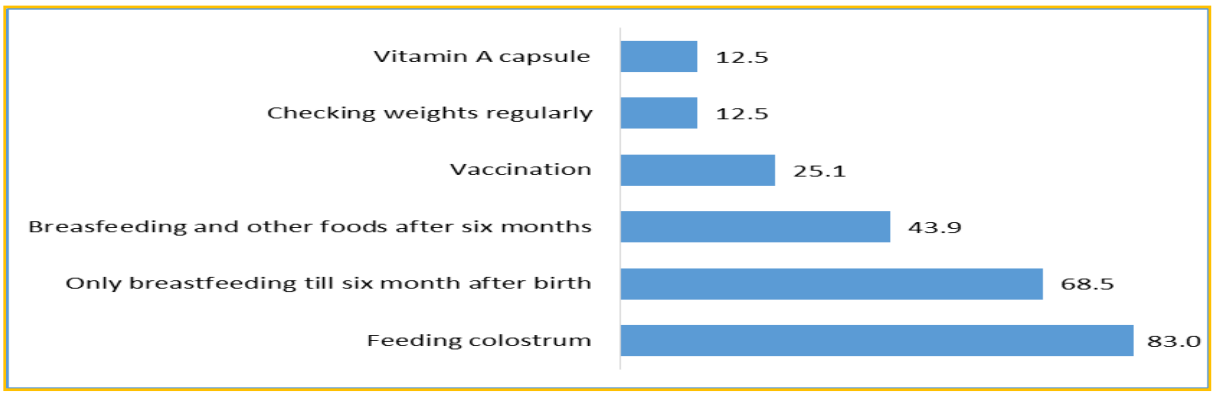
2.3.9 Sources of knowledge about postnatal care among low parity women

Majority low parity women were informed about postnatal care from outdoor IEC/BCC activities. In addition, about two-third low parity women mentioned that they learned about sources of PNC services from various activities of IEC/BCC broadcasted in electronic media. A small proportion of low parity women also reported that they were benefitted from IEC/BCC activities published in the print media (Annex Table 5).

2.3.10 Status of newborn and child care among low parity women

Majority of the low parity women have knowledge about necessacity of taking care of newborn. For instance, 83.0 percent of the low parity women know the importance of feeding colostrum which is followed by exclusive breastfeeding till six moths after birth, breastfeeding supplementary foods after six months, giving vaccination, checking weights regularly, and giving vitamin A capsul (Figure 35). In connection with this, it was found that 91.8 percent of the low parity women had given vaccination to their child. However, the rate of giving vaccination is the lowest among low parity women living in slums (83.3%).

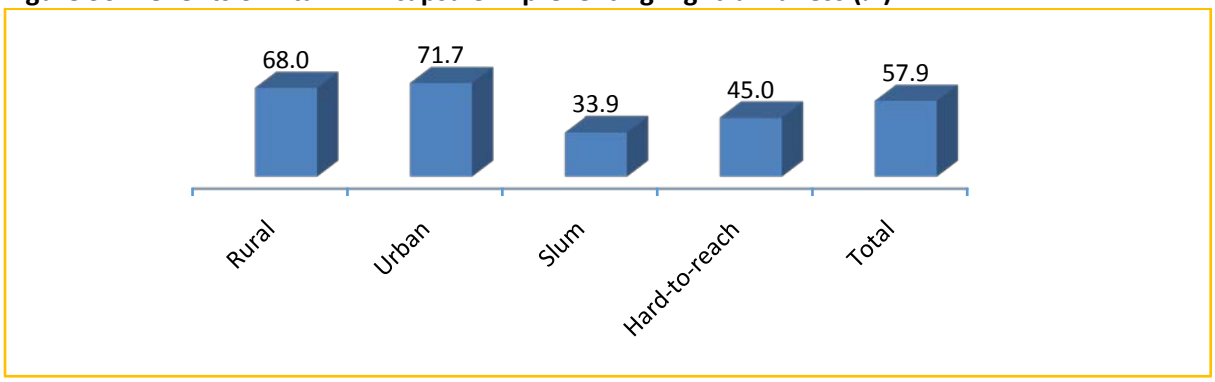
Figure 35: Knowledge about necessity of taking care of newborn among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Among low parity women more than 72.0 percent had provided vitamin A capsule to their children within last six months of the survey. However, the rate of providing vitamin A capsule is lowest among low parity women in slums (61.5%). Although more than 50.0 percent of the low parity women know the benefits of vitamin A in preventing night blindness only one-third women in slums are aware about the benefits of vitamin A (Figure 36).

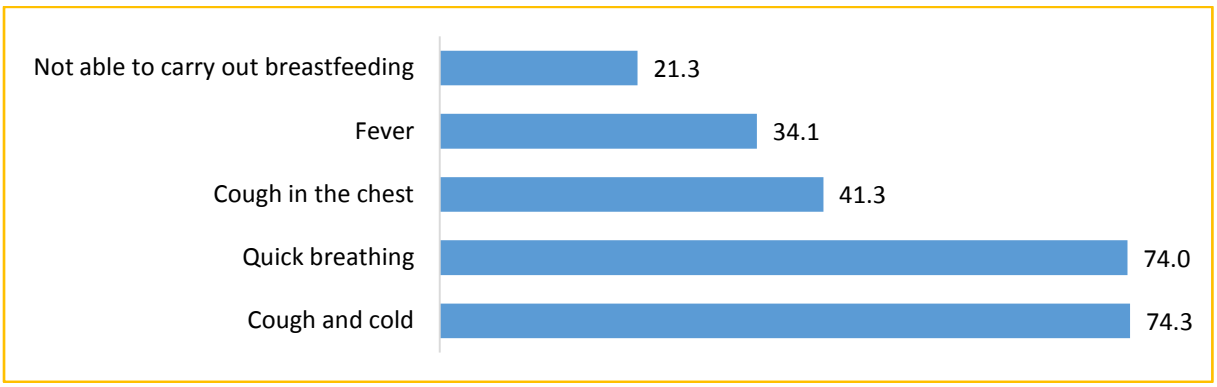
Figure 36: Benefits of vitamin A capsule in preventing night blindness (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Low parity women also have very good knowledge about required services for child diarrhea and symptoms of Pneumonia. For example, 98.6 percent low parity women know the importance of feeding saline which is followed by going to health center (44.7%), giving home-made liquid (31.7%), feeding normal saline (24.7%), and continuing breastfeeding (11.4%). They are also aware about various symptoms of Pneumonia such as cough and cold, quick breathing, cough in the chest, fever, and not able to carry out breastfeeding (Figure 35).

Figure 37: Knowledge about symptoms of Pneumonia among low parity women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.3.11 Sources of knowledge about newborn and child care among low parity women

More than ninety percent low parity women have got information about newborn and child care from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiaries, folksong and street drama. Moreover, more than half of low parity women mentioned that they learned about newborn and child care from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, Billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Table 6).

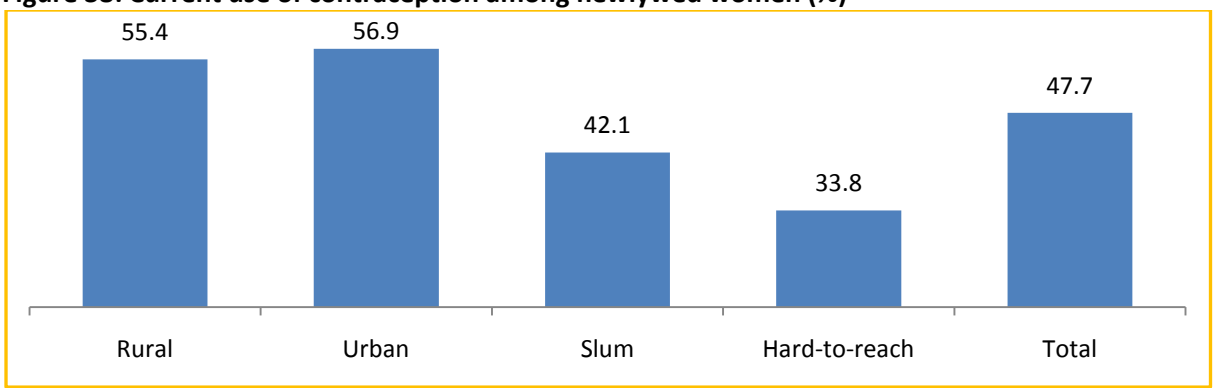
2.4 Findings of Newlywed Women

It should be mentioned that in this impact survey newlywed women are those who got married in the last 12 months of the survey. These women are neither pregnant nor have children at the time of the survey. As a result, we collected information on their knowledge about contraception, antenatal care, delivery care, postnatal care, and newborn and child care. In addition, information related to their knowledge and practices were also collected.

2.4.1 Knowledge and practice of family planning among Newlywed Women

Among newlywed women 47.7 percent were using family planning methods at the time of the survey. The use of family planning methods was the highest in urban areas (56.9%) and the lowest in hard-to-reach areas (33.8%) (Figure 38). Regarding the source of collecting contraceptive methods, 62.6 percent users mentioned pharmacy (blue star/general), which is followed by government field worker/FWV (32.5%), UH&FWC (13.5%), community clinic (8.1%), MCWC (5.5%), Upazila Health Complex (3.7%), hospital (3.0%), medical college (1.8%) and NGO clinic (1.2%).

Figure 38: Current use of contraception among newlywed women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.4.2 Sources of knowledge about family planning among Newlywed Women

More than 97.0 percent of the newlywed women mentioned that they were informed about family planning methods from outdoor activities of IEC/SBCC. A vast majority of the respondents also reported electronic media as a source for their knowledge of family planning methods and services. However, this percentage is much lower in hard-to-reach areas compared to rural and urban areas. The use of print media in gathering knowledge on family planning is the highest in urban areas (43.1%), followed by rural areas (33.8%), and hard-to-reach areas (7.9%) (Annex Table 8).

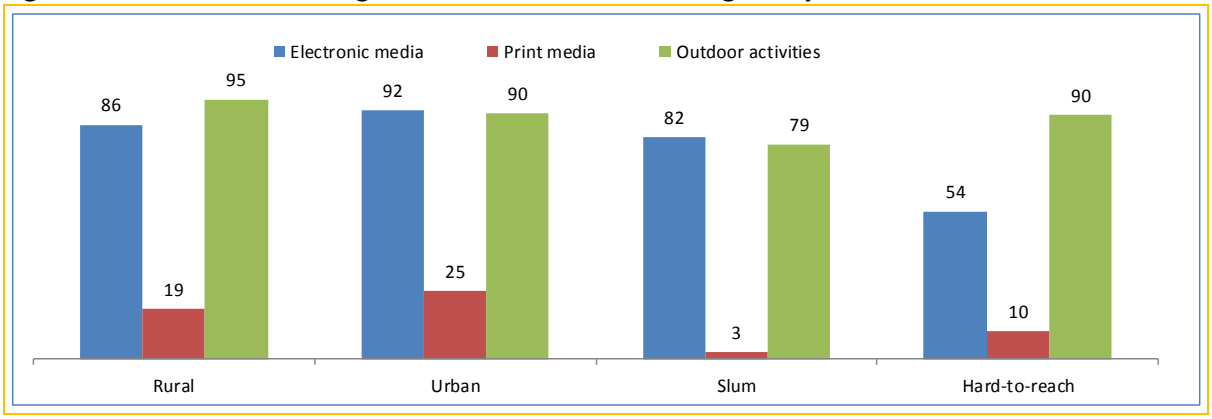
2.4.3 Status of Antenatal Care of Newlywed Women

Newly wed women were asked whether there is any necessity of checkup during pregnancy. All newlywed women mentioned that checkup during pregnancy was very much needed. However, only 58% of them mentioned that four or more checkups are needed during pregnancy. Majority of the newly wed women know the places for ANCduring pregnancy. For instance, more than half of the women mentioned the name of Upazila health complex which is followed by district hospital (42.2%), UH & FWC (35.3%), private clinic (33.3%), MCWC (20.6%), satellite clinics (15.7%), and community clinic (10.8%).

2.4.4 Sources of knowledge about antenatal care among Newlywed Women

More than 90 percent respondents were informed about ANC from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiaries, folksong and street drama (Figure 39). In addition, more than two third newlywed women mentioned that they learned about ANC from various IEC/BCC broadcasted in electronic media. In contrast, print media has smaller percentages in all categories of respondents in dissemination of knowledge related to antenatal care (Annex Table 7).

Figure 39: Source of knowledge about antenatal care among newlywed women

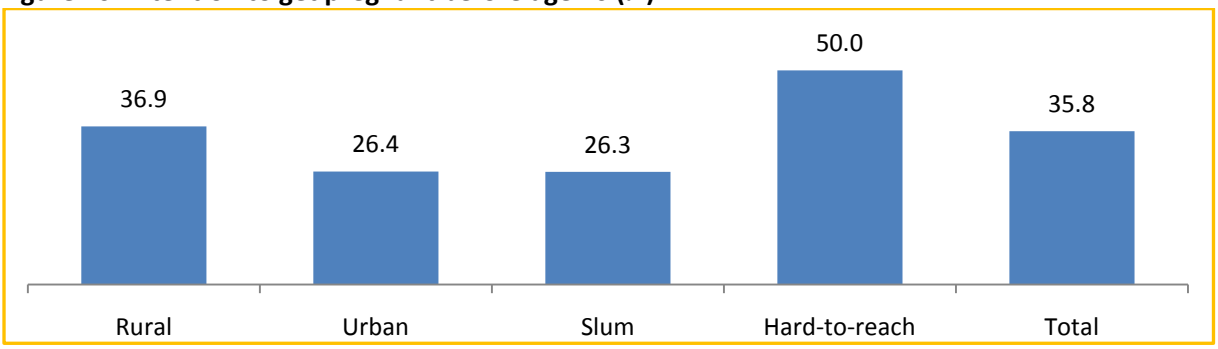


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.4.5 Status of delivery care among Newlywed women

All newlywed women mentioned that TT vaccination is needed during pregnancy. Overall, 35.8 percent newlywed women intended to get pregnant before 20 years of age. The proportion of newlywed women intended to get pregnant before age of 20 yearsis the highest for for newly wed women living in hard-to-reach areas (50%) and similar in urban and slums (26%) (Figure 40).

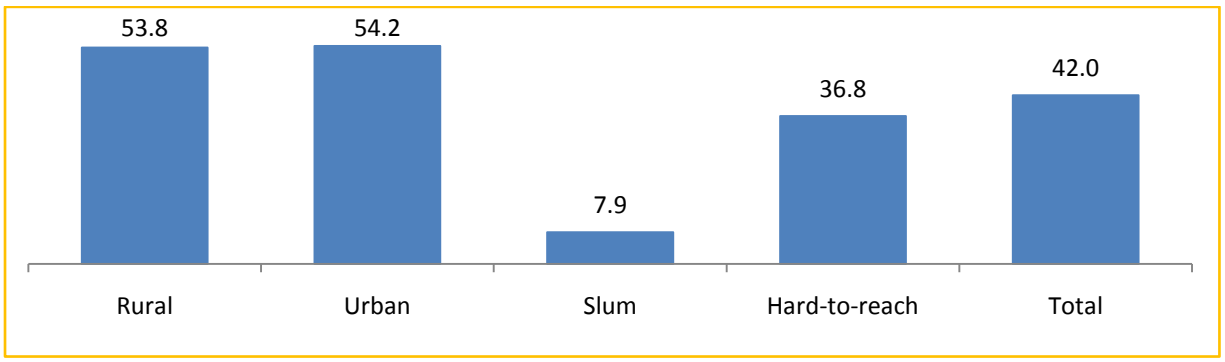
Figure 40: Intention to get pregnant before age 20 (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Concerning necessity of care during pregnancy 81.7 percent newlywed women mentioned not allowing to do heavy work which is followed by supplementary food (76.2%), taking adequate rest (73.2%), taking iron tablets when needed (21.3%), monitoring weight regularly (14.5%), taking vaccination (10.2%), and taking vitamin A capsule when needed (3.4%). Overall, 42.0 percent newlywed women intended to give birth at facility. The proportion of women who want to give birth at facility is more than 50.0 percent both in rural and urban areas but in slums it is only 7.9% (Figure 41).

Figure 41: Intention to give birth at facility among newlywed women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

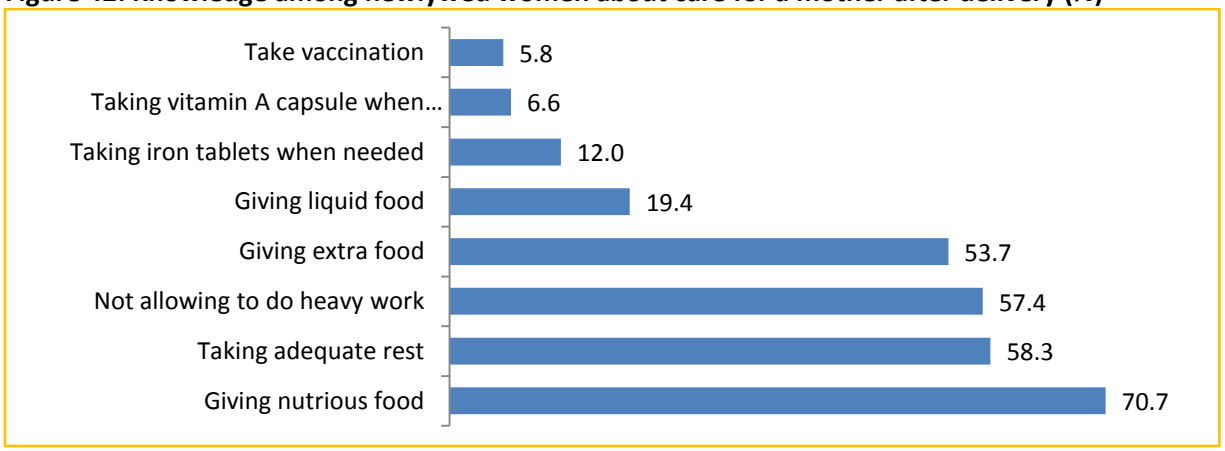
2.4.6 *Sources of knowledge about delivery care among Newlywed Women*

In consistent with that source of antenatal care most of the newlywed women reported that they were informed about delivery care from outdoor IEC/SBCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiaries, folksong and street drama. Although the use of electronic media in gathering knowledge for delivery care was more than 80.0 percent both in rural and urban areas it is only 53.1 percent in the case of hard-to-reach areas (Annex Table 7).

2.4.7 *Status of postnatal care among Newlywed Women*

Most of the newlywed women have knowledge about various care for a mother after delivery. For instance, 70.7 percent newlywed women mentioned the need for giving nutritious food which is followed by taking adequate rest, not allowing to do heavy work, giving extra food, taking iron tablets when needed, taking vitamin A capsule when needed, and taking vaccination (Figure 42)

Figure 42: Knowledge among newlywed women about care for a mother after delivery (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

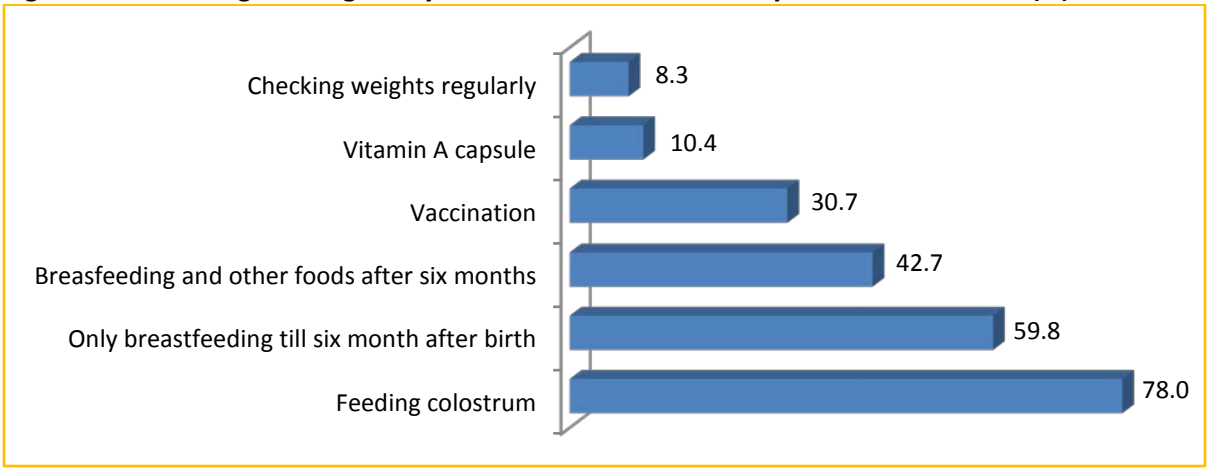
2.4.8 *Sources of knowledge about post natal care among Newlywed Women*

More than 90.0 percent newlywed women reported the source of outdoor activities of IEC/SBCC in gettingknowledge about postnatal care. The source of electronic media is also higher in rural and urban areas in gathering knowledge about postnatal care (90.0% and 91.5% respectively) but the rate is comparatively lower forhard-to-reach areas (57.4%). Again, print media as a source of gathering knowledge for postnatal care is the lowest among newlywed women in all categories of respondents (Annex Table 7).

2.4.9 Newborn and child care among Newlywed Women

Newly married women have very good knowledge about newborn and child care. For example, 78.0 percent newlywed women have knowledge about the importance of feeding colostrum to newborn followed by exclusive breastfeeding till six months after birth, breastfeeding and other foods after six months, giving vaccination, providing vitamin A capsule and checking weights regularly (Figure 43).

Figure 43: Knowledge among newlywed women about necessity of care of newborn (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

All newlywed women mention that vaccinationis necessary for the newborn babies. Similar to the high parity and low parity women, newlywed women have good knowledge about causes of child's diarrhea, required services for child's diarrhea, causes and symptoms of Pneumonia.

2.4.10 Sources of knowledge about newborn and child care among Newlywed Women

Newlywed women were highly benefitted from various activities of IEC/BCC related to newborn and child health. For example, a vast majority of newlywed women gathered knowledge about necessity of taking care of newborn, child immunization, giving Vitamin A capsule, taking care of children having diarrhea and Pneumonia from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiary, folksong and street drama. Moreover, more than half of newlywed women mentioned that they learned about taking care of newborn, child immunization, giving Vitamin A capsule, taking care of diarrhea and Pneumonia affected children from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Tables 8).

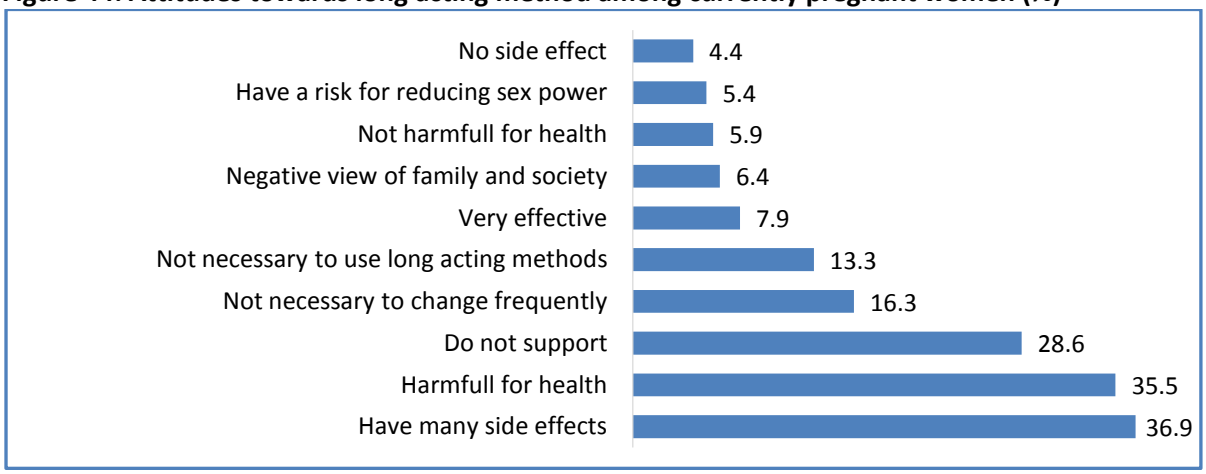
2.5 Findings of Currently Pregnant Women

2.5.1 *Knowledge and practice of family planning among currently pregnant women*

About 95.0 percent of currently pregnant women are interested in using family planning method after giving birth. The intention of using family planning method after giving birth among currently pregnant women is the lowest for women living in hard-to-reach areas (91.5%) and highest in urban areas (96.7%). Two-third of the currently pregnant women want to use pill and 20.0 percent want to use injectable, 1.5% want to use implant, 1.0% want to use IUD and only 0.5% want to do tubectomy.

Concerning attitude towards long acting methods, 36.9 percent currently pregnant women reported that long acting methods have many side effects which is followed by harmful for health, do not support, negative view of family and society, have risk of reduced sex power. However, many of the currently pregnant women also reported positive aspects about long acting methods of family planning such as need not to change frequently, very effective, and no side effect (Figure 44). It should be mentioned that attitude towards permanent method of family planning among currently pregnant women were almost identical to that of long acting methods except for one aspect: 38.4 percent currently pregnant women do not support permanent method of family planning.

Figure 44: Attitudes towards long acting method among currently pregnant women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

More than half of the currently pregnant women (56.8%) believe that use of condom can prevent HIV/AIDS and STD. The extent of this awareness is highest in rural areas (68.3%) and lowest in hard-to-reach areas (44.1%). Majority of the currently pregnant women are conscious about the negative aspects of having more children. For instance, 71.4 percent currently pregnant women believe that having more children would lead to family insolvency which is followed by health risk of mother (65.5%), malnutrition of mother (53.9%), malnutrition of newborn (27.2%), increase child mortality (16.0%), and future insecurity of family (12.1%).

2.5.2 *Sources of knowledge about family planning among currently pregnant women*

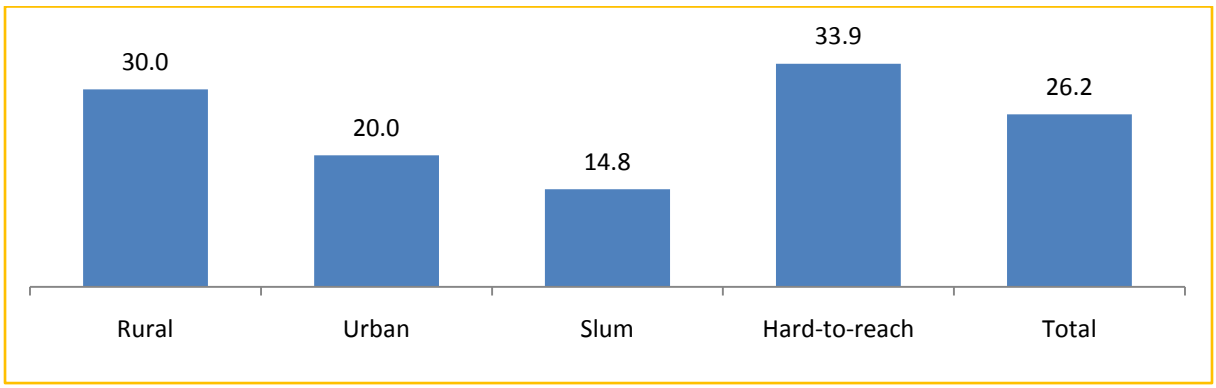
More than 94.0 percent of the currently pregnant women mentioned that they have got information on family planning from outdoor activities of IEC/SBCC. A vast majority of the respondents also reported electronic media as a source for their knowledge of family planning. However, this percentage is much lower in hard-to-reach areas compared to rural and urban areas. The use of print

media in gathering knowledge on family planning is highest in urban areas (25.0%), followed by rural areas (22.5%), and hard-to-reach areas (11.1%) (Annex Table 10).

2.5.3 *Status of antenatal care among currently pregnant women*

Among currently pregnant women, 26.2 percent reported that their pregnancy was unintended. The prevalence of unintendedpregnancy is highest in the hard-to-reach areas and lowest in the slums (Figure 45).

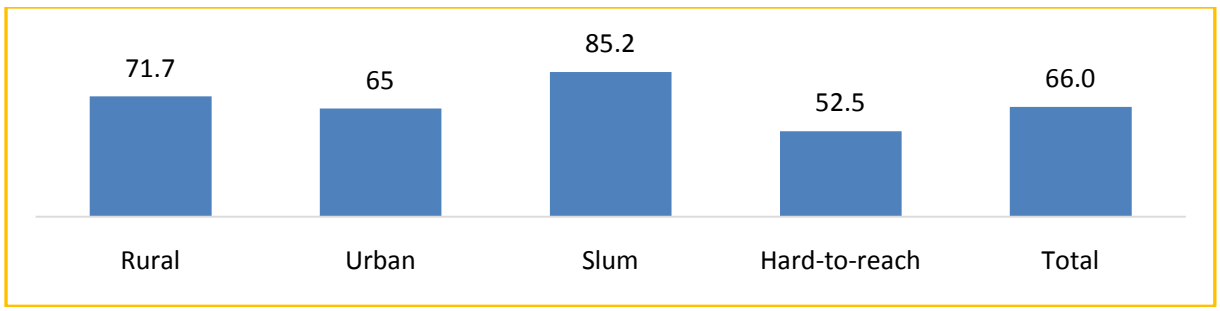
Figure 45: Prevalence of unwanted pregnancy among currently pregnant women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Among currently pregnant women 66.0 percent have done checkup during their pregnancy. The rate of checkup is highest in slums (85.2%) followed by rural, urabn and hard-to-reach areas (Figure 46). Among those who did not have any ANC 84.8 percent mentioned that they did not feel necessary to do the check up. In addition, about ten percent of them mentioned that they had financial crisis to do checkup during pregnancy. Top five sources of ANC were private clininc (25.7%), NGO clinic (11.8%), union health and FWC (11.0%), zilla hospital (10.3%), and satelite clinnc (8.8%).

Figure 46: Percentage distribution of currently pregnant women who have done checkup



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Among currently pregnant women only 20.6 percent have done four and above checkups during pregnancy. In addition, the percentage of four plus checkup among currently pregnant women is the lowest in slums (8.7%). It should be mentioned that during checkup women were mostly accompanied by their husbands 933.8%) followed by neighbors (13.2%), father-in-law/mother-in-laws (12.5%), parents (8.8%), brother-in-law/sister-in-laws (5.9%), and broth/sisters (4.4%).

Among currently pregnant women 46.1 percent have taken TT vaccine during pregnancy and the rate of taking TT vaccination is lowest in urban areas (41.7%). It should be mentioned that some of the currently pregnant women have taken required number of TT vaccines before current pregnancy for which they did not take TT vaccine during current pregnancy. Majority of the currently pregnant

women have knowledge about necessity of care during pregnancy. For instance, 81.6 percent currently pregnant women mentioned the importanceofnot allowing heavy work which is followed by eating additionalfood (81.1%), taking adequate rest (72.8%), taking iron tablets (27.2%), monitoring weights regularly (21.8%), taking vitamin A capsule (9.7%), and taking vaccination (9.2%).

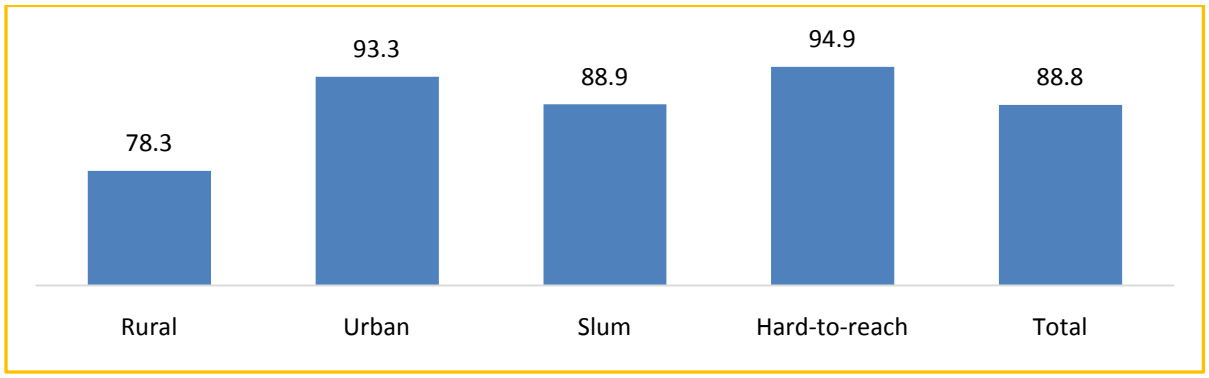
2.5.4 *Sources of knowledge about antenatal care among currently pregnant women*

More than 90.0 percent of the currently pregnant women learned about antenatal care from outdoor activities of IEC/BCC such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiaries, folksong and street drama. Moreover, more than half of low parity women in urban and rural areas mentioned that they learned about antenatal care from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). Furthermore they were benefitted from IEC/BBC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon. It should be mentioned that the rates of using IEC/BCC activities in slum and hard-to-reach areas were comparatively lower than other areas (Annex Table 9).

2.5.5 *Knowledge and intention about breastfeeding among currently pregnant women*

Among currently pregnant women 88.8 percent want to initiate breastfeeding immediately after birth. The intention to initiate breastfeeding immediately after birth is the highest in slums and lowest in rural areas (Figure 47). More than 90.0 percent currently pregnant women mentioned that they willfeed colostrum to their newborn. Among currently pregnant women 80.1 percent reported that they willcontinue exclusive breastfeeding up to six month after child birth.

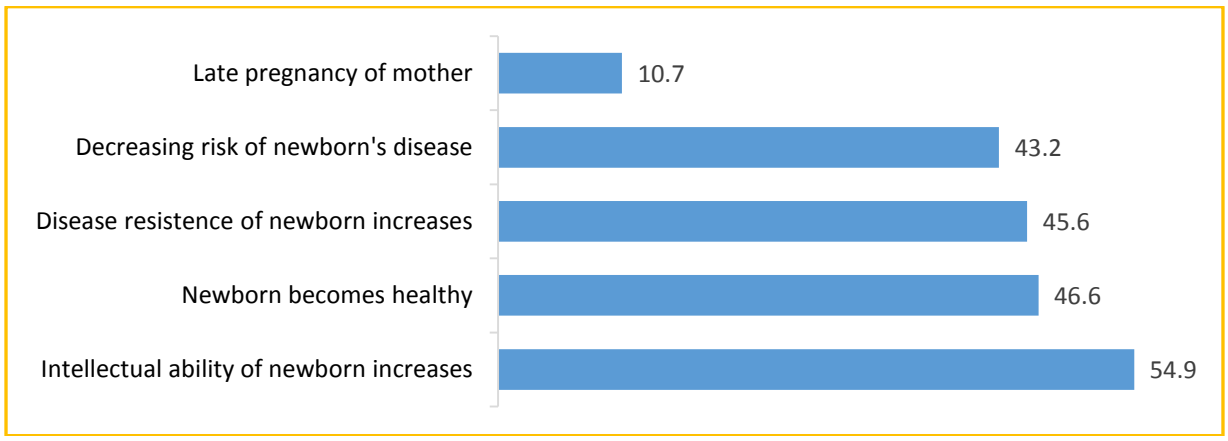
Figure 47: Percentage of women who want to initiate breastfeeding immediately after birth (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Currently pregnant women are also aware about benefits of breastfeeding. For example, currently pregnant women mentioned that benefits of breastfeeding includes increase in intellectual ability of newborn, newborn becomes healthyand disease resistant,and delayedpregnancy of mother (Figure 48).

Figure 48: Benefits of breastfeeding up to six months among currently pregnant women (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

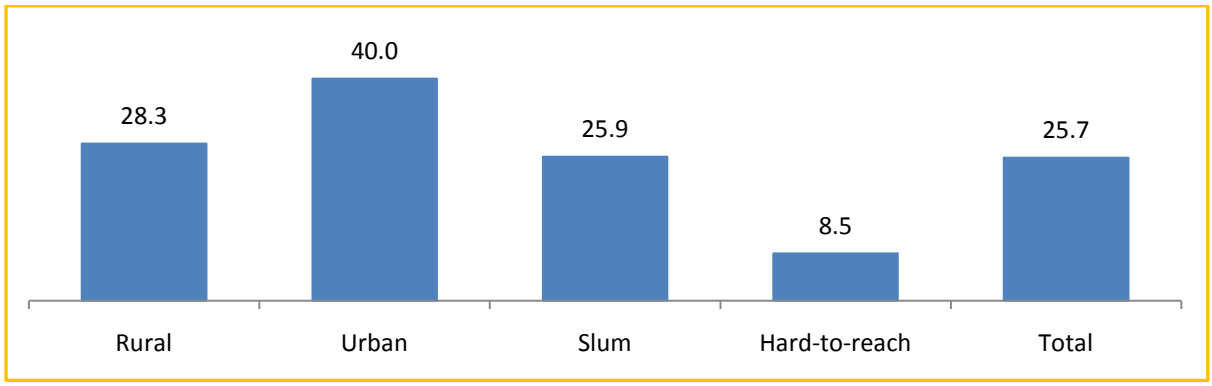
2.5.6 *Sources of knowledge about breastfeeding among currently pregnant women*

More than 90.0 percent currently pregnant women mentioned that they learned about various aspects of breastfeeding from outdoor IEC/SBCC activities which include family planning workers, health workers, NGO workers, billboards, polligan/folksong, courtyard meeting, workshop/ seminar, and street drama. In addition, electronic media as a source of information has been mentioned by 83.3 percent currently pregnant women in rural areas which is followed by urban areas (76.7%), slum (77.8%) and hard-to-reach areas (42.4%). However, only very small proportion of currently pregnant women reported print media as a source of information with regard to benefits of breastfeeding (Annex Table 10).

2.5.7 *Delivery and postnatal care among currently pregnant women*

Only one-fourth of the currently pregnant women intended to give birth at facility. The intention of giving birth at facility is the highest in urban areas and the lowest in rural areas (Figure 49). Similar to high parity, low parity, and newlywed women, currently pregnant women also have good knowledge about various care for a mother after delivery. For instance, 73.8 percent currently pregnant women reported the importanceofgiving nutritious food which is followed by not allowing to do heavy work (64.1%), taking adequate rest (56.8%), giving extra food (51.9%), giving liquid food (17.0%), taking iron tablets (8.7%), taking vaccination (6.3%), and taking vitamin A capsule (4.4%).

Figure 49: Percentage of currently pregnant women who intended to give birth at facility

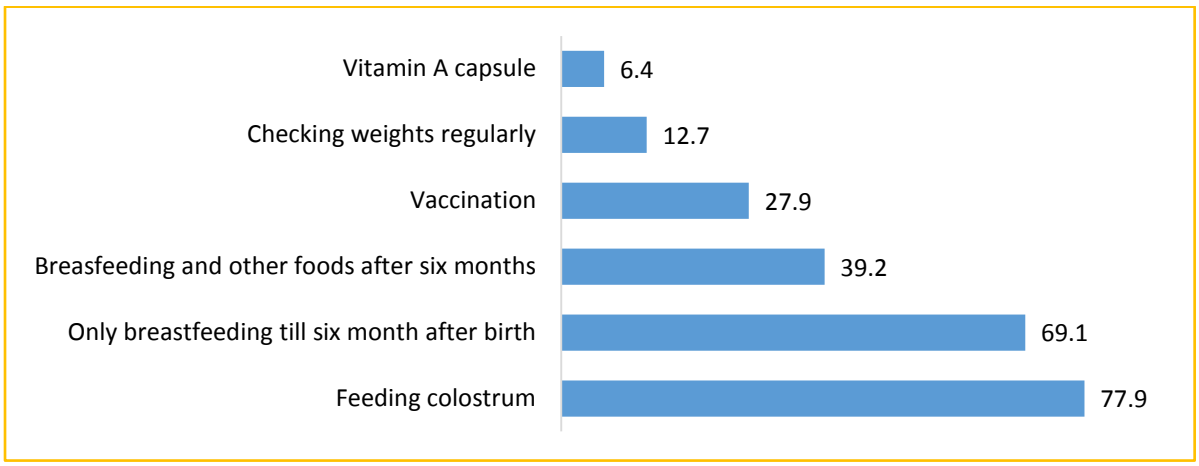


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.5.8 *Newborn and child care among currently pregnant women*

Findings related to knowledge among currently pregnant women about the necessity of taking care of newborn showed that 77.9 percent mentioned feeding colostrum to newborn is important which is followed by exclusive breastfeeding till six months after birth, breastfeeding with supplementary foods after six months, vaccination, checking weights regularly and providing vitamin A capsule (Figure 49).

Figure 50: Necessity of taking care of newbornamong currently pregnant women (%)



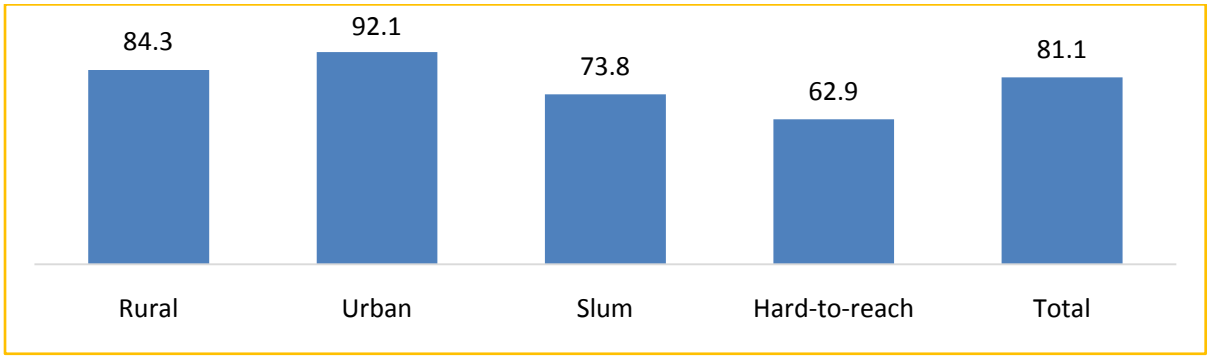
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.6 Findings of Lactating Mothers

2.6.1 *Knowledge and practice of family planning among lactating mothers*

Among lactating mothers 67.6 percent were using family planning methods at the the time of the survey. The rate of using methods were higher in slums (83.3%) followed by urban (70.5%), rural (65.2%) and hard-to-reach areas (62.8%). More than half of the contraceptive users were taking pills (51.3%) which is followed by condom (17.7%), injectables (17.2%), tubectomy (4.8%), implant (3.4%), abstinence (1.9%), IUD (1.5%), and NSV (0.7%). On average, they started using contraception after 6.1 months of giving births. The time to start using contraception after birth is the highest in slums (7.8 moths) which is followed by urban areas (7.4 months), rural areas (5.7 months), and hard-to-reach areas (3.5 months). Among lactating mothers 81.1 percent know about postnatal family planning methods. The percentage of women having this knowledge is the highest in urban areas (92.1%) and the lowest in hard-to-reach areas (62.9%) (Figure 51).

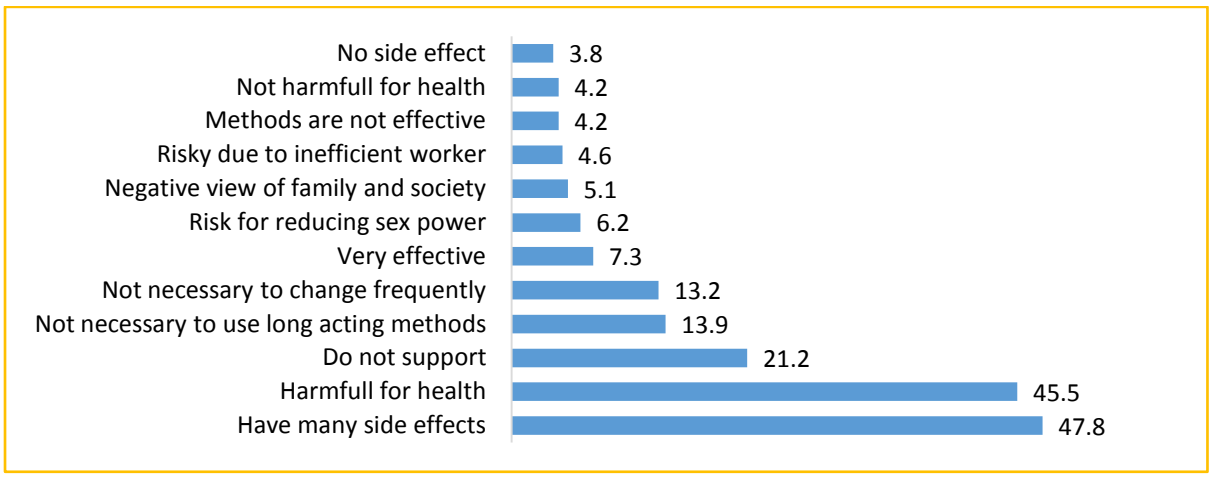
Figure 51: Knowledge about postnatal family planning method among lactating mothers (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Findings related to attitude towards long acting and permanent methods showed mixed results: both positve and negative. For example, 47.8 percent of the lactating mothers mentioned that long acting methods have many side effects which are followed by harmful for health, do not support, risk for reduced sex power, negative veiw of family and society, risky due to inefficient service providers, and methods are not effective. About 14.0 percent lactating mothers stated that long acting methods are not necessary to change frequently followed by very effective, not harmful for health, and no side effect (Figure 52). The finding related to attitude towards permanent methods among lactating mothers are similar to that of attitude towards long acting methods with an exception for the proportion of women who do not support. Among lactating mothers, 35.9 percent do not support permanent methods of family planning. It should be mentioned that the sources of knowledge about family planning methods among lactating morthers are also similar to that of high parity, low parity, and currently pregnant women (Annex Table 12).

Figure 52: Attitudes towards long acting methods among lactating mothers (%)

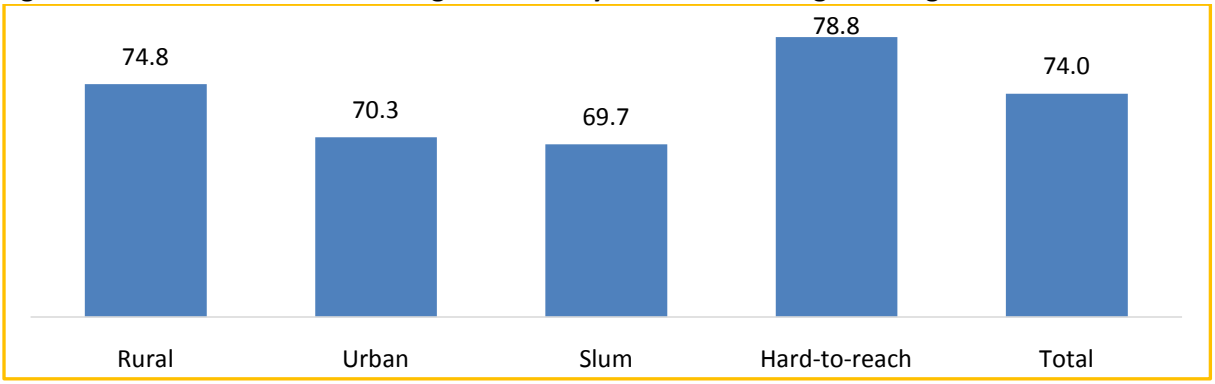


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.6.2 *Breastfeeding knowledge and practices among lactating mothers*

Overall 74.0 percent lactating mothers started breastfeeding immediately after birth, 19.6 percent lactating mothers started breastfeeding within 24 hours of birth, and 6.4 percent lactating mothers started breastfeeding after 24 hours of birth.The rate of starting breastfeeding immediately after birth is the highest in hard-to-reach area and the lowest in slums (Figure 53). Overall 98.3 percent lactating mothers fed colostrum to their babies with slight variations across place of residence.

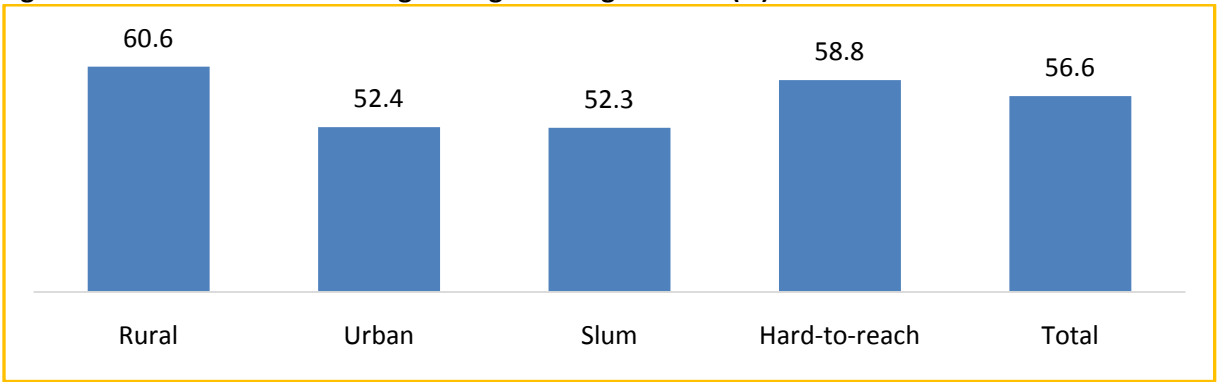
Figure 53: Initiation of breastfeeding immediately after birth among lactating mothers



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

In general, 56.6 percent lactating mothers did exclusive breastfeeding with the highest rate in rural areas and the lowest rate in slums (Figure 54). Majority of the lactating mothers know about the advantages of exclusive breastfeeding. For example, 51.3 percent lactating mothers mentioned no disease for newborn which is followed by increase in newborn's disease resistance (13.8%), no disease for mother (13.0%), no disease for mother and newborn (10.2%), and increase in mother's disease resistance (9.7%).

Figure 54: Exclusive breastfeeding among lactating mothers (%)



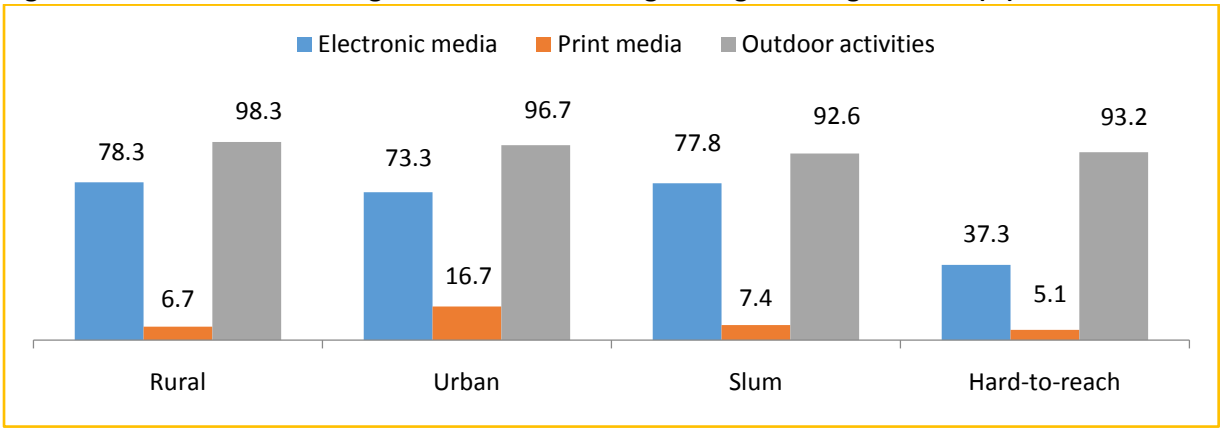
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Concerning giving other foods beside breastfeeding 93.4 percent lactating mothers mentioned that after six months they would start giving other foods beside breastfeeding, 3.3 percent lactating mothers reported that they would start giving other foods after one year, and 3.3 percent mentioned after two years. Among lactating mothers 41.6 percent are eating more to increase breast milk, and 7.0 percent taking more liquid.

2.6.3 *Sources of knowledge about breastfeeding among lactating mothers*

More than 90.0 percent lactating mothers gathered knowledge about breastfeeding from various outdoor activities of IEC/SBCC (Figure 55). The electronic source of gathering knowledge on breastfeeding from IEC/SBCC activities is the highest in rural areas (77.2%) and the lowest in hard-to-reach areas (43.1%). This is also true in the case of print media but the protions are very low compared to electronic and outdoor activities (Annex Table 11).

Figure 55: Sources of knowledge about breast feeding among lactating mothers (%)

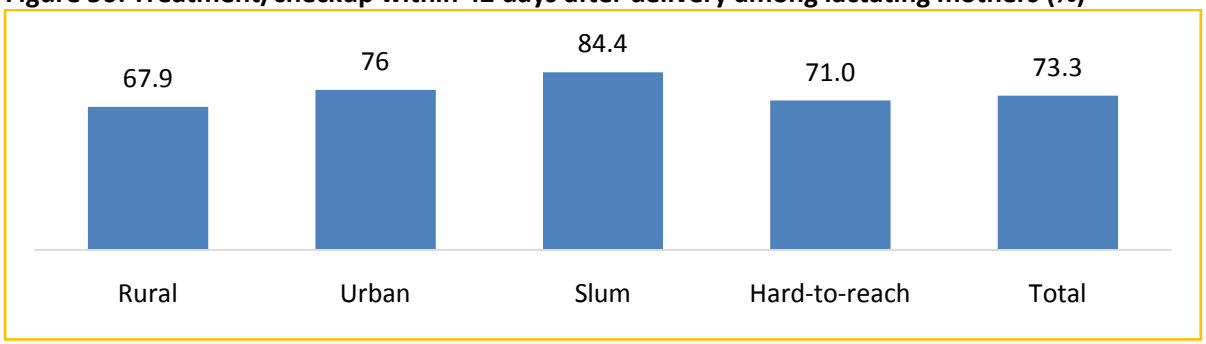


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.6.4 *Status of postnatal care among lactating mothers*

Overall, 73.3 percent lactating mothers did check up within 42 days after delivery with the highest rate prevailing in urban areas and the lowest rate prevailing in rural areas (Figure 56). Among those who had PNC within 42 days after delivery 42.4 percent did the check up within seven days of giving birth. The source of gathering knowledge on postnatal care among lactating mothers are similar to that of high parity and low parity women in all areas of residence.

Figure 56: Treatment/checkup within 42 days after delivery among lactating mothers (%)

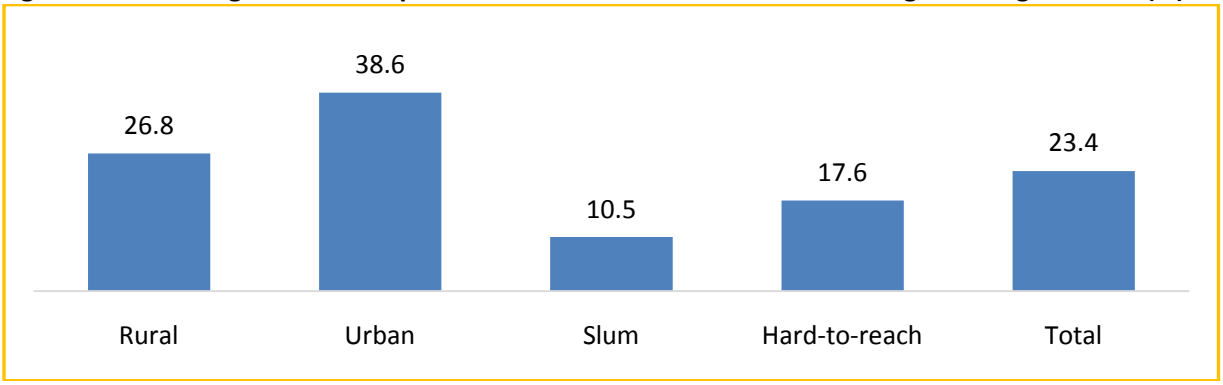


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.6.5 *Status of child care among lactating mothers*

Among lactating mothers 85.9 percent have given vaccination to their last child. The rate of giving vaccination to their children is the highest in urban areas (90.7%) and the lowest in hard-to-reach areas (83.3%). About one-fourth of the lactating mothers have given vitamin A capsule to their children within last 6 mothns of the survey with the highest rate prevailing in urban areas (38.6%) and th lowest rate prevailing in slums (10.5%) (Figure 57). Overall, three in every four lactating mothers know about benefits of vitamin A capsule in preventing night blindness. However, in slums and hard-to-reach areas the percentages of women who know the benefits of vitamin A are lower compared to rural and urban areas.

Figure 57: Providing vitamin A capsule for child within last 6 months among lactating mothers (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

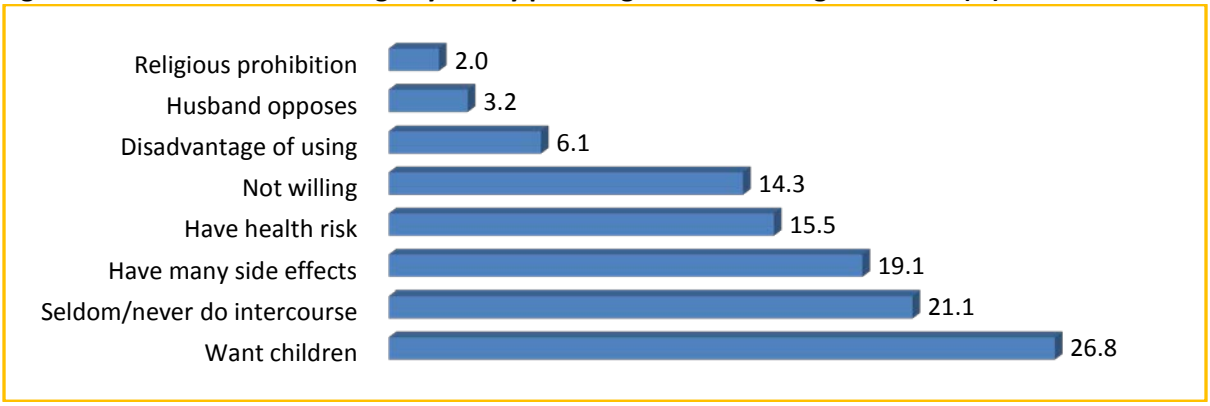
Lactating mothers also know various causes of diarrhea such as eating contaminated food (79.0%), not washing hand before eating (63.8%), drinking contaminated water (58.1%), not washing hands with soap after defecation (35.7%), and not using latrines (10.5%). Concerning required services for child's diarrhea, lactating mother mentioned the need for feeding saline (95.7%), going to the health centre if needed (45.2%), continuing breastfeeding (25.5%), feeding home made liquid (31.7%), and normal feeding (27.4%). The sources of knowledge about child care among lactating mothers were identical with that of high parity, low parity, and newlywed women showing higher use of outdoor activities followed by electronic and print media activities of IEC/SBCC (Annex Table 11).

2.7 Findings of Non-User Women of Family Planning

2.7.1 *Knowledge and practice of family planning among non-user of family planning*

Regarding causes for not using contraception, 26.8 percent nonusers mentioned that they want more children which is followed by seldom/never do intercourse, have many side effects, not willing, disadvantage of using contraceptives, husband opposes, and religious prohibition (Figure 58).

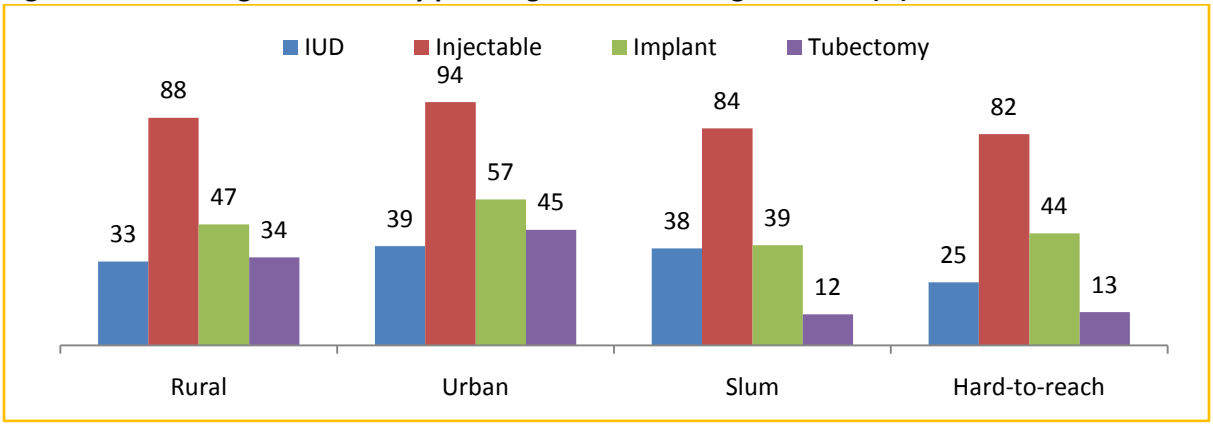
Figure 58: Reasons for not using any family planning method among non-users (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

It should be mentioned that all nonuser women have heard about family planning methods. They know name of several methods such as pill (98.9%), injectables (87.7%), condom (72.7%), implant (47.7%), IUD (32.6%), tubectomy 28.3%), and NSV (10.9%). Nonusers knowledge about long acting and permanent methods by study area is shown in Figure 59. Overall, 75.0 percent nonusers know that health and family planning centers provide family planning services. However, this knowledge is the lowest in slums (68.3%) compared to rural areas (77.1%).

Figure 59: Knowledge about family planning methods among nonusers (%)

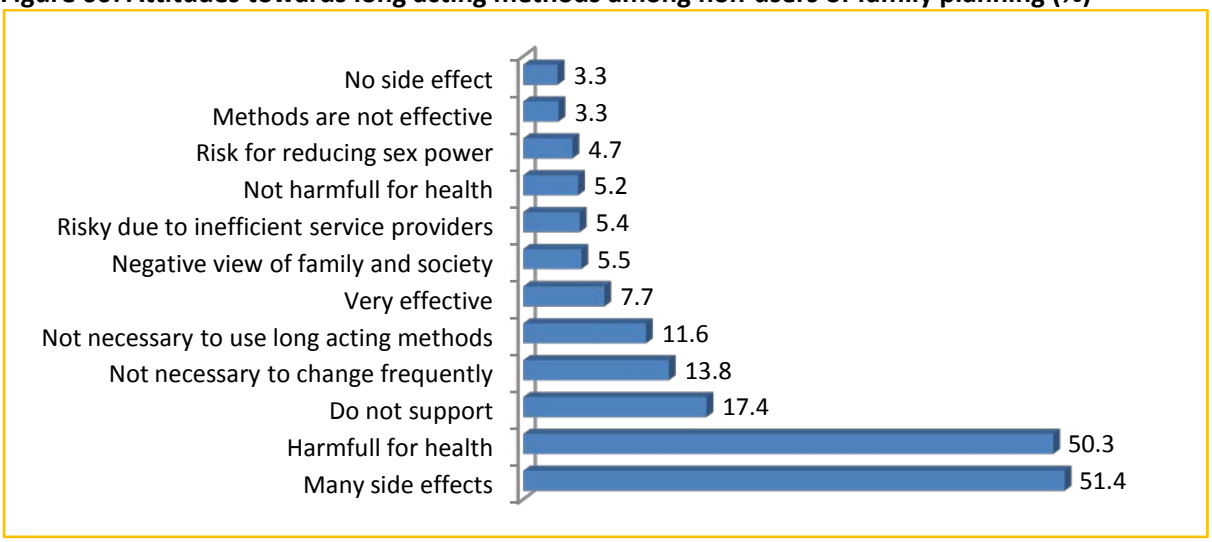


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Concerning attitude towards long acting methods of family planning, 51.4 percent nonuser women mentioned that those had many side effects which is followed by harmful for health, do not support, negative view of family and society, risky due to inefficient service providers, risk reduced sex power, and methods are not effective. However, 13.8 percent nonuser women stated that the advantage of long acting methods is that it was not necessary to change frequently which was followed by very effective not harmful for health, and no side effect (Figure 60). The findings related to attitudes

towards permanent methods are identical with that of longacting methods except for percentage of women not supporting. Among nonuser women 32.8 percent do not support permantment menthods.

Figure 60: Attitudes towards long acting methods among non-users of family planning (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

More than half of the nonuser women know that STD and HIV/AIDS can be prevented by using condom (55.9%). The percentage of these women who know that use of condom can prevent STD and HIV/AIDS is the highest in urban area (77.1%) followed by rural (56.5%), hard-to-reach (42.7%) and slum (37.0%). Considering all these factors, overall 37.4 percent nonuser women intend to take family planning services in future.

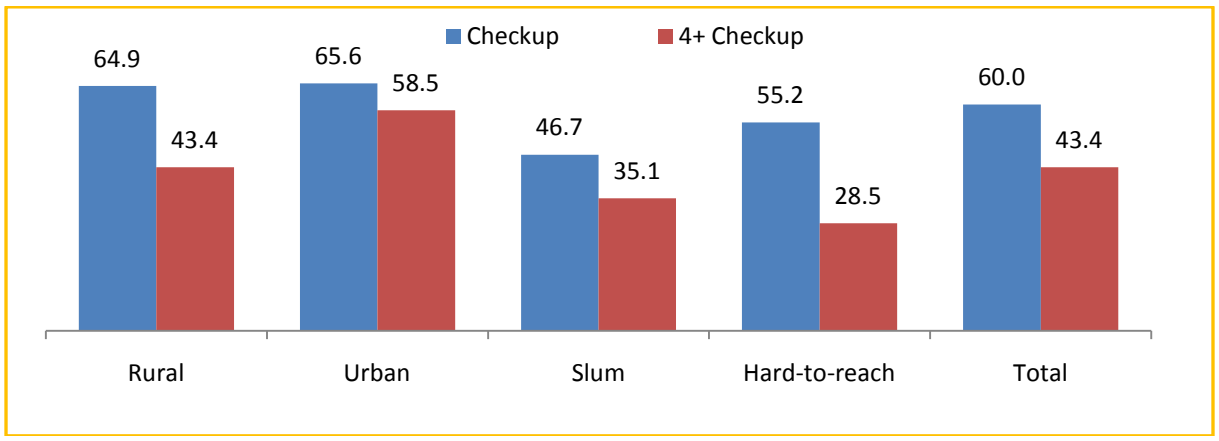
2.7.2 *Sources of knowledge of family planning among nonuser women*

More than 90.0 percent nonuser women gathered knowledge about family planning from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, court yard meetings, workshop/seminars, satisfied beneficiary, folksong and street drama. In addition, more than half of the nonuser women mentioned that they learned about family planning from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of high parity women also reported that they were benefitted from IEC/BCC activities published in the print media such as newspaper and magazines, quarterly, newsletter, billboard, poster, leaflet, brochure, flier, booklet and festoon (Annex Table 13).

2.7.3 *Status of antenatal care among non-user of family planning*

Among non-user women of family planning methods (hereafter nonusers) 60.0 percent have done at least one ANC checkup in last pregnancy. The rates of at least one checkup during pregnancy are almost identical in rural and urban areas with the lowest rate prevailing in slums. However, the rate of 4+ ANC checkups among non-users in last pregnancy is 73.4 percent with the lowest rate in hard-to-reach areas (Figure 61). One-fourth of them have done checkup at private clinics which is followed by Upazila health complex (17.9%), union health and FWC (16.6%), satellite clinics (15.8%), NGO clinics (14.1%), Zilla hospital (13.4%), mother and child service centre (10.1%), community clinic (8.3%), and private hospital (3.6%).

Figure 61: At least one checkup and 4+ checkups in last pregnancy among non-users (%)



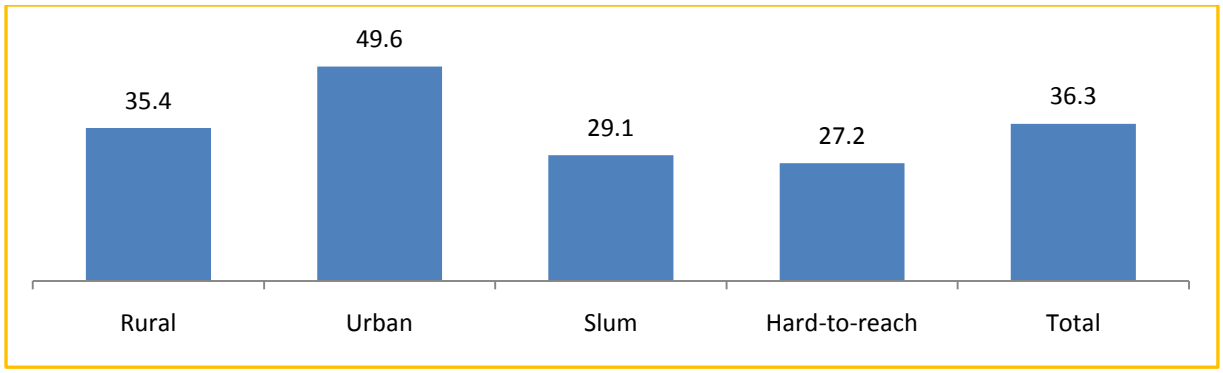
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Among the non-users 59.7 percent have taken TT vaccination during last pregnancy. The rate of taking TT vaccination during last pregnancy among nonusers is the highest in rural areas (66.0%) which is followed by slums (58.2%), urban (57.6%), and hard-to-reach areas (56.3%). Majority of the nonuser women are aware about various care during pregnancy such as eating additionalfood (80.0%), taking adequate rest (77.8%), not allowing heavy work (73.9%), monitoring weight regularly (20.8%), taking iron tablets (20.6%), taking vaccination (7.9%), and taking vitamin A capsule (3.9%). It should be mentioned that the sources of knowledge among nonusers about ANC care are similar to that of high parity and low parity women (Annex Table 13).

2.7.4 Status of delivery careamong non-user of family planning

Among nonusers of family planning 36.3 percent women gave births their last child at facility. The rate of giving birth among nonusers in facility is the highest in urban and the lowest in hard-to-reach areas (27.2%) (Figure 62). More than 90.0 percent of the nonusers learn about delivery care from outside IEC/SBCC activities. In addition, 83.7 percent nonuser women mentioned the source of electronic media in urban areas which is followed by rural (73.4%), slum (61.8%) and hard-to-reach areas (38.1%). The source of print media for gathering knowledge on delivery care was the highest in urban areas (27.7%0 and the lowest in slums (4.8%) (Annex Table 13).

Figure 62: Facility delivery of last child among nonusers of family planning (%)

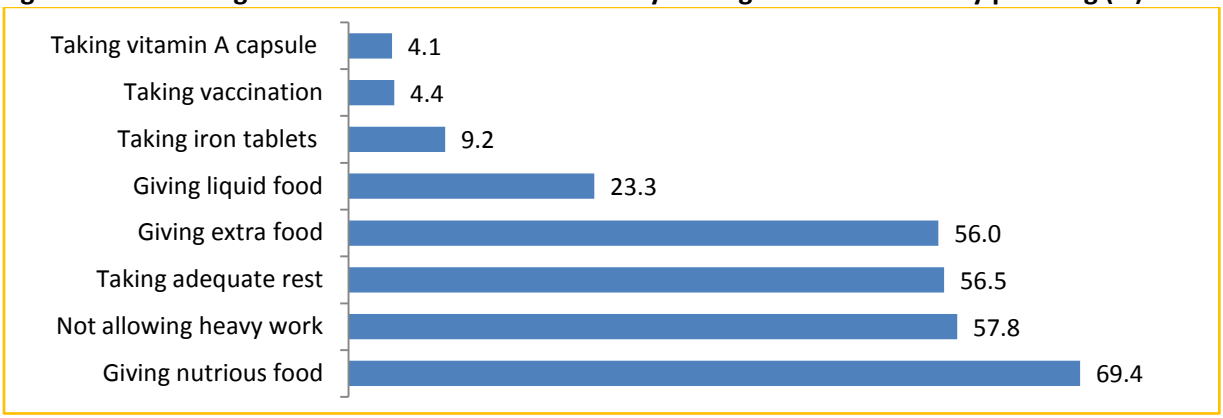


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.7.5 Status of postnatal care among non-user of family planning

More than half of the nonuser women have done checkup/treatment within 42 days after delivery. The rate of checkup is highest in slums (56.4%) and lowest in rural areas (47.1%). Majority of the nonuser women are aware about various care for a mother after delivery such as giving nutritious food (69.4%), not allowing heavy work (57.8%), taking adequate rest (56.5%), giving additionalfood (56.0%), giving liquid food (23.3%), taking iron tablets (9.2%), taking vaccination (4.4%), and taking vitamin A capsule (4.1%) (Figure 63). Regarding sources of knowledge about postnatal care among nonuser women it was found that outdoor activities of the IEC/SBCC was their predominant source of gettinmg information about postnatal care followed by electronic source and print media (Annex Table 13).

Figure 63: Knowledge of care for mother after delivery among nonusers of family planning (%)

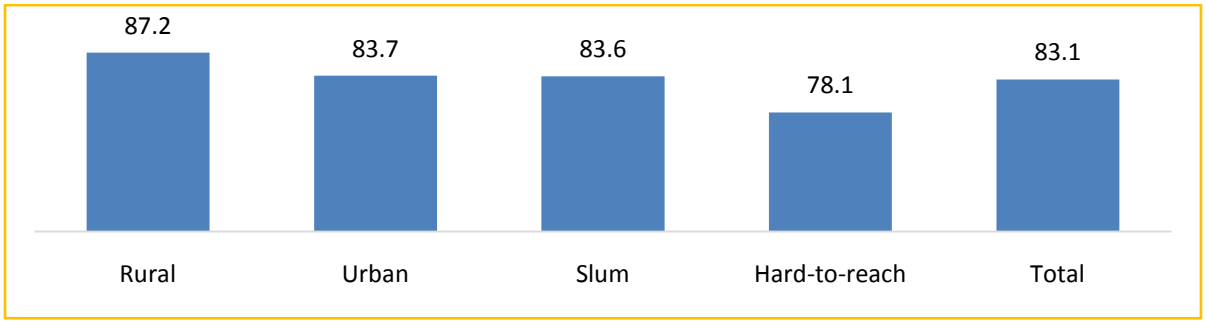


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.7.6 Newborn and child care among non-user of family planning

Nonuser women of family planning methods have very good understanding about taking various care of newborn such as feeding colostrum (82.5%), exclusive breastfeeding till six months after birth (62.1%), breastfeeding and other foods after six months (43.4%), vaccination (29.3%), vitamin A capsule (9.1%), and checking weights regularly (8.8%). Regarding vaccination it was found that 83.1 percent nonuser women gave vaccination to their last child with the highest rate prevailing in rural areas and the lowest rate in hard-to-reach areas (Figure 64).

Figure 64: Giving vaccination to your last child among non-users (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Among nonuser women only one-third have given vitamin A capsule to their children within last six months. This rate is highest in hard-to-reach areas (38.9%) followed by rural (33.0%), urban (32.5%) and slum (22.4%). However, majority of nonuser women know that benefits of taking vitamin A capsule include prevting night blindness (59.7%), and no disease (30.5%). They also know which foods contain vitamin A such as vegetables (87.3%), fish and meat (66.4%), egg-milk (64.9%), fruits

(64.4%) and sweet potato (4.6%). In addition, nonuser women of family planning also have knowledge about causes of child diarrhea and required services for treatment of child diarrhea similar to that of other categories of women such as high parity and low pairty women. It should be mentioned that majority nonuser women gathered knwoledge about newborn and child care from various outdoor activities of IEC/SBCC and electronic media (Annex Table 13).

2.8 Findings of Adolescent Girls

2.8.1 *Knowledge about health and family planning centres among adolescent girls*

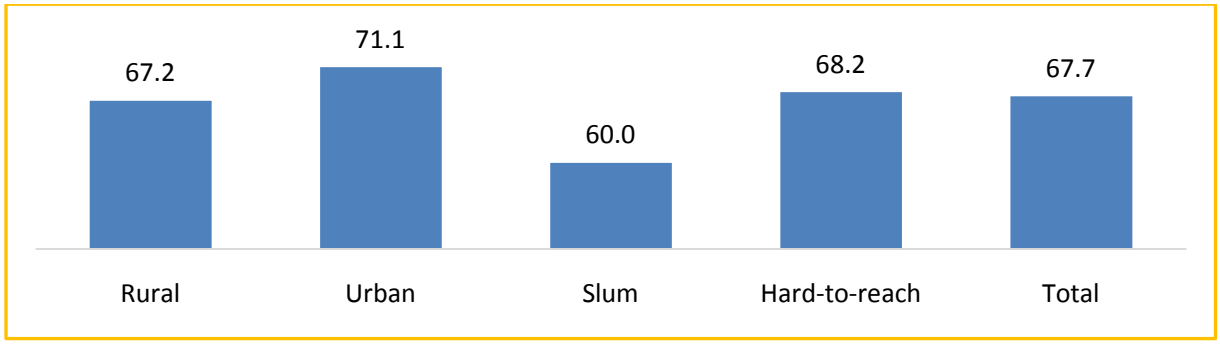
Among adolescent girls 71.2 percent have gone to health center for receiving required services. Three-fourth of them have gone to health centers for normal diseases, 9.2 percent have gone for health education, 5.2 percent for nutrition and 2.9 percent for menstruation problem. Majority of them have gone to UH&FWC (26.1%) which is followed by satellite clinics/EPI service centers (25.5%), community clinics (14.7%), Upazila health complex (14.1%), NGO clinic (12.2%), district hospital (8.8%), private clinic (8.0%), MCWC (4.6%) and private hospital (4.0%).

2.8.2 *Knowledge about health, nutrition and dowry among adolescent girls*

Majority adolescent girls have knowledge about health and nutrition. For example, 84.1 percent adolescent girls mentioned green vegetables contain nutrition which is followed by fish.meat (77.6%), egg/milk (77.1%), fruits (44.2%), rice/bread (38.2%), lentil (11.3%), and oil/ghee (2.5). In addition, most of them also know about foods that prevent diseases such as green vegetables (82.4%), fish/meat (74.6%), egg/milk (72.3%), rice/bread (37.0%), fruits (32.4%), lentil (6.3%), and oil/ghee (2.3%). Among adolescent girls 96.4 percent think that dowry is not good.

Among adolescent girls 67.7 percent have taken TT vaccination. The rate of taking TT vaccination is the highest in urban areas and the lowest in slums (Figure 71).

Figure 65: Taking TT vaccine among adolescent girls (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.8.3 *Sources of knowledge about health, nutrition and dowryamong adolescent girls*

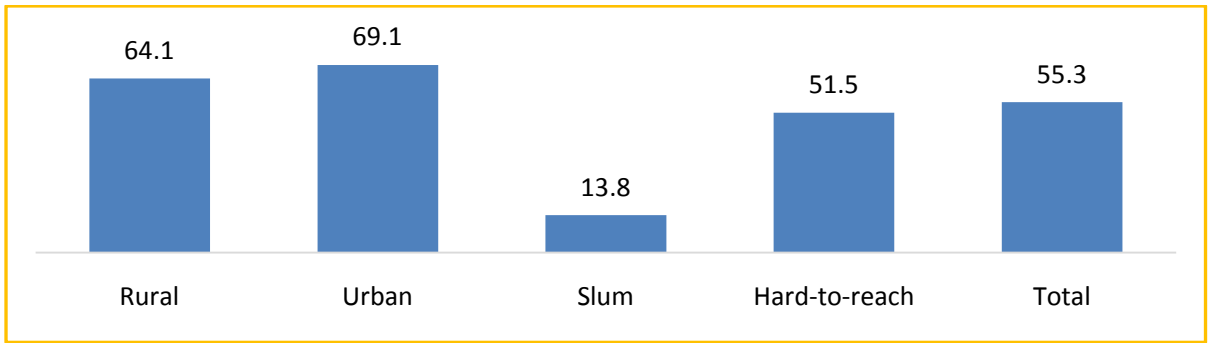
More than 95.0 adolescent girls have got information related tohealth, nutrition and dowry from outdoor IEC/BCC activities such as family planning workers/health workers, NGO workers, courtyard meetings, workshop/seminars, satisfied beneficiaries, folksong and street drama. In addition, more than three-fourth adolescent girls mentioned that they learned about health, nutrition and dowry from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of adolescent girls also reported that they were benefitted from IEC/BBC activities published in the print media (Annex Table 14).

2.8.4 *Sexual and reproductive health management among adolescent girls*

One-fifth of the adolescent girls had problems related to menstruation while more than half of the adolescent girls know about menstrual regulation (55.3%). However, this knowledge among adolescent girls is the lowest in slums (13.8%) compared to hard-to-reach (51.5%), rural (64.1%) and

urban (69.1%) (Figure 66). Concerning knowledge about services for menstrual regularization 31.8 percent adolescent girls mentioned UH&FWC which is followed by district hospital (29.5%), upazila health complex (27.3%), private clinic (20.8%), satellite clinic (13.3%), NGO clinic (12.5%), community clinic (12.1%), MCWC (10.2%), medical college hospital (8.0%) and private hospital (4.9%).

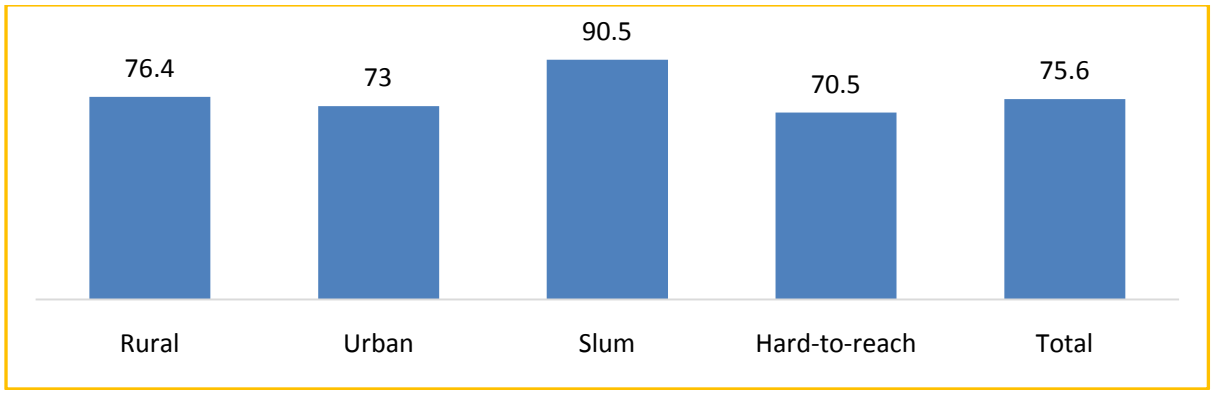
Figure 66: Knowledge about menstrual regularization among adolescent girls (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Among adolescent girls 75.6 percent do not know the most risky time of getting pregnant. This rate is the highest in slums and the lowest in hard-to-reach areas (Figure 67). Among adolescent girls 59.3 percent know about STD. The knowledge about STD among adolescent girls is the highest in urban (75.6%) followed by slum (54.5%), rural (52.6%) and hard-to-reach areas (46.4%).

Figure 67: Adolescent girls who do not know the most risky time of getting pregnant (%)

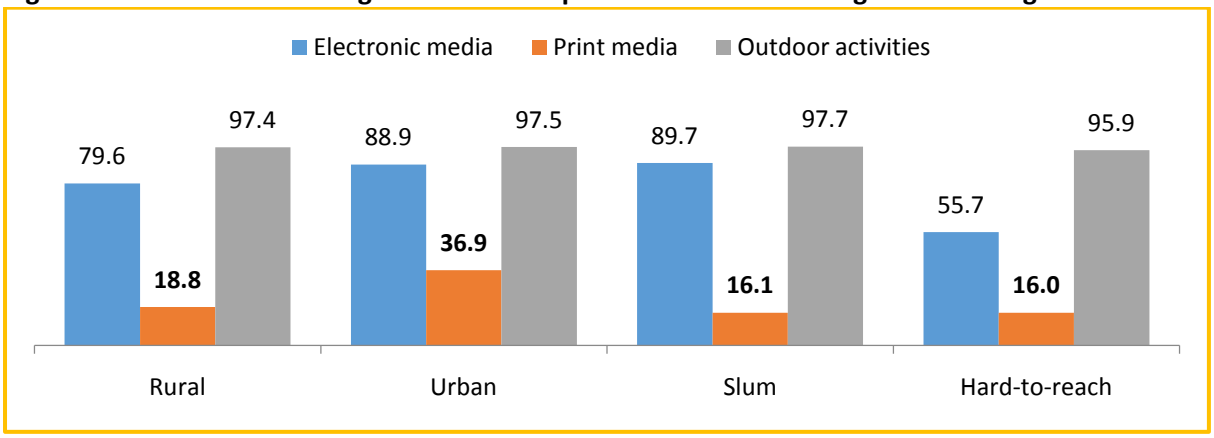


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.8.5 Sources of knowledge about reproductive health management among adolescent girls

More than 95.0 adolescent girls gathered knowledge reproductive health management from outdoor IEC/BCC activities (Figure 68). In addition, more than sixty percent adolescent girls mentioned that they learned about reproductive health management from various activities of IEC/BCC broadcasted in electronic media which includes Bangladesh Betar, FM/community radio, Bangladesh television, and private television channels (advertisement/scroll). A small proportion of adolescent girls also reported that they were benefitted from IEC/BBC activities published in print media (Annex Table 15).

Figure 68: Source of knowledge on sexual &reproductive health management among adolescents



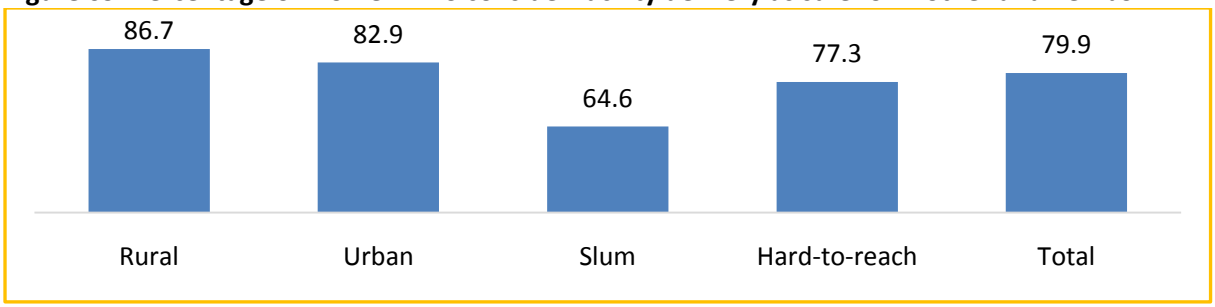
Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.8.6 *Knowledge about antenatal care, delivery care and postnatal care among adolescent girls*

Among adolescent girls 69.6 percent know the required number of checkup during pregnancy. This rate is highest in urban areas (79.6%) followed by rural (69.5%), slum (66.2%) ans hard-to-reach areas (59.8%). Most of the adolescent girls are aware about various types of care needed for a pregnant mother such as eating additionalfodd (81.4%), taking adequate rest (75.5%), not allowing heavy work (73.2%), monitoring weight regulalry (19.2%), taking iron tablets (14.8%), taking vaccination (9.1%), and taking vitamin A capsule (3.4%).

Concerning knowledge about safe delivery place for mother and newborn 79.9 percent adolescent girls mentioned facility as the safe delivery place. The percentages of aoldescent girls who consider facility delivery as safe for mother and newborn are the highest in rural areas and the lowest in slums (Figure 69).

Figure 69: Percentage of women who consider facility delivery as safe for mother and newborn



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Most of the adolescent girls know about various care that are needed for a mother after child birth such as giving nutritious food (70.4%), taking adequate rest (58.3%), not allowing heavy work (52.4%), giving extra food (51.2%), giving liquid food (19.5%), taking iron tablets (12.2%), taking vitamin A capsule (6.5%), and taking vaccination (4.8%).

2.8.7 *Sources of knowledge about antenatal care, delivery care and postnatal care*

More than 95.0 adolescent girls gathered knowledge on antenatal care, delivery care and postnatal care from outdoor IEC/BCC activities. Moreover, more than sixty percent adolescent girls mentioned that they learned about antenatal care, delivery care and postnatal care from various activities of IEC/BCC broadcasted in electronic media. A small proportion of adolescent girls also reported that they were benefitted from IEC/BBC activities published in the print media (Annex Table 14).

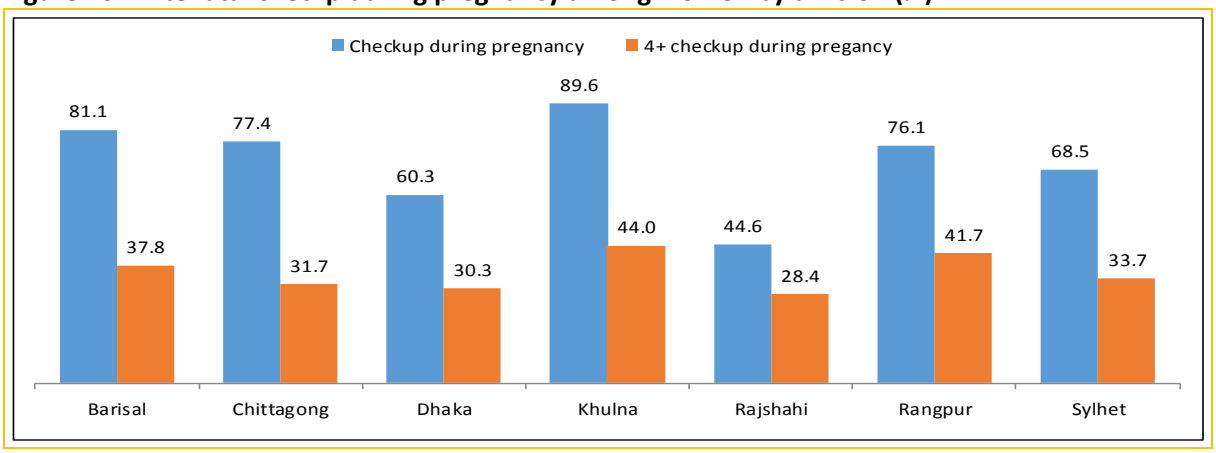
DIVISIONAL VARIATIONS IN THE IMPACT OF IEC/SBCC ACTIVITIES

2.9 Divisional Variations in the Impact of IEC/SBCC Activities

2.9.1 Divisional variations in antenatal checkup

There are susbtantial variations in at least one checkup and 4+ checkup during pregnancy. For example, the highest rate of checkup during pregnancy is in Khulna and the lowest in Rajshahi. This is also true in the case of 4+ checkup during pregnancy (Figure 70).The major source of knowledge for antenatal check is outdoor IEC/SBCC activities and electronic media is the second largest source of gathering knowledge. Barisal division has the highest rate of gathering knowledge from outdoor activities of IEC/SBCC which is followed by Sylhet, Khulna, Rajshahi, Dhaka, and Chittagong. This trend is also consistent in two other media of IEC/SBCC activities: electronic and print media (Annex Table 16).

Figure 70: Antenatal checkp during pregnancy among women by division (%)

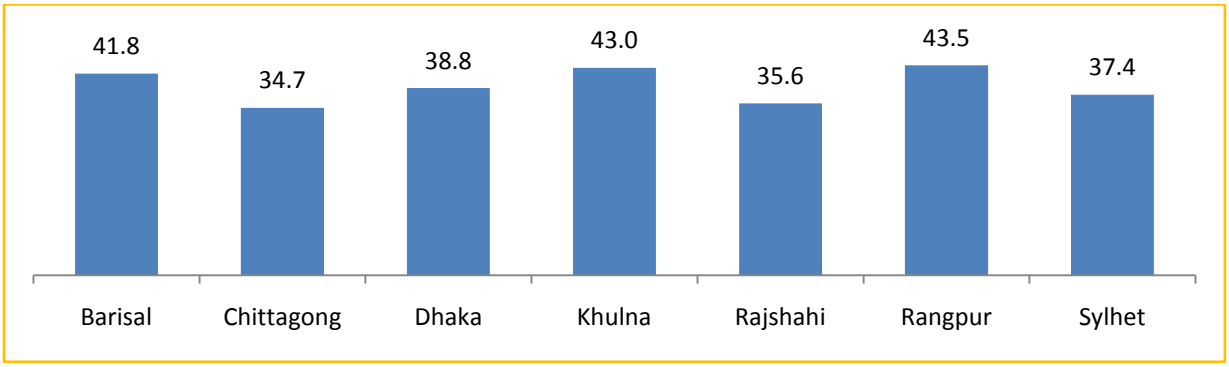


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.9.2 Divisional variations in facility delivery

There are also variations in the rates of facility delivery across divisions. For instance, the rate of facility delivery is highest in Rangpur disvision and the lowest in Chittagong division (Figure 71). The dominat source of gathering knowledge on facility delivery is outdoor IEC/SBCC activities which is followed by electronic media and print media.Barisal division has the highest rate of gathering knowledge from outdoor activities of IEC/SBCC which is followed by Sylhet, Khulna, Rangpur, Rajshahi, Dhaka, and Chittagong. This trend is also consistent in two other media of IEC/SBCC activities: electronic and print media (Annex Table 15).

Figure 71: Facility Delivery by division (%)

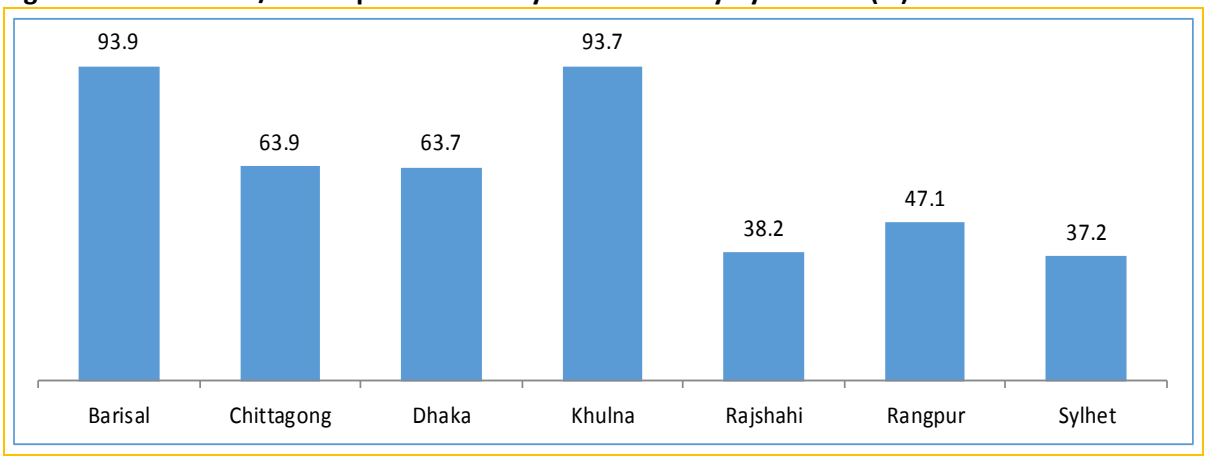


Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

2.9.3 *Divisional variations in postnatal checkup/treatment*

Concerning treatment/checkup within 42 days after delivery it was found that Barisal and Khulna have highest rates of checkup/treatment and Rajshahi and Sylhet had the lowset rates of checkup/treatment within 42 days after delivery (Figure 72). The major source of knowledge for postnatal checkup/treatment is outdoor IEC/SBCC activities and electronic media is the second largest source of gathering knowledge for postnatal checup/treatment. Khulna division has the highest rate of gathering knowledge from outdoor activities of IEC/SBCC which is followed by Barisal, Sylhet, Rangpur, Rajshahi, Dhaka, and Chittagong. This trend is also consistent in two other media of IEC/SBCC activities: electronic and print media (Annex Table 15).

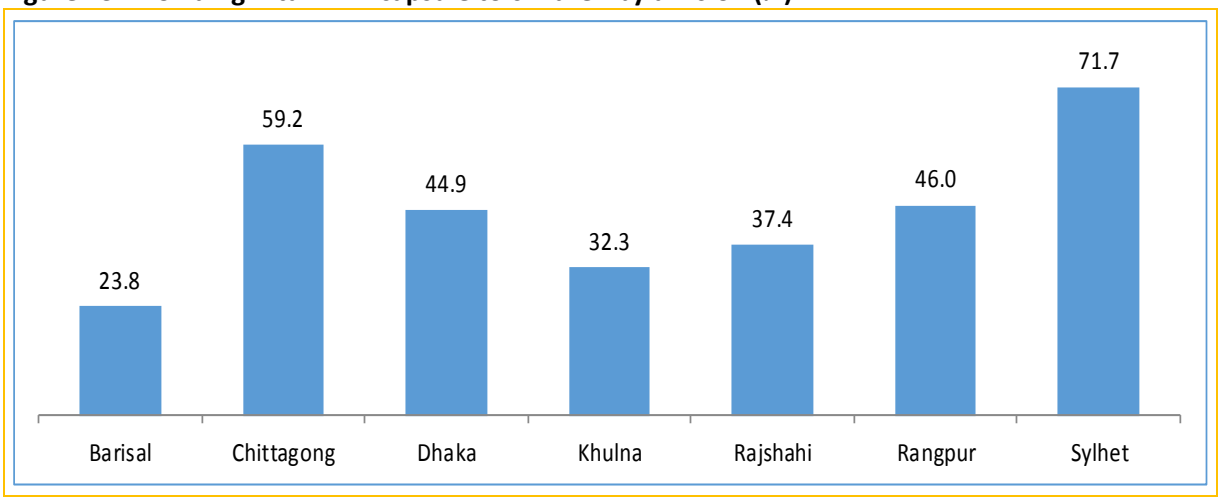
Figure 72: Treatment/checkup within 42 days after delivery by division (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

Providing vitamin A capsule to children is an important determinat of child health. Figure 73shows that Sylhet division has the highest rate of giving vitamin A to children and Barisal division has the lowest rate of providing vitan A capsule to their children. The main source of knowledge for providing vitamin A capsule to children is outdoor IEC/SBCC activities followed by electronic media and print media. Khulna division has the highest rate of gathering knowledge from outdoor activities of IEC/SBCC which is followed by Barisal, Sylhet, Dhaka, Rangpur, Rajshahi, and Chittagong. This trend is also consistent in two other media of IEC/SBCC activities: electronic and print media (Annex Table 16).

Figure 73: Providing Vitamin A capsule to children by division (%)



Source: Impact Survey on IEC/SBCC Activities of DGFP, 2016

SECTION THREE

3.1 Major Qualitative Findings: Focus Group Discussion

3.1.1 Mixed perception about child marriage

Although most FGD particpants were able to mention that arranging marriage of their daughters befre age 18 is known as child marriage still some participants could not mention this. Their prercption was that giving marriage before age 15 is considered as child marriage. They mentioned that girls marriage should be arranged after they complete education at least upto HSC. Concerning reasons for child marriage they mention that family pressure, expectation of grandparents, fiancial hardship, and scoial insecurity palys an important role in child marriage. They are also conscious about various negative consequences of child marriage such as discontinuation of girls' education, more children at younger ages, lower birth spacing, risk of maternal mortality, risk of child mortality, conflit in conjugal life, risk of suicide, and higher risk of divorce. They suggest that males and females in each family should be united and determined to prevent child marriage; and adequate knowledge should be given in school and colleges to create awareness about negative consequences of child marriage. They have gathered knowledge and have become aware about child marriage from various activies of IEC/SBCC such as TV programs, folksong, street dram, leaflets, psoters, brocheures and shortfilms. They emphasized on strict implementation of laws top prevent child marriage in Bangladesh. One of the FGD participant mention that *"we know that it is not good to arrange girls' marriage before age 18 but we have many problems such a financial hardship, concern about social insecurity and sexual harassment…for this reason we arrangedgirls' marriage at younger ages…however, we have learned many thing about negative sides of child marriage from radio, TV and yard meeting…I will no more give my daughter's marriage beofre age 18".*

3.1.2 Higher preference for smaller family

It was found that FGD participants are aware about advantages of having fewer children and negative consequences of having more children. For instance, they mentioned many advantages of having fewer children such as ability to provide nutritious food increases; afford educational expenditure of children; can fulfil other basic needs of children such as medicine and clothes; adequacy of land for livelihoods; and good for environment. They believe that it is better to have only two children. They have become aware about smaller family size from various awareness activities of the government broadcasted in TV, newspaper, radio and in outdoor activities. In coonection with this one participant argue that *"we do not want more children now because we do not have capability to provide adequate support for them…we cannot pay their educational expenses…so we want one or two children….we have leanred this from street drama, and yard meetings".*

3.1.3 Desire for receiving quality services in health and family planning

FGD participants are aware about various health and family planning centers in their loaclity such as upazila health complex, union health and family welfare centers. They also know that various health and family planning services are provided in these centers such as services for illness, antenatal care, delivery care, postnatal care, and family planning related couselling and services. They have been informed on theese centers and their services from various activities of IEC/SBCC broadcasted in radio, TV, newspaper and through outdoor activities such as workshop, seminar, yard meeting, polligaan, and street drama. However, they mentioned that the quality of health and family planning services given by these ceters should be improved a lot. One FGD participant mentioned *that "there are many health facilities in our area but we do not get quality services in most cases…service providers do not give equal attention and respect to us…because we are poor…we have seen they are giving better service for some people…we need equal treatment and respect from them".*

3.1.4 Misconceptions about long acting and permanent methods

All FGD participants know about family planning methods. They have learntabout family planning from their relatives, friends, newspaper, radio, TV and outdoor activities organized by GO-NGOs in their locality. However, majority of them do not use family planning methods because their wives use family planning methods. Among men users of family planning most are users of condom and they have some negative perception about long acting and permanent methods. Such as they are very concerned about negative attitude of family and society, and many side effects of the long acting and permanent methods. Many believe that adopting permant methods will reduce their sex power. For these reasons a substantial number of men do not support long acting and permanent methods of family planning. However, some participants mentioned that long acting and permanent methods have some adavntages such as those are not needed to be changed frequently, very effectgive and have no side effects. Some participants mentioned that the service providers of long acting and permanent methods are not very efficent, as a result they undergo various complications after adopting these methods. Conisdering all these issues, majority men preferred temporary methods of family planning. One participant mention that *"many people in our society still are not positive about permanent methods for male in particular…for this reason I cannot share my thoughts with others about adapting male permanent methods…in addition, incentives for adapting permanet method is also not attractive…increasing this amount will encourge more people".*

However, some adavantages of temporary methods of family planning as mentioned by the participants include they can stop using these methods whenever they want to havechildren. They mentioned that the wage compensation given by the government for adopting permanent methods are insufficient. Increasing this amount substantially would have very positive impact on increasing users of permant methods of family planning.

3.1.5 Lack of knowledge about required number of ANC checkup

All FGD participants mentioned that check up should be done during pregnancy. However, many of them do not know the required number of checkups during pregnancy. Their perception about benefits of checkup during pregnancy include knowing position of child, knowing health status of mother and child, having better understanding about possible complications, and taking preventive measures to aviod loss f pregnancy. However, some of the participants are not quite aware about what types of complications can arise due to pregnancy particularly among girls who are having children at younger ages such as before age 18. All participant know about various places where antenatal checkup can be done such as district hospital, upazilla health complex, union health and family welfare centers, satellite clinincs, NGO clinincs, private clinincs, and medical college hospitals. All participants are aware about benefits of TT vaccination during pregnancy and they strongly encourage their wives to take TT vaccine during pregnancy. They have learntabout ANC from doctors, FWA/FWV, radio, TV, newspapers and various activities of IEC/SBCC. One participant mentions that *"we know that pregnant women should get check up by doctors….they need to get treatment for any complicaitons…however, our wives have better knowledge about required number of antental check up and knowledge about various care needed during pregnancy…FWA workers come in our locality to disseminate knowledge on maternal health….we have also learn those from television, yard meetings and friends and relatives".*

3.1.6 Higher preference for home delivery due to failure to anticipate risks of home delivery

Many FGD participants mentioned that it is better to give birth at facility instead of giving birth at home. This is safer both for mother and newborn. However, many of the FGD participants mentioned that they prefer their wives to give birth at home unless there is any severe complication. Part of the reason is that in some cases facility delivery is expensive which they cannot afford. Some

of the participants have bitter experience while delievring their babies in the facilities . They are also concerned about higher rate of cesarean delivery in the clinics and hospitals. Overall, it was found that further awareness building program is needed to motivate men in ctrease facility delivery. Concerning giving birth at home one FGD participant told, *"my wife gave birth at home because there was no problem or complication…we did not go to hospital or clinic for delivery because in private clinics it is very expensive….they also try do caesarian birth without any reason"*. However, some participants mention that they know that giving birth at facility is completely free but still they did not go due to failure to understand complications of giving birth at home.

3.1.7 Better informed about child and newborn care

Most of the FGD participants have very good knwoledge about newborn and child care. They have leantabout newborn and child care from dotors, FWV, FWA, radio, TV, and newspapers. They have also attended many courtyard meetings and workshops/seminars for gatheirng knowledge on newbron and child care. Most of the participants know that benefits of giving vaccination to children incude getting rid of six diseases, increased disease resitence of children, mental and physical development of children, and protection from severe dieseases in future. Similarly, they mentioned various benefits of vitamin A capsule such as prevention of night blindness, disease resistence and development of brain. They know about various measures for child diarrhea such as continuation of breastfeeding, providing normal food along with brestfedding, and feeding saline. They mentioned several preventive measures for diarrhea such as staying clean, not eating contaminated food, living in health environment, washing hands with soap before and after eating. Most of the participants know that getitng cold is the main reason of pneumonia. They know about several initiatives for taking care of pneumonia affected children such as keeping them in dry place, cleaning sweating, giving bath with warm water everyday in the morning, and going to doctors and health centrers for receiving further treatment. One participant mentioned, *"now a days all have very good knowledge about newborn and child care….we are conscious about giving immunization to children and giving vitamin A capsule….various GO-NGO activities have helped us to gather knowledge about newborn and child care".*

3.1.8 Breasfeeding is the best medicine for children

Most of the participants mentioned that there is no alternative of exclusive brteastfeeding for the babiesuntil six months of age . They know the benefits of breastfeeding for children such as colustrum contributes to development of disease resistence among newborn, and newborn get many vitamins from colustrum. However, after six months other foods such as eggs, vegetables, fruits and meat should be given to children for their proper growth and development: *"we have learned from sorkshops, courtyard meetings, billboards and street drama that exclusive breasfeeding upto six months of child birth is very useful for newborn….we encourage our wives to practice breastfeeding".*

3.1.9 Positive attitudes towards IEC/SBCC activities

Overall, FGD participants are very positive about benefits of various activities of IEC/SBCC broadcasted through electronic media, print media and outdoor activities such as workshop/seminar, courtyard meetings, billboards, polligaan, and street drama. According to them, increasing duration of broadcasting these activities and broadcasting frequently would have higher positive impact in achieving desired success in maternal, and child health and family planning programmes: *"various activites implemented by GO-NGOs on creating awarenss about family planning methods, check up during pregnancy, taking care of pregnant women, giving birth at facility and taking care of mother after giving birth are very important for us……government should expand these programs to a large scale so that everyone become conscious about these things….knowing various aspects of maternal and child health and family planning is good both for mother and children".*

Major Qualitative Findings: Key Informant Interviews

- Most of the program managers and service providers have knowledge about various MCH-FP activities implenented by GO-NGOs in their locality. For example, activities related to preventing child marriage, antenatal care, delivery service, newborn care, immunization, vitamin A program and family planning services.
- However, some service providers do not have very clear understanding about all objectives and activities of IEC/SBCC programmes. Further training and information dissemination activities should be taken to address this limitation of the IEC/SBCC aqctivities.
- All program managers and service providers mentioned various actitivities taken by them for preventing child marriage and they are very aware about negative consequences of child marriage such as deterioration of health status, early childbearing, dropout from education and risk of maternal mortality. Program managers, service providers, community leaders have emphasized on various activities such as creating mass awareness against child marriage, courtyard meetings, announcing through miking, creating awareness about negative consequences of child marriage, not registering marriage without birth registration, providing quality education and strict implementation of child marriage.
- Service providers reproted that among various methods of family planning pill and condom are most popular. Permanent methods of family planning for males (NSV) is the least popularbecause many users of FP believe that this will reduce sex power of men and will make them weaker in performing daily activities.
- Program mangers and service providers suggested various initiatives to increase contraceptive prevalence rate in general and to increase use of long acting and permanent methods in particular. Such as engaging various social organization and NGOs in family planning activites, involving elected representatives of local government at union level, providing counselling through community leaders, teachers, and other people for motivation. Most importantly, providing attractive financial incentive and providing shcolarships for their children for adapting permant method of family planning will have positive impact in increasing the rate of contraceptive use.
- Lack of adequate and quality services on maternal and child health is clealry visible at union levels. The service providers reported that although various services are given at union health compplex such as checkup of pregnant mothers, providing iron tablets, immunization and vitamin A capsule, these service are not adequate for local people. Services related to delivery and postnatal checkup are not only inadequate but also do not maintain quality. Nurses and doctors are needed in service centers on a regular basis; and logistic supports including ambulance should be adequate.
- Service providers have very good knowledge about benefits of breastfeeding. They also emphasized on exclusive breastfeeding upto six months of child birth.
- Although various services on maternal health, child health and family planning are provided in hard-to-reach areas program managers and service providers reported that communication problem, higher expenditure of transport, lack of EmOC services, and lack of quality services were actingas barriers to achieve the goals of IEC/SBCC activities. The rate of facility delivery is comparatively much lower in hard-to-reach areas due to lack of adequate support service for facility delivery.
- In some cases the program managers and service provers do not have adequate capability in providing quality services to achieve the desired goals of IEC/SBCC activities. Therefore, further training should be given to them. The program managers and service providers are also interested in receiving further professional development training.
- It was found that there was limited Interpersonal Communication between service providers and service receivers of IEC/SBCC activities.

- Program managers and service providers have shown strong willingness to deliver quality services if they receive adequate logistic supports and encouragement.
- Program managers suggested various initiatives for making IEC/SBCC activities more effective. For example, creating more awareness through audiovisual van; arranging monthly meetings with newlywed women for information dissesmination on health and family planning activites; setting health and family planning related billboards in schools and colleges; providing training on health and family planning programmes to the head teachers of primary schools, members of ansar and VDP, and religious leaders annually.
- Program managers and service providers are very positive about IEC/SBCC activities because these are helping a lot to disseminate accurate and reliable information to people. They emphasized on emiminating barriers to IEC/SBCC activities. Their suggestions include delivering this impact survey report to field level, using local media of communication such as FM radio, local newspaper, particular channels of local cable operators to disseminate family planning messages; disseminating IEC/SBCC activities locally will have higher positive impact on maternal, child health, and family planning.
- IEC/SBCC programes such as folksong, street drama, and bioscope were popular among people. Hence program managers and service providers suggested to operate these activities frequently.

SECTION FOUR

4.1 Summary, Conclusion and Policy Recommendation

4.1.1 Conclusion

Bangladesh has made remarkable progress in achieving the Millennium Development Goals (MDGs). It has already met several targets of the MDGs like reducing headcount poverty and poverty gap ratio, reducing the prevalence of underweight children, attaining gender parity at primary and secondary education, under-five mortality rate reduction, containing HIV infection with access to antiretroviral drugs. In addition, Bangladesh has made remarkable progress in increasing enrolment at primary schools, lowering the infant mortality rate and maternal mortality ratio, improving immunization coverage and reducing the incidence of communicable diseases. IEC/SBCC activities implemented by the IEM unit of the DGFP have played an important role disseminating knowledge and creating awareness about child marriage, antenatal care, delivery care, postnatal care, newborn and child care and family planning.

Contracpetive prevalence rate in Bangladesh in 2014 was 62.4 percent of which 54.1 percent use anymodern method and 8.4 percent use any traditional method (NIPORT 2016). In the 7th Five Year Plan of Bangladesh (2016-2020) targets have been set on achieving total fertility rate of 2.0 and CPR of 75 percent by 2020. To improve population and family planning services various priority interventions were recommended in the HPNSDP (2011-2016) of Bangladesh such as promoting delay in marriage and childbearing, use of post partum FP, post abortion FP and FP for appropriate segments of population; strengthening FP awareness building efforts through IEC activities with special emphasis on mass communication and considering local specificities; using different service delivery approaches for different geographical regions and segments of population; maintaining focus on commodity security and ensuring uninterrupted availability of quality FP services closer to the people (at the CC level); registering eligible couples with particular emphasis on urban areas to establish effective communication and counseling; compensating for lost wages (reimbursement for opportunity costs) for long acting and permanent method contraceptive performance; strengthening FP services especially post partum and post abortion FP and demand generation through effective coordination of services with DGHS utilizing appropriate opportunities. Achieving the goals of reducing fertility and increasing CPR would have positive impact on declining adolescent fertility which will eventually lead to higher educational attainment and labour force participation of girls and thereby translating them into human resources. Increasing contraceptiveprevalence rates and reducing total fertility rate will also have positive impact on ensuring better maternal health status which is an essential criterion for higher productivity of women and girls. Thus ensuring better health and higher socioeconomic attainment through translating millions of adolescents will facilitate harvesting the benefits of demographic dividend for Bangladesh.

The objective of this impact survey was to investigate the extent to which different IEC/BCC interventions have impacted on disseminating informationand creating awareness about various aspects of family planning, maternal health and child health. This objective has been achieved through conducting the impact survey following mixed method approach: combination of quantitative and qualitative. Major findings of the impact survey can be summarized into eight categories. First, majority women are aware about various negative consequences of child marriage. Despite this awareness the prevalence of child marriage in our society is still high due to parents' concern about social stigma, eve-teasing, premarital sex, and fear of trafficking. Higher rate of child marriage has consequences on higher adolescent fertility which eventually leads to lower socioeconomic attainment for women and poor health status. Findings from the 2014 Bangladesh Demographic and Health Survey shows that 24.6 percent adolescents aged 15-19 became mothers and 6.2 percent of the same age group were pregnant at the time of the survey suggesting that

about one-third adolescent girls aged 15-19 had started childbeatring and their contribution to the total fertility rate in Bangladesh has actually increased over time despite substantial decrease in the over all total fertility rate. The IEC/SBCC activities should be strengthened to prevent child marriage and motivating adolescents for postponement of having children before age 20 in Bangladesh.

Second, the average age at first birth has increased and under-five mortality rate has decreased which will eventually contribute to reduce fertility rates in Bangladesh. Both quantitative and qualitative findings suggest that both men and women are conscious about the negative consequences of having more children which they learned from various activities of IEC/SBCC interventions. Third, a vast majority of women have knowledge about various health and family planning centres in their locality. They also know about services provided by health and family planning centres which they learned from IEC/SBCC activities broadcasted through electronic media, print media and outdoor activities.

Fourth, all women know about family planning and name of several methods of family planning. They also know about various sources of family planning methods. It has been found that more than two-third women are using contraception. However, there has been slower progress in increasing long acting and permanent methods of family planning partly due to several misconceptions about these methods, lack of quality services, poor inceptives for adopting these methods, and to a smaller extent sociocultural factors including religion. The target groups for increasing use of contraceptives are obviously non-users of family planning methods. Adequate attention should be given to address their reasons for not using contraceptive methods such as desire to have more children, concern about side-effects, perception about health risk, fear of side effects, opposition of husband, and religious prohibition.

Fifth, most women are very much aware about importance of antenatal check-up during pregnancy and many of them know required number of check-up during pregnancy. However, at least one antenatal check-up and 4+ check-up are much lower in slums compared to other areas.Women also have good knowledge about various types of care that needed during pregnancy such as taking adequate rest, eating extra food, not allowing heavy work, taking iron tablets when needed, monitoring weight regularly, taking vaccination, and Vitamin A capsule. Higher rate of facility delivery among low parity women than high parity women suggests that there is an increasing awareness about facility delivery among women in Bangladesh which can largely be attributed to various activities of IEC/SBCC. This is also true in the case of knowledge about caring for a mother after delivery.

Sixth, majority women have good understanding about various types of care needed for newborn and children such as feeding colostrum, doing exclusive breastfeeding, giving vaccination, providing vitamin A capsule, and knowledge about causes and treatment of diarrhea and pneumonia. However, it should be mentioned that the performance of urban and slums on these indicators are relatively lower than rural areas and even in some cases lower than hard-to-reach areas. For example, giving vaccination to last child among high parity women in urban and slums are lower even compared to hard-to-reach areas. Therefore, additional attention in terms of investment, intervention and management should be given to overcome the poor performance on newborn and child care in urban and slum areas.

Finally, though a vast majority of the managers and service providers are aware about various activities of IEC/SBCC in some cases they do not have adequate capability to deliver quality services to achieve the desired goals of IEC/SBCC activities. They also have limited Interpersonal Communication with the service receivers of IEC/SBCC activities. Encouragingly, program managers

and service providers have strong willingness todelivery quality services if they receive adequate logistic supports and professional development training.

4.1.2 Policy Recommendations

- National Broadcast Policy should be reformed for using TV as an electronic media to disseminate health and family planning related IEC/SBCC activities.
- DGFP should use TV as media more to communicate health and family planning related messages.
- The impact of IEC/SBCC activities is much lower through private TV channels compared to Bangladesh Television. Rural people have more access to BTV in compare to private TV channels. Considering the higher access of Bangladesh Television and Bangladesh Betar greater emphasis should be given in broadcasting IEC/SBCC activities through BTV and Bangladesh Betar.
- Emphasis should be given on broadcasting benefits of use of male methods though IEC/SBCC activities along with providing adequate services for male contraceptives, and service sites needs to be set up within the reach of mean to cater their needs.
- Area-specific strategy should be adopted in broadcasting IEC/SBCC activities for bringing desired change in health and family planning sectors.More importantly, additional resource allocation and increasing outdoor activites of IEC/SBCC should be ensured for regions where total fertility rates (TFR) are high and Contracpetive Prevalence Rates (CPR) are low such as Chittagong and Sylhet.
- Audience specific communication strategy should be adopted in implementing IEC/SBCC activities for bringing desired changes in behaviour.
- IEC/SBCC activities should disseminate adequate information and counselling to address side effects of using family planning methods.
- Capacity building of the front-line workers regarding interpersonal communication should be strengthened to provide FP-MCH information so that it motivates clients in using service centers.
- Engaging local NGOs/ IPT groups/folk talent team for expanding selected IEC/SBCC activities such as street drama, folksong.
- IEC/SBCC activities should introudce particular programs for target groups to address unmet need for family planning and to reduce dropout rates thropugh providing increasing knowledge and awareness on the benefits of using FP methods, providing clarifications about myths and misconceptions about famiply planning, and addressing barriers/systematic problems such as insufficient access to care through advocacy and providing adequate services for solving side effects of using FP methods.
- Increasing focus on eliminating misconceptions about Long Acting and Permanent Methods (LAPM) of family planning.
- There are substantial knowledge gap among adolescent regarding most risky period of getting pregnant. IEC/SBCC activities should give greater focus on this issue to reduce unwanted pregnancies in future.
- Providing comprehensive coverage of adolescent reproductive health and addressing their knowledge gaps through greater investment in IEC/SBCC activities.
- Increasing investment in monitoring and evaluation for further improvement in interpersonal communication between service providers and service receivers.

ANNEX 1: TABLES

Annex Table 1: Sample characteristics of the respondents							
Variables	**High Parity**	**Low parity**	**Newly wed**	**Currently Pregnant**	**Lactating**	**Non User**	**Adolescent**
Age (mean)	36.0	24.1	21.8	23.6	24.4	31.2	15.4
Education							
No education	42.9	11.9	6.6	10.7	17.5	29.9	0.7
Primary	32.5	25.4	17.3	27.2	28.6	26.3	14.8
Secondary	21.2	49.1	58.4	53.4	43.7	36.2	71.2
Higher	3.3	13.7	17.7	8.7	10.1	7.7	13.3
Employment							
Employed	8.3	8.4	7.0	2.9	4.3	8.0	na
Not employed	91.7	91.6	93.0	97.1	95.7	92.0	na
Age at first marriage (mean)	15.1	17.0	18.3	17.2	16.3		na
Religion							
Islam	89.5	84.2	86.0	85.0	85.2	87.6	87.0
Others	11.5	15.8	14.0	15.0	14.8	12.4	13.0
Death of any child under five years							
Yes	21.1	6.3	na	na	8.9	13.9	na
No	78.9	93.7	na	na	91.1	86.1	na
Age at giving birth							
First birth	17.6	19.9	na	na	19.3	18.3	na
Second birth	21.0	21.4	na	na	23.1	21.4	na
Third birth	25.1	25.2	na	na	25.4	24.2	na
Wealth Index							
Poorest	21.4	20.0	19.8	19.9	19.9	20.1	20.0
Poorer	21.2	19.9	20.2	19.9	20.3	20.1	20.0
Middle	19.1	20.2	20.2	19.9	19.7	19.9	20.1
Richer	19.2	20.0	20.2	20.4	20.1	19.9	19.9
Richest	19.1	20.0	19.8	19.9	20.0	20.1	20.0
N	**1470**	**1021**	**243**	**206**	**846**	**1291**	**670**

Annex Table 2:										
Child Marriage	Child Marriage					Health and family planning services				
	Rural	Urban	Slum	Hard-to-reach	Total	Rural	Urban	Slum	Hard-to-reach	Total
Bangladesh Betar	9.8	15.2	2.3	9.4	10.3	6.3	9.2	0.4	6.0	6.3
FM/community radio/other broadcasting centers	7.4	11.1	7.4	5.6	8.0	3.5	4.0	2.0	3.9	3.6
Bangladesh television	68.3	78.6	62.4	31.9	60.0	47.1	56.5	24.3	18.8	38.8
Private television channel (advertisement/scroll)	10.9	19.9	41.8	12.6	18.0	8.6	17.6	14.9	9.1	12.2
Family planning workers/health workers	51.0	41.4	24.3	42.9	42.4	72.2	63.9	41.2	66.8	64.2
NGO workers	14.4	22.7	36.0	15.0	19.8	18.5	26.5	49.1	14.8	23.8
Newspaper and magazines/quarterly/newsletter	3.3	7.9	2.3	3.0	4.4	1.7	3.9	0.9	1.2	2.1
Friends/relatives	68.3	70.8	76.5	63.7	68.8	78.7	82.7	90.2	72.1	79.5
Billboard/neonsign/trivision	3.6	4.7	0.8	0.7	2.7	2.1	4.3	0.9	0.7	2.2
Poster/leaflet/flier/brochure/booklet/festoon	4.7	10.8	2.3	1.6	5.3	3.6	7.4	1.8	0.6	3.6
Polli gaan/folksong	0.5	0.7	0.4	0.3	0.5	0.5	0.4	0.1	0.0	0.3
Workshop/seminar	3.3	3.4	0.5	1.6	2.5	2.5	2.6	0.8	0.8	1.8
Yard meeting	8.2	8.6	2.6	7.2	7.3	6.4	6.5	0.9	3.9	5.0
Satisfied beneficiary	6.5	9.5	12.4	3.3	7.2	10.9	17.1	27.7	8.9	14.3
Short film/TV drama	14.4	22.8	6.2	5.7	13.3	8.9	14.3	0.9	2.5	7.6
Film show in audio visual van	7.9	3.7	0.0	4.6	4.7	5.2	2.0	0.0	1.5	2.5
Myself/reading books	35.2	45.9	25.5	28.2	35.1	26.6	34.7	16.8	19.4	25.7
Street drama	3.7	2.5	5.4	3.5	2.6	1.9	2.5	1.5	1.7	2.0
IEC/BCC Activities	Child Marriage					Health and family planning services				
	Rural	Urban	Slum	Hard-to-reach	Total	Rural	Urban	Slum	Hard-to-reach	Total
Electronic media	73.3	85.3	75.7	42.3	68.2	76.1	87.4	78.1	44.4	70.5
Print media	7.6	17.5	4.3	4.2	9.1	9.9	22.0	5.8	5.1	11.5
Outdoor activities	85.3	83.2	68.7	76.2	79.9	96.7	93.7	91.9	90.5	93.4

Annex Table 3: High Parity												
Sources of knowledge	**Antenatal Care**				**Delivery care**				**Postnatal care**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	5.1	10.4	0.0	5.2	0.9	5.1	0.0	2.8	3.5	10.0	0.5	4.0
FM/community radio/other broadcasting centers	3.3	4.0	0.0	1.9	0.9	1.2	0.5	0.7	3.8	4.2	1.1	2.6
Bangladesh television	46.5	52.0	25.9	20.0	34.1	37.4	11.7	11.5	46.0	60.5	26.3	18.4
Private television channel (advertisement/scroll)	5.8	14.4	13.0	8.6	4.0	10.5	5.9	5.4	6.8	14.3	14.5	7.5
Family planning workers/health workers	80.0	68.5	49.1	78.6	60.0	56.3	30.3	60.3	75.6	64.3	44.1	68.6
NGO workers	23.6	33.9	57.4	19.5	17.3	18.0	43.6	13.8	20.0	27.3	45.7	14.4
Newspaper and magazines/quarterly/newsletter	1.8	2.3	0.0	0.5	0.5	1.6	0.0	0.9	0.5	3.0	0.0	0.9
Friends/relatives	77.5	81.2	86.1	72.9	86.7	88.1	93.1	81.7	78.6	82.5	88.2	66.0
Billboard/neonsign/trivision	0.7	3.0	0.0	0.0	0.9	2.1	0.0	0.2	1.2	1.6	0.0	0.2
Poster/leaflet/flier/brochure/booklet/festoon	2.5	7.4	0.0	0.0	1.9	3.0	0.0	0.0	1.9	7.7	0.5	0.5
Polli gaan/folksong	0.4	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.2	0.2	0.0	0.2
Workshop/seminar	2.2	1.3	0.9	0.5	1.2	0.7	0.0	0.2	1.9	1.2	0.5	0.9
Yard meeting	4.4	3.7	1.9	1.9	4.7	6.3	0.0	3.5	9.4	8.6	1.6	7.3
Satisfied beneficiary	5.8	10.1	12.0	4.8	12.6	17.1	23.4	8.9	8.7	14.0	19.4	5.9
Short film/TV drama	8.7	7.0	0.0	0.5	5.6	9.8	0.0	0.2	5.6	10.5	1.1	1.4
Film show in audio visual van	3.3	1.7	0.0	1.0	3.3	0.9	0.0	1.4	4.2	0.9	0.0	1.9
Myself/reading books	15.6	22.8	8.3	6.2	21.3	26.9	11.7	12.0	20.7	27.1	10.2	11.8
Street drama/others	2.5	3.0	1.9	1.0	3.0	2.2	1.6	1.4	5.6	4.2	5.9	1.4
Sources of knowledge	**Checkup during last pregnancy**				**TT Vaccine during last pregnancy**				**Caring for Pregnant Mother**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	61.2	71.3	36.1	35.1	74.3	85.7	60.2	46.9	80.8	83.9	56.7	47.9
Print media	5.8	13.0	2.5	2.9	9.8	23.7	4.6	3.8	11.2	26.1	5.5	5.3
Outdoor activities	98.9	92.7	95.4	92.9	99.3	96.3	99.1	94.3	98.6	92.5	89.1	92.4

Annex Table 4: High Parity												
Sources of knowledge	**Newborn and Child Care**				**Family Planning**				**Consequences of having more children**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	3.2	5.9	0.0	4.5	3.5	8.1	0.0	3.1	3.3	7.2	0.5	4.7
FM/community radio/other broadcasting centers	2.4	4.2	2.6	2.3	1.0	2.5	0.0	1.7	4.7	4.2	0.5	3.8
Bangladesh television	51.2	58.5	24.4	21.6	40.8	46.7	12.2	11.8	54.2	67.3	36.6	23.0
Private television channel (advertisement/scroll)	6.4	15.3	14.1	7.4	6.3	13.4	11.0	6.0	5.8	14.5	20.4	10.6
Family planning workers/health workers	77.6	59.3	42.3	71.0	84.4	77.8	53.5	81.3	74.1	59.1	33.3	63.6
NGO workers	26.4	37.3	50.0	15.9	17.9	30.1	52.3	12.7	19.9	24.1	36.6	16.2
Newspaper and magazines/quarterly/newsletter	2.4	2.5	0.0	1.1	0.8	2.0	0.0	0.2	1.2	3.0	0.5	0.9
Friends/relatives	78.4	85.6	89.7	67.0	69.3	80.3	84.3	60.1	74.5	80.6	86.6	63.4
Billboard/neonsign/trivision	0.8	5.1	0.0	0.0	0.5	2.0	0.0	0.0	1.2	1.6	0.0	0.5
Poster/leaflet/flier/brochure/booklet/festoon	1.6	2.5	1.3	0.6	1.3	4.3	0.6	0.0	1.9	4.0	1.1	0.0
Polli gaan/folksong	0.8	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.2	0.5	0.0	0.0
Workshop/seminar	3.2	0.8	1.3	0.6	1.8	1.3	0.6	0.2	3.7	2.1	0.0	1.9
Yard meeting	8.0	11.0	1.3	5.1	6.0	7.6	0.0	3.6	10.0	8.4	1.1	6.3
Satisfied beneficiary	8.0	15.3	28.2	6.3	12.1	22.7	25.0	9.4	9.8	14.5	18.8	5.4
Short film/TV drama	9.6	9.3	1.3	0.0	3.3	10.6	0.0	0.2	11.0	18.9	1.1	2.1
Film show in audio visual van	3.2	3.4	0.0	0.6	1.0	1.0	0.0	1.0	5.1	1.6	0.0	2.3
Myself/reading books	27.2	24.6	20.5	14.2	17.4	23.0	7.6	7.0	25.0	36.9	26.3	19.2
Street drama/others	4.8	4.2	3.8	1.7	5.0	2.0	1.7	1.2	4.9	2.3	1.1	2.3
Sources of knowledge	**Newborn and Child Care**				**Family Planning**				**Consequences of having more children**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	80.8	85.3	57.5	49.8	69.9	84.5	78.9	47.1	87.1	94.4	90.0	69.6
Print media	11.6	26.1	6.3	5.7	17.1	25.9	9.2	9.3	17.8	36.1	5.7	11.3
Outdoor activities	96.5	93.5	85.6	90.1	100.0	96.6	100.0	98.3	100.0	98.9	100.0	99.0

Annex Table 5: Low Parity												
Sources of knowledge	**Antenatal care**				**Delivery Care**				**Postnatal Care**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	8.9	12.1	0.0	8.3	5.1	5.0	0.0	6.8	7.2	9.3	0.8	6.8
FM/community radio/other broadcasting centers	4.3	3.5	2.3	6.1	1.0	1.3	1.5	2.7	3.1	5.3	4.7	5.5
Bangladesh television	49.6	56.4	37.3	22.3	35.2	42.4	13.0	13.2	52.1	60.9	38.8	22.3
Private television channel (advertisement/scroll)	7.4	20.2	17.6	4.8	6.1	16.9	9.2	2.0	7.5	20.5	27.9	6.2
Family planning workers/health workers	70.5	64.9	34.3	71.2	61.1	52.6	26.0	56.6	73.6	63.6	34.1	64.6
NGO workers	24.8	30.1	50.0	22.7	13.0	19.5	36.6	15.6	15.8	32.1	47.3	18.8
Newspaper and magazines/quarterly/newsletter	0.8	5.0	2.0	0.4	0.7	4.0	1.5	0.7	1.4	4.6	0.8	0.7
Friends/relatives	82.2	84.0	87.3	72.9	93.9	85.4	96.2	86.1	79.8	80.5	85.3	69.9
Billboard/neonsign/trivision	1.9	2.8	2.0	1.3	1.4	3.0	0.0	0.0	2.1	3.0	0.0	0.3
Poster/leaflet/flier/brochure/booklet/festoon	3.5	10.3	0.0	1.3	2.4	8.3	0.0	0.0	4.5	8.9	3.1	2.4
Polli gaan/folksong	0.0	0.7	0.0	0.0	0.0	0.3	0.0	0.0	0.3	0.0	0.0	0.0
Workshop/seminar	0.4	0.7	0.0	0.0	0.7	1.7	0.0	0.0	0.3	1.3	0.0	1.0
Yard meeting	4.7	2.1	1.0	2.6	5.8	6.0	0.0	1.7	6.8	7.6	1.6	3.8
Satisfied beneficiary	12.0	11.3	14.7	5.2	16.0	21.2	23.7	8.1	10.3	16.9	18.6	4.1
Short film/TV drama	3.1	11.0	1.0	1.7	4.8	11.9	0.8	1.7	5.5	13.9	0.0	2.4
Film show in audio visual van	1.2	1.1	0.0	0.4	2.0	1.7	0.0	0.7	3.4	1.7	0.0	2.7
Myself/reading books	22.9	30.9	7.8	13.1	21.8	34.8	16.8	14.9	25.7	37.4	14.7	18.2
Street drama/others	5.0	6.4	0.0	1.3	4.8	4.3	1.5	2.4	6.5	5.6	1.6	2.4
Sources of knowledge	**Checkup during last pregnancy**				**Knowledge about place of delivery**				**Knowledge about postnatal care**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	63.6	76.2	45.1	40.4	77.9	86.2	69.6	51.7	83.8	88.5	70.5	51.9
Print media	7.4	22.0	4.9	2.6	14.0	29.4	9.8	5.2	16.2	32.6	11.4	6.7
Outdoor activities	96.9	93.6	95.1	90.9	99.2	98.2	96.1	96.1	94.0	94.2	93.0	91.0

Annex Table 6: Low Parity												
Sources of knowledge	**Newborn Care**				**Family Planning**				**Consequences of Having More Children**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	8.9	10.8	0.0	9.5	6.6	11.5	0.0	3.6	7.5	9.9	0.8	7.1
FM/community radio/other broadcasting centers	4.2	6.7	2.4	3.0	5.9	3.6	0.9	3.3	7.5	6.3	2.3	5.4
Bangladesh television	57.4	65.1	44.6	26.3	44.1	53.8	23.1	15.3	64.5	69.2	51.9	27.8
Private television channel (advertisement/scroll)	9.5	17.9	25.3	8.2	7.4	20.8	22.2	2.9	8.9	21.5	30.5	6.1
Family planning workers/health workers	77.4	69.7	27.7	65.9	79.7	62.4	53.0	74.5	65.9	54.0	26.0	55.5
NGO workers	19.5	29.2	44.6	17.7	14.8	28.7	53.0	14.6	11.9	26.5	36.6	16.9
Newspaper and magazines/quarterly/newsletter	1.6	6.2	2.4	1.7	1.2	4.3	1.7	0.4	1.0	4.3	3.8	1.0
Friends/relatives	79.5	85.1	90.4	78.4	79.3	78.1	90.6	74.1	78.8	81.1	90.1	71.9
Billboard/neonsign/trivision	3.2	2.1	0.0	0.0	1.2	3.2	0.9	0.4	4.4	4.0	0.0	0.3
Poster/leaflet/flier/brochure/ booklet/festoon	4.2	8.2	2.4	0.4	2.3	7.5	0.9	0.0	5.1	8.9	0.8	0.7
Polli gaan/folksong	0.5	3.1	0.0	0.0	0.4	1.4	0.0	0.4	0.0	1.0	0.0	0.0
Workshop/seminar	1.6	0.5	0.0	0.0	0.4	0.7	0.0	0.7	3.1	2.0	0.8	0.3
Yard meeting	6.8	8.2	2.4	3.4	6.6	5.4	0.9	2.9	7.8	6.3	2.3	7.8
Satisfied beneficiary	8.9	15.4	15.7	5.2	17.2	19.0	29.1	8.4	8.5	12.9	18.3	3.4
Short film/TV drama	8.9	13.8	2.4	3.4	5.9	14.7	0.9	1.8	12.3	20.9	0.8	4.1
Film show in audio visual van	6.3	1.5	0.0	3.0	2.0	1.8	0.0	0.7	5.5	1.3	0.0	5.8
Myself/reading books	28.9	42.6	20.5	22.8	21.9	34.4	11.1	14.6	34.8	48.0	30.5	30.8
Street drama/others	3.2	3.5	2.4	2.0	1.6	2.6	0.9	0.7	3.1	2.6	0.8	0.7
Sources of knowledge	**Q902 Knowledge about Newborn Care**				**Q1008 Knowledge about family planning**				**Q1016 Consequences of having more children**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	83.8	89.0	71.4	53.8	84.6	91.2	88.8	59.1	94.2	94.1	96.4	78.7
Print media	16.7	34.4	11.4	7.6	27.1	38.7	20.0	8.4	32.2	43.3	20.0	12.5
Outdoor activities	99.5	99.1	98.1	96.2	100.0	99.0	100.0	97.8	100.0	99.6	100.0	99.3

Annex Table 7: Newly Wed												
Sources of knowledge	**Antenatal care**				**Delivery Care**				**Postnatal Care**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	9.5	10.7	0.0	0.0	9.2	11.1	0.0	4.0	9.2	13.9	0.0	7.5
FM/community radio/other broadcasting centers	7.1	10.7	0.0	6.3	6.2	2.8	0.0	7.4	1.5	5.6	2.7	6.0
Bangladesh television	78.6	57.1	0.0	15.6	52.3	44.4	7.9	23.5	66.2	73.6	27.0	25.4
Private television channel (advertisement/scroll)	11.9	25.0	0.0	21.9	12.3	15.3	5.3	10.3	10.8	20.8	10.8	16.4
Family planning workers/health workers	66.7	46.4	0.0	46.9	49.2	43.1	21.1	48.5	40.8	47.2	27.0	49.3
NGO workers	7.1	10.7	0.0	0.0	6.2	6.9	15.8	7.4	9.2	20.8	21.6	7.5
Newspaper and magazines/quarterly/ newsletter	4.8	10.7	0.0	3.1	3.1	1.4	0.0	2.9	3.1	1.4	2.7	4.5
Friends/relatives	78.6	78.6	0.0	78.1	80.0	86.1	89.5	80.9	83.1	88.9	86.5	77.6
Billboard/neonsign/trivision	7.1	0.0	0.0	0.0	3.1	2.8	0.0	0.0	4.6	1.4	0.0	0.0
Poster/leaflet/flier/brochure/booklet/festoon	7.1	14.3	0.0	0.0	3.1	6.9	2.6	0.0	4.6	11.1	0.0	0.0
Polli gaan/folksong	2.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Workshop/seminar	4.8	3.6	0.0	0.0	6.2	1.4	0.0	0.0	7.7	2.8	0.0	0.0
Yard meeting	7.1	0.0	0.0	0.0	7.7	2.8	0.0	2.9	7.7	2.8	0.0	0.0
Satisfied beneficiary	9.5	10.7	0.0	3.1	12.3	6.9	26.3	4.4	9.2	6.9	16.2	4.5
Short film/TV drama	11.9	14.3	0.0	0.0	6.2	5.6	0.0	1.5	10.8	9.7	2.7	3.0
Film show in audio visual van	9.5	3.6	0.0	0.0	4.6	0.0	0.0	0.0	7.7	0.0	0.0	0.0
Myself/reading books	38.1	32.1	0.0	34.4	32.3	33.3	34.2	30.9	35.4	43.1	16.2	35.8
Street drama	2.4	0.0	0.0	0.0	1.5	0.0	0.0	0.0	1.5	0.0	0.0	0.0
Mobile message	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Street drama/others	0.0	0.0	0.0	0.0	1.5	2.8	0.0	0.0	4.6	1.4	0.0	0.0
Sources of knowledge	**Checkup during last pregnancy**				**Knowledge about place of delivery**				**Knowledge about postnatal care**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	86.2	91.7	81.6	54.4	90.6	91.5	83.8	53.1	89.2	93.1	81.6	57.4
Print media	18.5	25.0	2.6	10.3	23.4	31.0	5.4	10.9	24.6	31.9	7.9	10.3
Outdoor activities	95.4	90.3	78.9	89.7	96.0	94.4	86.5	92.2	96.0	95.0	91.0	90.0

Annex Table 8: Newly Wed								
Sources of knowledge	**Newborn Care**				**Family Planning**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	12.3	13.9	0.0	7.7	7.5	9.1	0.0	8.9
FM/community radio/other broadcasting centers	3.1	8.3	7.9	7.7	0.0	3.0	4.5	2.2
Bangladesh television	69.2	73.6	31.6	33.8	60.4	59.1	27.3	17.8
Private television channel (advertisement/scroll)	10.8	19.4	15.8	16.9	17.0	13.6	36.4	11.1
Family planning workers/health workers	56.9	45.8	26.3	50.8	71.7	51.5	31.8	48.9
NGO workers	16.9	22.2	31.6	6.2	7.5	16.7	22.7	2.2
Newspaper and magazines/quarterly/newsletter	3.1	4.2	0.0	3.1	5.7	4.5	0.0	2.2
Friends/relatives	76.9	80.6	94.7	70.8	79.2	86.4	100.0	75.6
Billboard/neonsign/trivision	3.1	1.4	0.0	1.5	1.9	1.5	4.5	0.0
Poster/leaflet/flier/brochure/booklet/festoon	3.1	12.5	0.0	0.0	3.8	7.6	0.0	0.0
Polli gaan/folksong	0.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0
Workshop/seminar	6.2	1.4	0.0	0.0	0.0	1.5	0.0	0.0
Yard meeting	3.1	0.0	2.6	3.1	1.9	3.0	0.0	2.2
Satisfied beneficiary	6.2	4.2	2.6	0.0	15.1	13.6	18.2	6.7
Short film/TV drama	4.6	6.9	0.0	0.0	0.0	3.0	4.5	0.0
Film show in audio visual van	4.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Myself/reading books	23.1	37.5	7.9	21.5	30.2	34.8	0.0	11.1
Street drama	1.5	1.4	0.0	0.0	1.9	1.5	0.0	0.0
Mobile message	0.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0
Street drama/others	6.2	2.8	0.0	0.0	0.0	9.1	0.0	0.0
Sources of knowledge	**Knowledge about Newborn Care**				**Knowledge about family planning**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	89.2	93.1	81.6	58.8	90.8	93.1	92.1	58.8
Print media	26.2	36.1	7.9	10.3	33.8	43.1	7.9	14.7
Outdoor activities	100.0	98.6	94.7	95.6	98.0	98.2	96.0	97.1

Annex Table 9: Currently Pregnant												
Sources of knowledge	**Antenatal care**				**Delivery Care**				**Postnatal Care**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	11.6	7.9	0.0	3.2	6.7	3.3	0.0	1.7	6.7	8.3	0.0	1.7
FM/community radio/ other broadcasting centers	4.7	2.6	0.0	3.2	1.7	3.3	0.0	0.0	3.3	5.0	0.0	5.1
Bangladesh television	48.8	50.0	22.7	12.9	43.3	36.7	33.3	8.5	53.3	55.0	37.0	16.9
Private television channel (advertisement/scroll)	9.3	13.2	22.7	9.7	6.7	11.7	14.8	3.4	1.7	15.0	25.9	10.2
Family planning workers/ health workers	74.4	60.5	27.3	54.8	55.0	46.7	33.3	39.0	76.7	60.0	40.7	45.8
NGO workers	27.9	18.4	54.5	3.2	6.7	16.7	44.4	3.4	25.0	20.0	48.1	8.5
Newspaper and magazines/quarterly/newsletter	0.0	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	0.0	0.0
Friends/relatives	81.4	94.7	90.9	87.1	83.3	91.7	77.8	76.3	86.7	91.7	92.6	81.4
Billboard/neonsign/trivision	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	1.7	0.0	0.0
Poster/leaflet/flier/brochure /booklet/festoon	0.0	2.6	0.0	0.0	0.0	6.7	0.0	0.0	8.3	5.0	0.0	0.0
Polli gaan/folksong	0.0	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Workshop/seminar	2.3	0.0	0.0	0.0	3.3	0.0	0.0	0.0	6.7	0.0	0.0	0.0
Yard meeting	9.3	5.3	0.0	9.7	6.7	3.3	0.0	0.0	15.0	6.7	0.0	5.1
Satisfied beneficiary	4.7	23.7	18.2	9.7	21.7	10.0	14.8	5.1	11.7	11.7	22.2	6.8
Short film/TV drama	7.0	15.8	4.5	3.2	1.7	16.7	7.4	0.0	1.7	15.0	3.7	1.7
Film show in audio visual van	7.0	2.6	0.0	6.5	1.7	1.7	0.0	1.7	0.0	1.7	0.0	0.0
Myself/reading books	23.3	42.1	9.1	22.6	31.7	31.7	18.5	15.3	23.3	38.3	11.1	37.3
Street drama/others	2.3	5.7	4.5	2.2	1.7	8.3	2.4	3.4	5.0	6.7	3.7	2.4
Sources of knowledge	**Checkup during last pregnancy (%)**				**Knowledge about facility delivery (%)**				**Knowledge about postnatal care (%)**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	58.1	52.6	36.4	22.6	80.0	73.3	77.8	39.0	83.3	75.0	77.8	42.4
Print media	0.0	2.6	0.0	0.0	6.7	18.3	7.4	5.1	11.7	20.0	7.4	5.1
Outdoor activities	93.0	92.1	81.8	74.2	100.0	96.7	100.0	93.2	100.0	98.3	100.0	96.6

Annex Table 10: Currently Pregnant												
Sources of knowledge	**Breastfeeding**				**Family Planning**				**Consequences of having more children (%)**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	5.0	10.0	0.0	1.7	7.5	10.0	0.0	0.0	8.3	10.0	3.7	5.2
FM/community radio/other broadcasting centers	5.0	5.0	3.7	5.1	2.5	5.0	0.0	5.6	3.3	6.7	0.0	8.6
Bangladesh television	60.0	58.3	44.4	16.9	45.0	50.0	33.3	5.6	68.3	71.7	59.3	12.1
Private television channel (advertisement/scroll)	6.7	15.0	33.3	5.1	5.0	17.5	33.3	2.8	10.0	18.3	29.6	8.6
Family planning workers/health workers	70.0	55.0	37.0	44.1	82.5	62.5	40.0	75.0	65.0	41.7	37.0	43.1
NGO workers	21.7	21.7	51.9	10.2	15.0	20.0	53.3	5.6	18.3	20.0	33.3	5.2
Newspaper and magazines/quarterly/newsletter	1.7	1.7	0.0	0.0	2.5	2.5	0.0	2.8	0.0	5.0	0.0	1.7
Friends/relatives	88.3	86.7	88.9	81.4	92.5	90.0	86.7	75.0	85.0	81.7	81.5	70.7
Billboard/neonsign/trivision	1.7	1.7	0.0	0.0	0.0	0.0	0.0	0.0	1.7	1.7	0.0	0.0
Poster/leaflet/flier/brochure/ booklet/festoon	6.7	11.7	0.0	0.0	2.5	7.5	0.0	0.0	0.0	5.0	0.0	0.0
Polli gaan/folksong	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Workshop/seminar	3.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.7	0.0	0.0	0.0
Yard meeting	11.7	5.0	0.0	1.7	10.0	10.0	0.0	2.8	6.7	8.3	0.0	6.9
Satisfied beneficiary	11.7	13.3	11.1	8.5	22.5	27.5	20.0	19.4	11.7	8.3	11.1	13.8
Short film/TV drama	3.3	13.3	3.7	1.7	2.5	20.0	0.0	2.8	15.0	20.0	3.7	5.2
Film show in audio visual van	1.7	1.7	0.0	3.4	0.0	2.5	0.0	0.0	5.0	3.3	0.0	3.4
Myself/reading books	28.3	30.0	7.4	27.1	27.5	40.0	26.7	19.4	35.0	48.3	40.7	43.1
Street drama/others	3.1	5.0	3.1	3.1	2.5	7.5	2.3	2.3	2.1	2.3	2.1	1.3
Sources of knowledge	**Knowledge about Newborn Care (%)**				**Knowledge about family planning (%)**				**Consequences of having more children (%)**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	83.3	76.7	77.8	42.4	80.0	87.5	86.7	38.9	92.7	92.1	100.0	73.1
Print media	16.7	23.3	7.4	5.1	22.5	25.0	6.7	11.1	22.0	36.8	8.3	11.5
Outdoor activities	91.0	88.2	92.0	91.0	94.0	94.3	94.5	95.8	97.0	98.2	96.1	93.0

Annex Table 11: Lactating Mothers												
Sources of knowledge	**Breastffeding related knowledge**				**Childcare**				**Family Planning**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	3.6	5.9	0.0	3.4	5.3	8.5	0.0	5.4	7.0	7.9	0.0	4.0
FM/community radio/other broadcasting centers	2.4	4.3	0.0	2.3	4.4	6.7	0.0	3.0	2.7	3.9	0.0	2.0
Bangladesh television	43.1	55.1	16.3	7.5	53.9	66.8	25.8	13.3	42.7	53.2	19.7	14.0
Private television channel (advertisement/scroll)	9.0	15.0	12.0	1.7	10.2	18.8	12.9	4.4	13.0	14.8	15.5	6.7
Family planning workers/health workers	73.7	60.4	46.7	78.7	83.5	71.3	55.9	79.8	83.2	69.0	42.3	66.7
NGO workers	15.0	31.6	54.3	12.6	25.7	29.1	62.4	15.3	17.3	28.1	46.5	16.7
Newspaper and magazines/quarterly/newsletter	1.2	3.2	1.1	0.6	0.5	2.7	1.1	0.0	0.0	2.0	2.8	0.0
Friends/relatives	82.0	91.4	93.5	73.0	70.4	72.2	68.8	52.2	75.7	83.3	88.7	69.3
Billboard/neonsign/trivision	2.4	5.3	0.0	0.0	3.4	4.0	1.1	1.0	2.7	4.4	0.0	0.0
Poster/leaflet/flier/brochure/ booklet/festoon	4.8	9.1	1.1	0.0	10.2	14.8	0.0	0.0	5.9	8.4	0.0	0.0
Polli gaan/folksong	0.6	0.5	0.0	0.0	5.3	14.3	0.0	0.0	0.0	0.5	0.0	0.0
Workshop/seminar	1.2	3.2	0.0	0.0	0.5	2.7	1.1	0.0	0.0	2.0	1.4	0.0
Yard meeting	6.0	4.8	2.2	2.9	7.3	4.0	0.0	3.0	5.4	2.5	1.4	4.7
Satisfied beneficiary	16.8	15.0	30.4	7.5	11.7	14.8	23.7	6.4	15.7	14.8	19.7	9.3
Short film/TV drama	4.8	17.6	1.1	0.0	5.3	11.7	1.1	0.5	6.5	9.9	0.0	0.0
Film show in audio visual van	3.0	0.5	0.0	0.0	3.4	1.3	0.0	1.5	4.3	0.0	0.0	0.0
Myself/reading books	21.6	30.5	12.0	9.2	25.2	36.3	10.8	10.8	24.5	33.0	11.3	21.3
Street drama	5.4	9.1	4.3	4.0	7.8	4.5	2.2	6.4	2.2	3.4	2.8	0.7
Sources of knowledge	**Breastfeeding**				**TT for children (%)**				**Knowledge about FP (%)**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	77.2	87.2	78.3	43.1	76.8	87.4	77.4	44.6	74.3	89.2	80.3	49.3
Print media	12.6	22.5	4.3	2.9	18.8	31.8	4.3	3.4	19.3	33.5	4.2	4.6
Outdoor activities	99.4	96.8	97.8	95.4	99.0	97.8	97.8	98.5	98.9	99.0	98.6	96.7

Annex Table 12: Non User												
Sources of knowledge	**Family Planning**				**Antenatal care**				**Delivery care**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	3.8	9.6	0.0	6.1	3.7	8.1	0.0	3.9	1.5	7.8	0.0	4.1
FM/community radio/ other broadcasting centers	2.4	4.0	2.5	3.5	1.2	2.4	0.0	3.9	0.0	0.6	0.7	1.3
Bangladesh television	47.5	59.7	28.6	16.3	43.2	50.8	27.3	15.9	32.0	35.8	12.8	11.7
Private television channel (advertisement/scroll)	8.8	15.2	23.0	7.2	9.5	17.5	10.4	6.8	5.6	13.4	7.4	5.0
Family planning workers/health	82.6	66.1	46.0	74.3	74.5	63.8	40.3	70.5	58.2	53.3	29.7	47.3
NGO workers	18.5	29.6	57.8	15.5	16.9	27.6	55.8	16.9	14.5	15.0	45.3	10.4
Newspaper and magazines/quarterly / newsletter	2.4	4.3	0.6	2.1	1.2	3.7	1.3	1.4	0.9	2.5	0.0	0.9
Friends/relatives	74.5	81.6	90.1	71.7	83.1	82.9	87.0	71.5	90.8	91.6	94.6	82.6
Billboard/neonsign/trivision	2.1	5.1	0.0	1.3	2.1	5.7	1.3	0.5	0.9	2.5	0.0	0.0
Poster/leaflet/flier/brochure/ booklet/festoon	4.0	8.0	0.6	0.3	1.6	6.1	1.3	1.0	2.7	5.0	0.0	0.0
Polli gaan/folksong	0.5	0.0	1.9	0.3	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Workshop/seminar	2.9	1.6	0.0	1.1	3.7	1.2	0.0	0.5	2.1	0.3	0.0	0.0
Yard meeting	4.0	6.9	0.0	1.9	3.7	4.9	0.0	3.9	4.2	4.0	0.0	1.6
Satisfied beneficiary	15.3	12.5	27.3	11.2	9.9	15.9	18.2	8.2	15.7	18.7	26.4	7.6
Short film/TV drama	9.7	14.4	0.6	2.1	8.6	9.8	1.3	3.9	1.8	9.0	0.0	1.3
Film show in audio visual van	4.3	2.4	0.0	1.1	4.9	0.8	0.0	1.9	1.8	1.2	0.0	0.9
Myself/reading books	20.4	29.1	11.2	14.7	20.2	28.9	9.1	19.3	18.4	24.6	10.8	19.6
Street drama	0.8	0.3	0.0	0.0	0.4	0.4	0.0	0.0	0.3	0.0	0.0	0.0
Mobile message	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Street drama/others	0.8	1.9	1.2	0.0	5.3	4.9	6.5	1.4	3.9	3.1	1.4	1.6
Sources of knowledge	**Knowledge about FP (%)**				**Knowledge to checkup during pregnancy (%)**				**Knowledge about delivery center service (%)**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	62.5	79.5	44.7	31.5	69.3	82.5	64.9	39.1	73.4	83.7	61.8	38.1
Print media	11.5	20.5	2.5	4.5	11.9	24.0	5.2	6.8	15.2	27.7	4.8	7.2
Outdoor activities	97.1	91.7	94.4	90.1	98.4	95.9	97.4	95.7	99.5	97.3	98.8	94.4
Others	79.4	90.4	91.3	78.9	90.6	93.5	96.1	88.9	97.1	98.1	100.0	94.1

Annex Table 13: Non User												
Sources of knowledge	**Newborn Care**				**Vitamin A**				**Pneumonia**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	4.5	10.5	1.2	4.3	6.1	10.3	1.2	6.2	5.9	7.0	0.6	5.3
FM/community radio/other broadcasting centers	5.3	8.6	3.1	4.0	5.6	5.4	4.3	4.1	4.3	4.8	1.8	5.6
Bangladesh television	50.3	65.0	35.0	21.4	59.5	69.9	34.6	22.2	51.6	62.0	26.4	20.6
Private television channel (advertisement/scroll)	9.1	14.8	20.2	6.7	7.7	14.9	20.4	8.6	9.6	13.6	17.8	7.8
Family planning workers/health workers	70.6	60.1	39.3	57.2	66.7	61.5	33.3	54.9	63.0	51.3	33.1	56.1
NGO workers	17.9	28.0	41.7	12.0	17.9	27.4	42.0	12.7	14.4	22.7	39.9	13.9
Newspaper and magazines/quarterly/newsletter	0.8	3.2	0.6	0.8	1.6	5.4	1.9	1.6	1.1	3.7	0.0	0.3
Friends/relatives	76.5	82.2	87.7	69.8	74.9	80.2	82.7	69.7	81.9	83.4	95.1	74.9
Billboard/neonsign/trivision	1.9	3.8	0.0	0.3	2.1	5.1	0.0	0.3	2.9	5.6	0.0	0.5
Poster/leaflet/flier/brochure/booklet/festoon	4.8	7.5	1.2	1.1	5.9	7.9	0.6	0.3	4.5	6.4	1.2	1.1
Polli gaan/folksong	0.3	1.1	0.0	0.0	0.3	2.4	0.0	0.3	0.3	0.3	0.0	0.0
Workshop/seminar	2.7	2.7	0.6	1.6	2.7	2.4	0.0	0.8	3.5	2.9	0.0	0.8
Yard meeting	5.1	7.0	0.6	4.8	7.2	6.8	0.6	4.6	6.6	7.2	0.0	4.3
Satisfied beneficiary	9.1	12.1	17.8	5.6	10.7	9.8	14.8	7.3	8.0	11.2	15.3	7.8
Short film/TV drama	9.9	14.0	0.0	3.5	8.5	16.5	2.5	2.2	9.3	12.8	1.2	3.5
Film show in audio visual van	3.7	1.6	0.0	1.1	4.8	2.2	0.0	1.4	6.1	1.9	0.0	2.9
Myself/reading books	22.5	31.0	10.4	25.7	29.3	36.3	21.0	27.8	24.5	32.6	27.6	27.0
Street drama	0.8	0.0	0.0	0.0	0.5	1.1	0.0	0.3	0.3	0.0	0.0	0.0
Mobile message	0.0	0.0	0.0	0.0	2.4	1.9	0.0	0.0	0.0	0.0	0.0	0.0
Street drama/others	5.1	7.3	2.5	2.7	4.3	3.3	1.2	1.9	15.7	15.0	6.7	5.9
Sources of knowledge	**Knowledge about newborn care (%)**				**Knowledge about Vitamin A (%)**				**Knowledge about Pneumonia (%)**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	77.7	86.4	70.3	44.0	80.1	86.7	75.8	46.1	80.9	89.1	80.6	50.1
Print media	17.0	32.0	8.5	8.5	20.2	36.3	10.9	9.9	21.8	38.4	13.3	10.7
Outdoor activities	100.0	98.7	99.4	95.7	100.0	98.7	100.0	97.3	100.0	98.7	100.0	97.9

Annex Table 14: Adolescent Girls								
Sources of knowledge	**Knowledge about health, nutrition and family planning**				**Knowledge about the care of pregnant mother**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	7.9	10.7	0.0	5.3	10.2	10.6	0.0	6.2
FM/community radio/ broadcasting centers	6.3	4.0	9.4	5.3	5.5	4.6	10.8	6.2
Bangladesh television	54.8	69.3	51.6	34.4	57.5	69.5	60.0	33.1
Private television channel (advertisement/scroll)	9.5	13.3	40.6	12.2	6.3	15.9	43.1	12.3
Family planning workers/health workers	34.1	30.0	4.7	35.1	27.6	31.1	7.7	33.8
NGO workers	4.0	15.3	18.8	6.1	7.1	15.2	20.0	6.9
Newspaper and magazines/quarterly/newsletter	2.4	6.0	6.3	4.6	3.9	4.6	6.2	3.1
Friends/relatives	75.4	79.3	89.1	61.1	78.0	80.8	89.2	68.5
Billboard/neonsign/trivision	7.1	2.0	4.7	0.8	2.4	4.0	4.6	0.8
Poster/leaflet/flier/brochure/booklet/festoon	4.8	9.3	7.8	2.3	2.4	9.3	7.7	1.5
Polli gaan/folksong	0.0	0.0	0.0	0.0	0.8	0.0	0.0	0.0
Workshop/seminar	4.0	6.7	0.0	5.3	5.5	6.0	0.0	3.1
Yard meeting	3.2	4.7	0.0	4.6	3.1	3.3	0.0	6.2
Satisfied beneficiary	3.2	4.0	9.4	4.6	0.8	13.9	6.2	3.8
Short film/TV drama	7.1	15.3	6.3	4.6	8.7	13.9	6.2	3.8
Film show in audio visual van	8.7	0.0	0.0	4.6	8.7	0.0	0.0	5.4
Myself/reading books	54.8	69.3	50.0	58.8	50.4	62.3	47.7	52.3
Street drama	7.9	6.7	1.6	6.1	7.1	7.3	1.5	2.3
Sources of knowledge	**Knowledge about health, nutrition and family planning**				**Knowledge about the care of pregnant mother**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	78.9	88.4	89.7	54.1	79.6	88.9	89.7	55.7
Print media	17.9	33.8	13.8	14.4	18.8	36.4	16.1	16.0
Outdoor activities	97.4	97.0	96.6	95.4	97.4	97.5	97.7	95.9

Annex Table 15: Adolescent Girls								
Sources of knowledge	**Knowledge about menstrual services**				**Knowledge about STD**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Bangladesh Betar	0.0	7.7	0.0	0.0	10.0	9.7	0.0	0.0
FM/community radio/other broadcasting centers	5.7	0.0	0.0	0.0	5.0	9.7	0.0	0.0
Bangladesh television	22.9	25.6	20.0	9.5	60.0	77.4	50.0	30.8
Private television channel (advertisement/scroll)	2.9	7.7	20.0	0.0	20.0	19.4	33.3	7.7
Family planning workers/health workers	25.7	15.4	0.0	38.1	15.0	12.9	0.0	7.7
NGO workers	14.3	2.6	10.0	0.0	5.0	0.0	0.0	0.0
Newspaper and magazines/quarterly/newsletter	0.0	0.0	10.0	0.0	10.0	12.9	16.7	0.0
Friends/relatives	77.1	94.9	90.0	61.9	50.0	54.8	50.0	61.5
Billboard/neonsign/trivision	0.0	2.6	10.0	0.0	0.0	6.5	16.7	0.0
Poster/leaflet/flier/brochure/booklet/festoon	0.0	5.1	10.0	0.0	5.0	12.9	16.7	7.7
Polli gaan/folksong	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Workshop/seminar	2.9	2.6	0.0	0.0	0.0	6.5	0.0	0.0
Yard meeting	0.0	2.6	0.0	0.0	0.0	3.2	0.0	0.0
Satisfied beneficiary	5.7	5.1	0.0	4.8	0.0	0.0	16.7	7.7
Short film/TV drama	2.9	12.8	0.0	4.8	0.0	25.8	0.0	15.4
Film show in audio visual van	0.0	2.6	0.0	4.8	10.0	3.2	0.0	0.0
Myself/reading books	22.9	33.3	30.0	33.3	70.0	83.9	66.7	46.2
Street drama	22.9	15.4	0.0	9.5	10.0	6.5	0.0	0.0
Sources of knowledge	**Knowledge about menstrual services**				**Knowledge about STD**			
	Rural	**Urban**	**Slum**	**Hard-to-reach**	**Rural**	**Urban**	**Slum**	**Hard-to-reach**
Electronic media	79.6	88.9	89.7	55.7	82.7	88.9	89.7	56.7
Print media	18.8	36.9	16.1	16.0	20.4	39.9	17.2	17.0
Outdoor activities	97.4	97.5	97.7	95.9	97.4	98.0	97.7	95.9

Annex Table 16							
	Barisal	**Chittagong**	**Dhaka**	**Khulna**	**Rajshahi**	**Rangpur**	**Sylhet**
Checkup during pregnancy							
Electronic media	78.1	39.7	67.1	72.1	46.4	77	52.9
Print media	2.6	4.9	10.1	7.9	17.8	19.7	7.2
Outdoor activities	97.8	82.8	91.5	95.3	91.7	93	95.9
Place of delivery							
Electronic media	80	39.3	63.2	72	41.6	75.8	49.1
Print media	3.6	4.7	9.8	9.3	17.2	20.9	6.7
Outdoor activities	97.5	82.1	92.3	96.6	93.3	94.3	97
Checkup with 42 days after giving birth							
Electronic media	78.5	38.6	61.3	70	41	76.1	51.7
Print media	3.1	4.5	9.9	9.2	18.3	21.6	6.6
Outdoor activities	97.5	83.2	94.6	97.6	93.6	94.3	96.4
Giving Vitamin A capsule to child							
Electronic media	78.5	38.6	61.3	70	41	76.1	51.7
Print media	3.1	4.5	9.9	9.2	18.3	21.6	6.6
Outdoor activities	96.5	83.2	93.6	96.6	91.6	92.3	95.3

Annex 2: Questionnaire

ID No……

পরিবার পরিকল্পনা অধিদপ্তর এর আইইএম ইউনিট কর্তৃক বাস্তবায়িত আইইসি/এসবিসিসি কার্যক্রম এর ইমপ্যাক্ট সার্ভে

পরিচিতি	
স্ট্যাডি এরিয়াঃ	
বিভাগ ঃ	
জেলা ঃ	
উপজেলা ঃ	
ইউনিয়ন ঃ	
এফডব্লিউএ ইউনিট/ওয়ার্ড ঃ	
মহল্লা/গ্রাম ঃ	
দম্পতি নং ঃ	
প্রশ্নপত্রের নম্বর ঃ	
উত্তরদাত্রীর নাম ঃ	
মোবাইল নম্বর ঃ	
উত্তরদাত্রীর স্বামীর নাম ঃ	

সেকশন ১ ঃ খানা সংক্রান্ত				
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	CODES	SKIP
১০১	আপনার খানায় খাবার পানির ***প্রধান*** উৎস কি?	ঘরের মধ্যে পাইপের পানি ..... ১ বাড়ির চত্বরে/আঙ্গিনায় পাইপের পানি..... ২ টিউবওয়েল ..... ৩ পুকুর/নদী/খাল/বাঁধ ..... ৪ অন্যান্য (নির্দিষ্ট করুন) ৮৮	|___|	
১০২	আপনার খানায় রান্নার কাজে ব্যবহৃত পানির ***প্রধান*** উৎস কি?	ঘরের মধ্যে পাইপের পানি ..... ১ বাড়ির চত্বরে/আঙ্গিনায় পাইপের পানি ..... ২ টিউবওয়েল ..... ৩ পুকুর/নদী/খাল/বাঁধ..... ৪ অন্যান্য (নির্দিষ্ট করুন)..... ৮৮	|___|	
১০৩	আপনার খানায় ঘরের কাজ (যেমন: কাপড় ধোয়া, গোসল করা, থালা-বাসন ধোয়া) করার জন্য ব্যবহৃত পানির ***প্রধান*** উৎস কি?	ঘরের মধ্যে পাইপের পানি ..... ১ বাড়ির চত্বরে/আঙ্গিনায় পাইপের পানি..... ২ টিউবওয়েল ..... ৩ পুকুর/নদী/খাল/বাঁধ ..... ৪ অন্যান্য (নির্দিষ্ট করুন).....৮৮	|___|	
১০৪	আপনার খানায় সদস্যরা ***প্রধাণতঃ*** কোন ধরনের পায়খানা ব্যবহার করেন?	ফ্লাশ ল্যাট্রিন ..... ১ ওয়াটার সিল/স্লাব ..... ২ পিট ল্যাট্রিন..... ৩ খোলা পিট ল্যাট্রিন..... ৪ খাল, নদী, খোলা জায়গা..... ৫ ঝুলন্ত/বাঁশ ..... ৬ অন্যান্য (নির্দিষ্ট করুন)..... ৮৮	|___|	
১০৫	আপনার খানায় বা খানার কোন সদস্যের নিম্নবর্ণিত জিনিসগুলো আছে কি? **[সবগুলো আইটেম জিজ্ঞাসা করবেন]**			
	বিদ্যুৎ ..... A		|___|	
	সৌর বিদ্যুৎ..... B		|___|	
	আইপিএস/জেনারেটর C		|___|	
	আলমারি/ওয়ারড্রব ..... D		|___|	
	রেডিও ..... E		|___|	
	টিভি..... F		|___|	

	মোবাইল ফোন.....G		|___|	
	ল্যান্ড ফোন/টেলিফোন.....H		|___|	
	কম্পিউটার/ল্যাপটপ.....I		|___|	
	রেফ্রিজারেটর/ফ্রিজ.....J		|___|	
	ডিভিডি/ভিসিডি প্লেয়ার.....K		|___|	
	বৈদ্যুতিক পাখা.....L		|___|	
	এসি.....M		|___|	
	পানির পাম্প.....N		|___|	
১০৬	বসত ঘরের দেয়ালের ***প্রধান*** নির্মাণ সামগ্রী কি?	ইট/সিমেন্ট/কংক্রিট ..... ১ টিন ..... ২ কাঠ/বাঁশ ..... ৩ পলিথিন ..... ৪ মাটি ..... ৫ অন্যান্য (নির্দিষ্ট করুন).....৮৮	|___|	
১০৭	আপনার বসত ঘরের ছাঁদ কিসের তৈরী?	ইট/সিমেন্ট/কংক্রিট ..... ১ টিন ..... ২ কাঠ/বাঁশ ..... ৩ পলিথিন ..... ৪ মাটি/টালি ..... ৫ অন্যান্য (নির্দিষ্ট করুন).....৮৮	|___|	
১০৮	আপনার বসত ঘরের মেঝে কি উপাদান দিয়ে তৈরী?	ইট/সিমেন্ট/কংক্রিট ..... ১ কাঠ/বাঁশ ..... ২ মাটি ..... ৩ অন্যান্য (নির্দিষ্ট করুন).....৮৮	|___|	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	CODES	SKIP
২০১.	আপনার বর্তমান বয়স কত?	.....বৎসর	|___|	
২০২.	আপনার শিক্ষাগত যোগ্যতা কি?	কোন শিক্ষা নেই .....01 প্রাথমিক/এবতেদায়ী .....02 মাধ্যমিক/দাখিল .....03 মাধ্যমিকের বেশী/আলিম/ফাযিল/কামিল.....04 কওমি.....05	|___|	
২০৩.	আপনি কোন ধর্মের অনুসারী?	মুসলমান.....01 হিন্দু.....02 বৌদ্ধ.....03 খ্রীস্টান.....04 অন্যান্য (নির্দিষ্ট করুন).....77	|___|	
২০৪.	কত বছর বয়সে আপনার বিয়ে হয়েছে?	.....বৎসর	|___|	
২০৫.	আপনি বর্তমানে স্বামীর সাথে থাকেন কি?	হ্যাঁ.....01 না.....02	|___|	
২০৬.	আপনার জীবিত ছেলেমেয়ের সংখ্যা ?	.....ছেলে .....মেয়ে	|___|	
২০৭.	আপনার সর্বশেষ সন্তানের বয়স কত?	.....বৎসর	|___|	
২০৮.	পাঁচ বছরের কম বয়সী আপনার কোন সন্তান মৃত্যুবরণ করেছে কি?	হ্যাঁ .....1 না .....2 →	|___|	২১০
২০৯.	হ্যাঁ হলে কত জন মৃত্যুবরণ করেছে?	.....জন	|___|	
২১০.	আপনার সন্তান জন্মদানের সময় আপনার বয়স কত ছিল?	*প্রথম সন্তানঃ..... বছর* *দ্বিতীয় সন্তানঃ..... বছর* *ততীয় সন্তানঃ..... বছর* *চতুর্থ সন্তানঃ..... বছর* *পঞ্চম সন্তানঃ..... বছর*	|___|	
২১১.	আপনি আরও কতজন সন্তান নিতে চান?	.....*জন*	|___|	
২১২.	আপনার প্রধান/মূখ্য পেশা কি? (সাধারণতঃ আপনি কি কাজ করে থাকেন?)	বাড়ীর কাজ / গৃহিনী.....1 কৃষিকাজ.....2 কৃষি শ্রমিক.....3	|___|___|	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	CODES	SKIP
		দিনমজুর.....4 ঘরের কাজে সাহায্য করি/গৃহপরিচারিকা.....5 পেশাজীবি/বেতনভুক্ত কর্মচারী .....6 ব্যবসায়ী .....7 কুটির শিল্প .....8 কিছুই করেন না/বেকার .....9 অন্যান্য (নির্দিষ্টভাবে উলেণ্ঢখ করুন) 77		
২১৩.	আপনার স্বামী কি করেন?	ব্যবসা .....1 ক্ষুদ্র ব্যবসা.....2 চাকুরী.....3 কৃষিকাজ.....4 প্রবাসী .....5 রিক্সা/ভ্যান চালক.....6 দিনমজুর .....7 অন্যান্য (নির্দিষ্ট করুন) 77	|___|___|	

সেকশন ৩: গণমাধ্যমের ব্যবহার ও আইইসি/বিসিসি কার্যক্রম সংক্রান্ত				
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	CODES	SKIP
৩০১.	আপনি কি কখনো পত্রিকা/ম্যাগাজিন পড়েছেন?	হ্যাঁ .....1 না .....2 →	|___|	৩০৩
৩০২.	আপনি গত এক সপ্তাহে কতদিন পত্রিকা/ ম্যাগাজিন পড়েছেন?	প্রতিদিন .....1 সপ্তাহে অন্তত ১ দিন.....2 সপ্তাহে একাধিক দিন.....3 একদিন ও না 4	|___|	
৩০৩.	আপনি কি কখনো রেডিও শুনেছেন?	হ্যাঁ .....1 না .....2 →	|___|	৩০৫
৩০৪.	আপনি গত এক সপ্তাহে কতদিন রেডিও শুনেছেন?	প্রতিদিন .....1 সপ্তাহে অন্তত ১ দিন.....2 সপ্তাহে একাধিক দিন.....3 একদিন ও না 4	|___|	
৩০৫.	আপনি কি কখনো টেলিভিশন দেখেছেন?	হ্যাঁ .....1 না .....2 →	|___|	৩০৮
৩০৬.	আপনি গত এক সপ্তাহে কতদিন টেলিভিশন দেখেছেন?	প্রতিদিন .....1 সপ্তাহে অন্তত ১ দিন.....2 সপ্তাহে একাধিক দিন.....3 একদিন ও না 4	|___|	
৩০৭.	আপনি সাধারণত কোন ধরনের টেলিভিশন চ্যানেল দেখেন?	**USE CODE BOOK**	|___|	
৩০৮.	আপনি কি কখনো ইন্টারনেট ব্যবহার করেছেন?	হ্যাঁ .....1 না .....2 →	|___|	৩১০
৩০৯.	আপনি গত এক সপ্তাহে কতদিন ইন্টারনেট ব্যবহার করেছেন?	প্রতিদিন .....1 সপ্তাহে অন্তত ১ দিন.....2 সপ্তাহে একাধিক দিন.....3 একদিন ও না 4	|___|	
৩১০.	**৩০৩ নং প্রশ্নের উত্তর হ্যাঁ হলে**, আপনি যখন বাংলাদেশ বেতার/এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচারের অনুষ্ঠানসমূহ শোনেন তা সাধারণত কতক্ষণ শোনেন? (দৈনিক)	.....মিনিট	|___|	
৩১১.	আপনি সাধারণত কোন সময়ে বাংলাদেশ	সকাল.....1	|___|	

সেকশন ৩: গণমাধ্যমের ব্যবহার ও আইইসি/বিসিসি কার্যক্রম সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
	বেতার/এফ এম রেডিও/কমিউনিটি রেডিও /অন্যান্য সম্প্রচারের অনুষ্ঠানসমূহ শোনেন?	দুপুর .....2 সন্ধ্যা.....3 রাত.....4 মধ্যরাত 5		
৩১২.	**৩০৫ নং প্রশ্নের উত্তর হ্যা হলে**, আপনি যখন বাংলাদেশ টেলিভিশনের সরকারী (বিটিভি)/প্রাইভেট অন্যান্য চ্যানেলের অনুষ্ঠানসমূহ দেখেন তা সাধারণত কতক্ষণ দেখেন?	.....মিনিট	|___|	
৩১৩.	আপনি সাধারণত কোন সময়ে বাংলাদেশ টেলিভিশনের সরকারী (বিটিভি)/প্রাইভেট অন্যান্য চ্যানেলের অনুষ্ঠানসমূহ দেখেন?	সকাল.....1 দুপুর .....2 সন্ধ্যা.....3 রাত.....4 মধ্যরাত 5	|___|	
৩১৪.	আপনি কি জানেন, বাংলাদেশ বেতারের বিভিন্ন সম্প্রচার কেন্দ্র স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক অনুষ্ঠানসমূহ প্রচারিত হয়?	হ্যাঁ .....1 না 2	|___|	
৩১৫.	আপনি কি জানেন, বাংলাদেশ টেলিভিশনের বিভিন্ন চ্যানেলে স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক অনুষ্ঠানসমূহ প্রচারিত হয়?	হ্যাঁ .....1 না 2	|___|	
৩১৬.	বাংলাদেশ বেতারের বিভিন্ন সম্প্রচার কেন্দ্র এবং বাংলাদেশ টেলিভিশনের বিভিন্ন চ্যানেলে স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক অনুষ্ঠানসমূহ শুনে বা দেখে আপনি ব্যক্তি ও পারিবারিক জীবনে এগুলো মেনে চলার চেষ্টা করেন কি?	হ্যাঁ .....1 না 2	|___|	
৩১৭.	বাংলাদেশ বেতার/এফ এম রেডিও/কমিউনিটি রেডিও /অন্যান্য সম্প্রচার কেন্দ্র এবং বাংলাদেশ টেলিভিশনের সরকারী (বিটিভি)/প্রাইভেট অন্যান্য চ্যানেলে স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক অনুষ্ঠান আরো জনপ্রিয় করার জন্য কী ধরণের পদক্ষেপ নেয়া যেতে পারে বলে আপনি মনে করেন?	প্রচারের সময় পরিবর্তন .....1 পুনঃপ্রচারের ব্যবস্থা করা .....2 প্রচারের সময় বৃদ্ধি করা .....3 প্রচার আরো আকর্ষণীয় করা .....4 অন্যান্য (নির্দিষ্ট করুন) .....77 জানি না 88	|___|	

সেকশন ৪: বাল্যবিবাহ সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৪০১.	আপনি কি জানেন কত বছর বয়সে বিয়ে হলে তাকে বাল্যবিবাহ বলে গণ্য করা হয়?	.....বছর জানি না 97	|___|___|	
৪০২.	কত বছর বয়সে মেয়েদের বিয়ে দেয়া উচিত?	.....বছর জানি না 97	|___|___|	
৪০৩.	আপনার মতে, মেয়েদের ১৮ বছরের আগে বিয়ের ফলে কি হয়? **[উত্তরদাতাকে উত্তর পড়ে শোনাবেন না। তাকে প্রোব করুন]** (একাধিক উত্তর হতে পারে)	অল্প বয়সে গর্ভধারণ .....A মায়ের অপুষ্টি বৃদ্ধি .....B মায়ের স্বাস্থ্যঝুঁকি .....C নবজাতকের স্বাস্থ্যঝুঁকি .....D মাতৃমৃত্যুর ঝুঁকি.....E শিশু মৃত্যুর ঝুঁকি.....F দাম্পত্য জীবনে কলহ .....G সংসারে অস্বচ্ছলতা .....H নারী নির্যাতন বৃদ্ধি.....I আত্মহত্যার ঝুঁকি বৃদ্ধি .....J বিবাহ বিচ্ছেদ .....K পড়ালেখা বন্ধ হওয়া .....L কোন ক্ষতিকর দিক নেই .....M অন্যান্য (নির্দিষ্ট করুন) X	|___| |___| |___| |___| |___|	

সেকশন ৪: বাল্যবিবাহ সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৪০৪.	*আপনার মতে, মেয়েদের ১৮ বছরের আগে বিয়ের সুবিধাগুলো কি কি?* [উত্তরদাতাকে উত্তর পড়ে শোনাবেন না। তাকে প্রোব করুন] *(একাধিক উত্তর হতে পারে)*	সামাজিক অপবাদ থেকে রক্ষা পাওয়া যায় .....A অপহরনের ঝুঁকি থেকে রক্ষা পাওয়া যায় .....B বিবাহপূর্ব যৌন সম্পর্ক থেকে মেয়েদেরকে রক্ষা করা যায়.....C বাবা মায়ের বোঝা কমে যায়.....D ইভ টিজিং থেকে বাঁচা যায় .....E যৌতুক কম দিতে হয়.....F কোন সুবিধা নেই.....G জানি না .....Z	|___| |___| |___|	
৪০৫.	*বাল্যবিবাহ সম্পর্কে আপনি কিভাবে জেনেছেন?* *(একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে .....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে.....L উঠান বৈঠকের মাধ্যমে .....M সন্তুষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___| |___| |___|	

সেকশন ৫: স্বাস্থ্য ও পরিবার পরিকল্পনা সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৫০১.	আপনি কি জানেন, আপনার এলাকায় কোন স্বাস্থ্য ও পরিবার পরিকল্পনা সেবা কেন্দ্র আছে? (না বললে প্রোব করুন)	হ্যাঁ .....1 না .....2 →	|__|	 ৫০৩
৫০২.	হ্যাঁ হলে, কি কি স্বাস্থ্য ও পরিবার পরিকল্পনা সেবা কেন্দ্র আছে? *(একাধিক উত্তর হতে পারে)*	মেডিকেল কলেজ হাসপাতাল.....A জেলা হাসপাতাল.....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....D মা ও শিশু কল্যাণ কেন্দ্র .....E কমিউনিটি ক্লিনিক .....F স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র .....G বেসরকারী হাসপাতাল/ক্লিনিক .....H এনজিও ক্লিনিক.....I প্রাইভেট ক্লিনিক .....J সিএসবিএ.....K অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___| |___|	
৫০৩.	আপনি জানেন কি স্বাস্থ্য ও পরিবার পরিকল্পনা সেবা কেন্দ্রগুলোতে কী কী সেবা প্রদান করা হয়?	হ্যাঁ .....1 না .....2 →		৬০১
৫০৪.	হ্যাঁ হলে, কি কি সেবা প্রদান করা হয়?	গর্ভকালীন যত্ন.....A প্রসবকালীন যত্ন.....B	|___|	

সেকশন ৫: স্বাস্থ্য ও পরিবার পরিকল্পনা সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
	(একাধিক উত্তর হতে পারে)	প্রসবোত্তর যত্ন.....C নিরাপদ ডেলিভারী .....D পরিবার পরিকল্পনা সেবা.....E সাধারণ রোগ ব্যধি.....F নবজাতকের যত্ন.....G টিকাদান.....H শিশুর যত্ন .....I এইচআইভি/এইডস বিষয়ক পরামর্শ.....J পুষ্টি .....K স্বাস্থ্য শিক্ষা .....L বিভিন্ন বিষয়ে পরামর্শদান .....M যৌনবাহিত রোগের চিকিৎসা.....N অন্যান্য (নির্দিষ্ট করুন) X	⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋	
৫০৫.	আপনি স্বাস্থ্য ও পরিবার পরিকল্পনা বিষয়ক সেবাসমূহ সম্পর্কে কিভাবে জেনেছেন? *(একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে.....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে.....L উঠান বৈঠকের মাধ্যমে .....M সন্তুষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋	

সেকশন ৬: গর্ভকালীন সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৬০১.	সর্বশেষ কত বছর আগে আপনি গর্ভধারণ করেছেন?	.....বছর	⌊__⌋	
৬০২.	আপনার গর্ভকালীন সময়ে কোন চেকআপ করিয়েছেন কি?	হ্যাঁ .....1 না .....2 →	⌊__⌋	৬০৪
৬০৩.	হ্যাঁ হলে, কোথায় চেকআপ করিয়েছেন? *(একাধিক উত্তর হতে পারে)*	মেডিকেল কলেজ হাসপাতাল.....A জেলা হাসপাতাল.....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....D মা ও শিশু কল্যাণ কেন্দ্র.....E কমিউনিটি ক্লিনিক .....F স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র .....G বেসরকারী হাসপাতাল/ক্লিনিক .....H এনজিও ক্লিনিক.....I প্রাইভেট ক্লিনিক .....J সিএসবিএ.....K অন্যান্য (নির্দিষ্ট করুন).....X	⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋	

সেকশন ৬: গর্ভকালীন সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৬০৪.	আপনার সর্বশেষ গর্ভকালীন সময়ে আপনি মোট কতবার চেকআপ করিয়েছেন?	.....বার	|___|	
৬০৫.	আপনার সর্বশেষ গর্ভকালীন সময়ে আপনি টিটি টিকা দিয়েছেন কি?	হ্যাঁ .....1 না 2	|___|	→ ৬০৮
৬০৬.	হ্যাঁ হলে, আপনার সর্বশেষ গর্ভকালীন সময়ে মোট কতবার টিকা নিয়েছেন?	.....বার	|___|	
৬০৭.	আপনি এ পর্যন্ত মোট কতবার টিটি টিকা নিয়েছেন? (বিয়ের আগে ও গর্ভধারণের সময়সহ)	.....বার	|___|	
৬০৮.	একজন গর্ভবতী মায়ের কি কি যত্ন নেয়া দরকার বলে আপনি মনে করেন? (*একাধিক উত্তর হতে পারে*)	নিয়মিত ওজন নেয়া.....A বাড়তি খাবার দেয়া .....B ভারী কাজ না করা .....C প্রয়োজনীয় বিশ্রাম নেয়া .....D প্রয়োজনে আয়রন ট্যাবলেট খাওয়া .....E প্রয়োজনে ভিটামিন এ ক্যাপসুল খাওয়া.....F টিকা নেয়া .....G অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___|	
৬০৯.	আপনার এই গর্ভধারণ কি ইচ্ছাকৃত ছিল?	*হ্যাঁ .....1* *না 2*	|___|	
৬১০.	আপনি বাচ্চা জন্মানোর কত সময় পর বুকের দুধ খাওয়ানোর ইচ্ছা পোষণ করেন?	জন্মের পর পর .....01 জন্মের ২৪ ঘন্টার মধ্যে.....02 জন্মের ২৪ ঘন্টা পর .....03 *অন্যান্য (নির্দিষ্ট করুন) 77*	|___|	
৬১১.	আপনি শাল দুধ কী করবেন?	বাচ্চাকে খাওয়াবেন.....01 ফেলে দিবেন.....02 কিছুই করবেন না.....03 *জানি না 04*	|___|	
৬১২.	আপনি বাচ্চাকে কত মাস কেবলমাত্র বুকের দুধ খাওয়ানোর ইচ্ছা পোষণ করেন?	৬ মাস .....01 ৬ মাসের কম .....02 ৬ মাসের বেশী .....03 অন্যান্য (নির্দিষ্ট করুন).....77	|___|	
৬১৩.	আপনি বাচ্চাকে কত মাস পর বুকের দুধের পাশাপাশি শক্ত খাবার খাওয়ানোর ইচ্ছা পোষণ করেন?	৬ মাস .....01 ৬ মাসের কম .....02 ৬ মাসের বেশী .....03 অন্যান্য (নির্দিষ্ট করুন).....77	|___|	
৬১৪.	বাচ্চাকে ছয় মাস পর্যন্ত বুকের দুধ খাওয়ালে কি কি উপকারিতা পাওয়া যায়? (*একাধিক উত্তর হতে পারে)*	বাচ্চার রোগ প্রতিরোধ ক্ষমতা বৃদ্ধি পায় .....01 বাচ্চার মেধাশক্তি বেশি হয় .....02 বাচ্চার অসুখ কম হয়.....03 বাচ্চা সুস্বাস্থ্যের অধিকারী হয়.....04 মায়ের স্বাস্থ্য ভালো হয়.....05 মা দেরীতে গর্ভবতী হয়.....06 অন্যান্য (নির্দিষ্ট করুন).....77	|___| |___| |___|	
৬১৫.	আপনার পূর্বের গর্ভকালীন সময়ে কোন চেকআপ করিয়েছেন কি? (কোন জীবিত সন্তান না থাকলে, এই প্রশ্ন প্রযোজ্য নহে)	হ্যাঁ .....1 না 2	|___|	→ ৬১৮
৬১৬.	হ্যাঁ হলে, কোথায় চেকআপ করিয়েছেন?(কোন জীবিত সন্তান না থাকলে, এই প্রশ্ন প্রযোজ্য নহে) (*একাধিক উত্তর হতে পারে)*	মেডিকেল কলেজ হাসপাতাল.....A জেলা হাসপাতাল.....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....D মা ও শিশু কল্যাণ কেন্দ্র .....E কমিউনিটি ক্লিনিক .....F স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র .....G বেসরকারী হাসপাতাল/ক্লিনিক.....H	|___| |___| |___|	

সেকশন ৬: গর্ভকালীন সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
		এনজিও ক্লিনিক.....I প্রাইভেট ক্লিনিক .....J সিএসবিএ .....K অন্যান্য (নির্দিষ্ট করুন).....X	|___|	
৬১৭.	আপনার গর্ভকালীন সময়ে আপনি মোট কতবার চেকআপ করিয়েছিলেন?(কোন জীবিত সন্তান না থাকলে, এই প্রশ্ন প্রযোজ্য নহে)	……বার	|___|	
৬১৮.	আপনার গর্ভকালীন সময়ে আপনি টিটি টিকা নিয়েছিলেন কি?(কোন জীবিত সন্তান না থাকলে, এই প্রশ্ন প্রযোজ্য নহে)	হ্যাঁ .....1 না 2	|___| →	 ৬২১
৬১৯.	হ্যাঁ হলে, আপনার গর্ভকালীন সময়ে মোট কতটি টিকা নিয়েছিলেন?(কোন জীবিত সন্তান না থাকলে, এই প্রশ্ন প্রযোজ্য নহে)	……টি	|___|	
৬২০.	আপনি এ পর্যন্ত মোট কতবার টিটি টিকা নিয়েছেন?(কোন জীবিত সন্তান না থাকলে, এই প্রশ্ন প্রযোজ্য নহে) (বিয়ের আগে ও গর্ভধারণের সময়সহ)	……বার	|___|	
৬২১.	আপনি গর্ভকালীন এবং গর্ভবতী মায়ের যত্নবিষয়ক সেবা সম্পর্কে কিভাবে জেনেছেন? *(একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে.....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে .....L উঠান বৈঠকের মাধ্যমে .....M সন্তুষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___| |___| |___| |___|	

সেকশন ৭: ডেলিভারি সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৭০১.	আপনার সর্বশেষ সন্তানের জন্ম কোথায় হয়েছে?	বাড়িতে.....01 মেডিকেল কলেজ হাসপাতাল.....02 জেলা হাসপাতাল.....03 উপজেলা স্বাস্থ্য কমপ্লেক্স.....04 ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....05 মা ও শিশু কল্যাণ কেন্দ্র.....06 কমিউনিটি ক্লিনিক.....07 স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র.....08 বেসরকারী হাসপাতাল/ক্লিনিক.....09 এনজিও ক্লিনিক.....10 প্রাইভেট ক্লিনিক.....11 সিএসবিএ.....12 অন্যান্য (নির্দিষ্ট করুন).....77	|___| |___| |___| |___| |___|	

সেকশন ৭: ডেলিভারি সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৭০২.	আপনার সন্তান কোথায় প্রসব করাতে চান?	বাড়িতে.....01 মেডিকেল কলেজ হাসপাতাল.....02 জেলা হাসপাতাল.....03 উপজেলা স্বাস্থ্য কমপ্লেক্স.....04 ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....05 মা ও শিশু কল্যাণ কেন্দ্র.....06 কমিউনিটি ক্লিনিক.....07 স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র.....08 বেসরকারী হাসপাতাল/ক্লিনিক.....09 এনজিও ক্লিনিক.....10 প্রাইভেট ক্লিনিক.....11 সিএসবিএ.....12 অন্যান্য (নির্দিষ্ট করুন).....77	|___| |___| |___| |___| |___|	
৭০৩.	জন্মের কতক্ষণ পর বাচ্চাকে বুকের দুধ খাওয়াতে শুরু করেছেন?	জন্মের পর পর.....01 জন্মের ২৪ ঘন্টার মধ্যে.....02 জনের ২৪ ঘন্টা পর.....03	|___|	
৭০৪.	আপনার বাচ্চাকে শাল দুধ খাইয়েছিলেন কি?	হ্যাঁ.....1 না.....2	|___|	
৭০৫.	না হলে, সদ্যজাত শিশুকে শালদুধ না খাওয়ানোর কারণ কি? *(একাধিক উত্তর হতে পারে)*	শিশুর পাকস্থলী বড় হয়.....A মায়ের ক্ষতি হয়.....B শিশুর ক্ষতি হয়.....C মা এবং শিশুর ক্ষতি হয়.....D অন্যান্য (নির্দিষ্ট করুন).....E	|___| |___|	
৭০৬.	আপনার বাচ্চাকে বুকের দুধ ছাড়া আপনি পানি বা বাজারের কোন দুধ খাওয়াচ্ছেন কি?	হ্যাঁ.....1 না.....2	|___|	
৭০৭.	জন্মের ৬ মাস পর্যন্ত বাচ্চাকে শুধুমাত্র বুকের দুধ খাওয়ানোর উপকারিতা কী কী?	মায়ের অসুখ হয় না.....01 শিশুর অসুখ হয় না.....02 মা ও শিশুর অসুখ হয় না.....03 মায়ের রোগ প্রতিরোধ ক্ষমতা বৃদ্ধি পায়.....04 শিশুর রোগ প্রতিরোধ ক্ষমতা বৃদ্ধি পায়.....05 অন্যান্য (নির্দিষ্ট করুন).....77	|___|	

৭০৮.	বাচ্চাকে জন্মের কত মাস পর বুকের দুধের পাশাপাশি শক্ত খাবার খাওয়ানো উচিত?	৬ মাস পর .....01 ১ বছর পর.....02 ২ বছর পর.....03 অন্যান্য (নির্দিষ্ট করুন) 77	|___|	
৭০৯.	আপনি বাচ্চাকে জন্মের কত মাস পর বুকের দুধের পাশাপাশি শক্ত খাবার খাওয়ানো শুরু করেছেন?	৬ মাস পর .....01 ১ বছর পর.....02 ২ বছর পর.....03 অন্যান্য (নির্দিষ্ট করুন) 77	|___|	
৭১০.	বুকের দুধ বৃদ্ধি পাওয়ার জন্য আপনি কী করছেন?	খাওয়া বৃদ্ধি করেছি.....01 তরল খাবার খাওয়া বৃদ্ধি করেছি.....02 কিছুই করিনি.....03 অন্যান্য (নির্দিষ্ট করুন) 77	|___|	
৭১১.	আপনি ডেলিভারি সেবাগুলো সম্বন্ধে কিভাবে জেনেছেন? (একাধিক উত্তর গ্রহণযোগ্য)	বাংলাদেশ বেতারের মাধ্যমে.....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে.....L উঠান বৈঠকের মাধ্যমে .....M সন্তুষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___| |___|	

সেকশন ৮: ডেলিভারি পরবর্তী সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
৮০১.	প্রসব পরবর্তী নিজের/শিশুর সেবা নেয়ার জন্য সন্তান জন্মের পর ৪২ দিনের মধ্যে আপনি কোন সেবাকেন্দ্রে গিয়েছেন কি?	হ্যাঁ .....1 না 2	|___| →	৮০৩
৮০২.	হ্যাঁ হলে, সন্তান জন্মের কতদিন পর আপনি সেবাকেন্দ্রে গিয়েছেন?	৭ দিনের মধ্যে.....01 ৭ দিন পর .....02 ১৪ দিন পর.....03 ২১ দিন পর.....04 ২৮ দিন পর .....05 অন্যান্য (নির্দিষ্ট করুন) 77	|___|	
৮০৩.	প্রসব পরবর্তী সেবা নেয়ার জন্য আপনি কোন সেবাকেন্দ্রে গিয়েছেন? *(একাধিক উত্তর হতে পারে)*	মেডিকেল কলেজ হাসপাতাল.....A জেলা হাসপাতাল.....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....D মা ও শিশু কল্যাণ কেন্দ্র .....E কমিউনিটি ক্লিনিক .....F স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র .....G বেসরকারী হাসপাতাল/ক্লিনিক .....H	|___| |___| |___| |___|	

সেকশন ৮: ডেলিভারি পরবর্তী সেবা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
		এনজিও ক্লিনিক.....I প্রাইভেট ক্লিনিক.....J সিএসবিএ.....K অন্যান্য (নির্দিষ্ট করুন).....X	⌊__⌋	
৮০৪.	প্রসব পরবর্তী সময়ে একজন মায়ের কি কি যত্ন নেয়া দরকার বলে আপনি মনে করেন? *(একাধিক উত্তর হতে পারে)*	বাড়তি খাবার দেয়া.....A তরল খাবার খাওয়া.....B পুষ্টিকর খাবার.....C ভারী কাজ না করা.....D প্রয়োজনীয় বিশ্রাম নেয়া.....E প্রয়োজনে আয়রন ট্যাবলেট খাওয়া.....F প্রয়োজনে ভিটামিন এ ক্যাপসুল খাওয়া.....G টিকা নেয়া.....H অন্যান্য (নির্দিষ্ট করুন).....X	⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋	
৮০৫.	প্রসব পরবর্তী সময়ে মায়ের যত্ন এবং সেবাসমূহ সম্পর্কে আপনি কিভাবে জেনেছেন? *(একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে.....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে.....E এনজিও কর্মীর মাধ্যমে.....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে.....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে.....K ওয়ার্কশপ/সেমিনারের মাধ্যমে.....L উঠান বৈঠকের মাধ্যমে.....M সন্তুষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক).....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে.....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে.....S অন্যান্য (নির্দিষ্ট করুন).....X	⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋	

সেকশন ৯: শিশুস্বাস্থ্য সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
	এই সেকশনের যাবতীয় প্রশ্ন শুধুমাত্র যাদের ৫ বছরের কম বয়সী সন্তান আছে তাদের জন্য প্রযোজ্য			
৯০১.	নবজাতকের কি কি যত্ন নেয়া দরকার বলে আপনি মনে করেন? *(একাধিক উত্তর হতে পারে)*	নিয়মিত ওজন নেয়া.....A শাল দুধ খাওয়ানো.....B জন্মের ৬ মাস পর্যন্ত শুধুমাত্র বুকের দুধ খাওয়ানো .....C ৬ মাস পর বুকের দুধের সাথে অন্য খাবার দেয়া.....D ভিটামিন এ ক্যাপসুল খাওয়ানো.....E টিকা নেয়া.....F অন্যান্য (নির্দিষ্ট করুন).....X	⌊__⌋ ⌊__⌋ ⌊__⌋	
৯০২.	আপনার সর্বশেষ সন্তানের টিকা দেয়া হয়েছে কি?	হ্যাঁ.....1 না.....2	⌊__⌋	
৯০৩.	আপনার সন্তানকে গত ৬ মাসে ভিটামিন এ ক্যাপসুল খাওয়ানো হয়েছে কি?	হ্যাঁ.....1 না.....2 প্রযোজ্য নয়.....3	⌊__⌋ →	৯০৫
৯০৪.	ভিটামিন এ ক্যাপসুল খাওয়ানোর উপকারিতা কী?	রাতকানা রোগ হয় না.....01 কোন রোগ হয় না.....02	⌊__⌋	

সেকশন ৯: শিশুস্বাস্থ্য সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
		অন্যান্য (নির্দিষ্ট করুন).....77		
৯০৫.	কী কী খাবার খেলে ভিটামিন এ এর অভাব পূরণ হয়? *(একাধিক উত্তর হতে পারে)*	শাক-সব্জি.....A ফল-মূল .....B মাছ-মাংস.....C ডিম-দুধ.....D মিষ্টি আলু .....E অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___|	
৯০৬.	কী কী কারণে শিশুর ডায়রিয়া হয়? *(একাধিক উত্তর হতে পারে)*	দূষিত পানি বা তরল খাওয়া .....A দূষিত/নষ্ট হয়ে যাওয়া খাবার খাওয়া.....B খাবার খাওয়ার আগে হাত না ধোয়া .....C পায়খানার পর সাবান দিয়ে হাত না ধোয়া .....D স্বাস্থ্যসম্মত পায়খানা ব্যবহার না করা.....E ২ বছর পর্যন্ত শিশুকে বুকের দুধ না খাওয়ালে .....F সঠিক সময়ে টিকা না দিলে .....G অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___|	
৯০৭.	ডায়রিয়া আক্রান্ত শিশুর কী ধরণের সেবা দেয়া উচিত? *(একাধিক উত্তর হতে পারে)*	ওরস্যালাইন খাওয়ানো .....A বাড়িতে তৈরি তরল খাওয়ানো.....B স্বাভাবিক খাবার খাওয়ানো.....C বুকের দুধ খাওয়ানো চালিয়ে যাওয়া .....D প্রয়োজনে নিকটস্থ স্বাস্থ্যকর্মী/পরিবার পরিকল্পনা কর্মী/ স্বাস্থ্যকেন্দ্রে যাওয়া .....E অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___|	
৯০৮.	কী কারনে শিশুর নিউমোনিয়া হয়? *(একাধিক উত্তর হতে পারে)*	কম ওজনের বাচ্চা (জন্মকালীন ওজন আড়াই কেজির কম)...A সঠিকভাবে বুকের দুধ না খাওয়ানো.....B পুষ্টিহীনতা.....C ৬ টি রোগের প্রতিষেধক না দেয়া .....D ভিটামিন এ এর অভাব .....E ঠান্ডা বা স্যাঁতস্যাঁতে আবহাওয়া .....F ঘন বসতি ও দূষিত পরিবেশ.....G অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___|	
৯০৯.	শিশুর নিউমোনিয়া হওয়ার প্রধান লক্ষণগুলো কী? *(একাধিক উত্তর হতে পারে)*	কাশি ও ঠান্ডা .....A জ্বর.....B দ্রুত শ্বাস-প্রশ্বাস .....C বুক ভিতরের দিকে ডেবে যাওয়া .....D বুকের দুধ টেনে খেতে না পারা.....E অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___|	
৯১০.	আপনি বাচ্চা জন্ম নেয়ার কত বৎসর পর আবার বাচ্চা নেয়ার ইচ্ছা পোষণ করেন?	.....বছর আর চাই না/ প্রয়োজন নেই.....77	|___|___|	
৯১১.	আপনি শিশুস্বাস্থ্যের যত্ন এবং শিশুস্বাস্থ্য সংক্রান্ত সেবা সম্পর্কে আপনি কিভাবে জেনেছেন? *(একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে.....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে.....L	|___| |___| |___| |___| |___|	

সেকশন ৯: শিশুস্বাস্থ্য সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
		উঠান বৈঠকের মাধ্যমে .....M সম্ভষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___|	

সেকশন ১০: পরিবার পরিকল্পনা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
১০০১.	বর্তমানে আপনি (স্বামী/স্ত্রী) কি কোন পরিবার পরিকল্পনা পদ্ধতি গ্রহণ করেছেন?	হ্যাঁ .....1 না 2	|___|	→ ১০০৩
১০০২.	হ্যাঁ হলে, প্রধানত কি ধরণের পদ্ধতি গ্রহণ করেছেন?	***মডার্ণ মেথড*** খাবার বড়ি .....01 কনডম.....02 আইইউডি.....03 ইনজেকশন.....04 ইমপ্ল্যান্ট.....05 এনএসভি .....06 টিউবেকটমি.....07 আপন/মিনিপিল (পিওলি).....08 ***ট্রেডিশনাল মেথড*** নিরাপদ দিনকাল গণনা.....09 প্রত্যাহার .....10 অন্যান্য (নির্দিষ্ট করুন).....77	|___| |___| |___|	
১০০৩.	গত এক বছরে আপনি কোন পদ্ধতি গ্রহণ করেও বন্ধ করেছেন কি?	হ্যাঁ .....1 না 2	|___|	→ ১০০৫
১০০৪.	হ্যাঁ হলে, কেন আপনি পদ্ধতি ব্যবহার করেও বন্ধ করেছেন? (একাধিক উত্তর হতে পারে)	পার্শ্বপ্রতিক্রিয়া/ স্বাস্থ্যঝুঁকি .....A পদ্ধতি গ্রহণ সত্ত্বেও গর্ভধারণ করা .....B কার্যকারিতা নেই.....C মাঠকর্মীদের সময়মত না পাওয়া.....D সময়মত সরবরাহ না পাওয়া.....E সন্তান নিতে চাওয়া.....F অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___|	
১০০৫.	গত এক বছরে আপনি এক পদ্ধতি থেকে আরেক পদ্ধতিতে গিয়েছেন কি না?	হ্যাঁ .....1 না 2	|___|	→ ১০০৭
১০০৬.	হ্যাঁ হলে, কেন পদ্ধতি পরিবর্তন করেছেন? (একাধিক উত্তর হতে পারে)	পার্শ্বপ্রতিক্রিয়া/ স্বাস্থ্যঝুঁকি .....A কার্যকারিতা নেই.....B মাঠকর্মীদের সময়মত না পাওয়া.....C সময়মত সরবরাহ না পাওয়া.....D অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___|	
১০০৭.	আপনি পরিবার পরিকল্পনা পদ্ধতি কোথা থেকে গ্রহণ করেছেন? *(একাধিক উত্তর হতে পারে)*	হাসপাতাল .....A মেডিকেল কলেজ.....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....D কমিউনিটি ক্লিনিক .....E মা ও শিশু কল্যাণ কেন্দ্র .....F সরকারী মাঠকর্মী/পরিবার কল্যাণ সহকর্মী/মাঠকর্মী .....Gএনি	|___| |___| |___|	

সেকশন ১০: পরিবার পরিকল্পনা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
		জওক্লিনিক.....H কমিউনিটি ক্লিনিক .....I এনজিও মাঠকর্মী .....J দোকান (ব্লু স্টার/সাধারণ) .....K অন্যান্য (নির্দিষ্ট করুন).....X	|__|	
১০০৮.	পরিবার পরিকল্পনা পদ্ধতি গ্রহণে স্বামীর সমর্থন পান কি না?	হ্যাঁ .....1 না 2	|__|	
১০০৯.	দীর্ঘমেয়াদী পদ্ধতি (আইইউডি, ইমপ্ল্যান্ট) সম্পর্কে আপনার দৃষ্টিভঙ্গি কি? (একাধিক উত্তর হতে পারে)	স্বাস্থ্যের জন্য ক্ষতিকর .....A অনেক পার্শ্বপ্রতিক্রিয়া রয়েছে .....B যৌন ক্ষমতা হ্রাস পাওয়ার ঝুঁকি রয়েছে .....C পরিবার এবং সমাজ নেতিবাচক দৃষ্টিতে দেখে .....D সেবাকর্মীরা অদক্ষ হওয়ায় এসব পদ্ধতি গ্রহণ ঝুঁকিপূর্ণ .....E পদ্ধতি কার্যকর হয় না .....F সহজলভ্য নয় .....G খুব কার্যকর পদ্ধতি .....H স্বাস্থ্যের জন্য ক্ষতিকর নয় .....I কোন পার্শ্বপ্রতিক্রিয়া নেই.....J দীর্ঘমেয়াদী হওয়ায় ঘন ঘন পদ্ধতি গ্রহণ করতে হয় না.....K দীর্ঘমেয়াদী পদ্ধতি গ্রহণ করার প্রয়োজন নেই.....L দীর্ঘমেয়াদী পদ্ধতি সমর্থন করি না.....M অন্যান্য (নির্দিষ্ট করুন).....X	|__| |__| |__| |__| |__|	
১০১০.	স্থায়ী বন্ধ্যাত্বকরণ পদ্ধতি (টিউবেকটমি, এনএসভি) সম্পর্কে আপনার দৃষ্টিভঙ্গি কি? (একাধিক উত্তর হতে পারে)	স্বাস্থ্যের জন্য ক্ষতিকর .....A অনেক পার্শ্বপ্রতিক্রিয়া রয়েছে .....B যৌন ক্ষমতা হ্রাস পাওয়ার ঝুঁকি রয়েছে .....C পরিবার এবং সমাজ নেতিবাচক দৃষ্টিতে দেখে .....D সেবাকর্মীরা অদক্ষ হওয়ায় এসব পদ্ধতি গ্রহণ ঝুঁকিপূর্ণ .....E সহজলভ্য নয় .....F পদ্ধতি কার্যকর হয় না .....G খুব কার্যকর পদ্ধতি .....H স্বাস্থ্যের জন্য ক্ষতিকর নয় .....I কোন পার্শ্বপ্রতিক্রিয়া নেই.....J স্থায়ী হওয়ায় ঘন ঘন পদ্ধতি গ্রহণ করতে হয় না.....K স্থায়ী পদ্ধতি গ্রহণ করার প্রয়োজন নেই.....L স্থায়ী পদ্ধতি সমর্থন করি না.....M অন্যান্য (নির্দিষ্ট করুন).....X	|__| |__| |__| |__| |__|	
১০১১.	*আপনি কি মনে করেন, কনডম ব্যবহারের ফলে এইচআইভি/এইডস এবং যৌনবাহিত রোগ থেকে রক্ষা পাওয়া যায়?*	*হ্যাঁ .....1* *না .....2* →	|__|	১০১৩
১০১২.	*হ্যাঁ হলে, কনডম ব্যবহারের ফলে এইচআইভি/এইডস এবং যৌনবাহিত রোগ থেকে রক্ষা পাওয়া যায় এ বিষয়টি কিভাবে জেনেছেন?* *(একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে .....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে L	|__| |__| |__| |__| |__| |__|	

সেকশন ১০: পরিবার পরিকল্পনা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
		উঠান বৈঠকের মাধ্যমে .....M সম্ভষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	⎿⎿⎿	
১০১৩.	*স্বামী কর্তৃক স্ত্রীকে আঘাত করার কারণ সংক্রান্ত নিম্নলিখিত বিষয়ে আপনার মতামত কি?* ১= হ্যাঁ ২= না ৮৮= জানি না	*যদি স্বামীকে না বলে বাহিরে যায় .....A* *যদি সন্তানের অবহেলা করে.....B* *যদি স্বামীর সাথে তর্ক করে .....C* *যদি স্বামী সাথে যৌনসঙ্গম করতে অস্বীকৃতি জানায়.....D* *যদি খাবার পুড়িয়ে ফেলে.....E* *স্বামীর অমতে পরিবার পরিকল্পনা পদ্ধতি গ্রহণ করলে .....F*	⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿	
১০১৪.	অধিক সন্তান নেয়া সংক্রান্ত নিম্নলিখিত বিষয়ে আপনার মতামত কি? *(একাধিক উত্তর হতে পারে)*	মায়ের স্বাস্থ্যঝুঁকি .....A শিশুর মৃত্যুহার বৃদ্ধি পাওয়া .....B মায়ের পুষ্টিহীনতা .....C শিশুর পুষ্টিহীনতা .....D পরিবারের ভবিষ্যত নিশ্চয়তা .....E পরিবারের স্বচ্ছলতা.....F পরিবারের অস্বচ্ছলতা .....G অন্যান্য (নির্দিষ্ট করুন).....X	⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿	
১০১৫.	গর্ভবতীহওয়ার পূর্বে পদ্ধতি ব্যবহার করতেন কি?	হ্যাঁ .....1 না 2	⎿⎿⎿	
১০১৬.	*হ্যাঁ হলে কোন পদ্ধতি গ্রহণ করতেন?*	**মডার্ণ মেথড** খাবার বড়ি .....01 কনডম.....02 আইইউডি .....03 ইনজেকশন.....04 ইমপ্ল্যান্ট.....05 এনএসভি .....06 টিউবেকটমি.....07 আপন/মিনিপিল (পিওলি).....08 **ট্রেডিশনাল মেথড** নিরাপদ দিনকাল গণনা.....09 প্রত্যাহার .....10 অন্যান্য (নির্দিষ্ট করুন).....77	⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿	
১০১৭.	আপনি পরিবার পরিকল্পনা পদ্ধতি কোথা থেকে গ্রহণ করতে ইচ্ছুক? *(একাধিক উত্তর হতে পারে)*	হাসপাতাল .....A মেডিকেল কলেজ.....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র.....D কমিউনিটি ক্লিনিক .....E মা ও শিশু কল্যাণ কেন্দ্র .....F সরকারী মাঠকর্মী/পরিবার কল্যাণ সহকর্মী/মাঠকর্মী .....Gএনি জওক্লিনিক.....H কমিউনিটি ক্লিনিক .....I এনজিও মাঠকর্মী .....J দোকান (ব্লু স্টার/সাধারণ) .....K অন্যান্য (নির্দিষ্ট করুন).....X	⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿ ⎿⎿⎿	

সেকশন ১০: পরিবার পরিকল্পনা সংক্রান্ত				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
১০১৮.	না হলে, কেন পরিবার পরিকল্পনা পদ্ধতি গ্রহণ করতে ইচ্ছুক নন? (একাধিক উত্তর হতে পারে)	পদ্ধতি গ্রহণে আগ্রহী নেই .....01 পদ্ধতি সহজলভ্য নয় .....02 সরকারী/এনজিও মাঠকর্মীদের পাওয়া যায় না .....03 বাজার থেকে কেনার সামর্থ্য নেই.....03 অন্যান্য (নির্দিষ্ট করুন).....77	⌊__⌋ ⌊__⌋	
১০১৯.	প্রসব পরবর্তী পরিবার পরিকল্পনা পদ্ধতি সম্পর্কে জানেন কি?	*হ্যাঁ .....1* *না 2*	⌊__⌋	
১০২০.	*হ্যাঁ হলে, বুকের দুধ খাওয়া চলাকালীন সময়ে পরিবার পরিকল্পনা পদ্ধতি ব্যবহার করলে কোন অসুবিধা হয় কি?*	বুকের দুধ কমে যায়.....01 পার্শ্বপ্রতিক্রিয়া বেশি হয় .....02 মায়ের ওজন কমে যায় .....03 কোন অসুবিধা হয় না .....04 অন্যান্য (নির্দিষ্ট করুন).....77	⌊__⌋	
১০২১.	পরিবার পরিকল্পনা পদ্ধতি গ্রহণের ইচ্ছা নিয়ে আপনি কখনো সেবা কেন্দ্রে গিয়েছিলেন?	হ্যাঁ .....1 না 2	⌊__⌋	
১০২২.	আপনি কি ভবিষ্যতে পরিবার পরিকল্পনা পদ্ধতি গ্রহণ করতে ইচ্ছুক?	হ্যাঁ .....1 না 2	⌊__⌋ →	১০২৪
১০২৩.	হ্যাঁ হলে, কতদিনের মধ্যে পদ্ধতি গ্রহণ করবেন?	.....দিনের মধ্যে	⌊__⌋	
১০২৪.	পরিবার পরিকল্পনা পদ্ধতি এবং সেবা সম্পর্কে আপনি কিভাবে জেনেছেন? (*একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে .....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে .....L উঠান বৈঠকের মাধ্যমে .....M সন্তুষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে .....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋ ⌊__⌋	

সেকশন ১১: কিশোরী প্রজনন সংক্রান্ড়				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
১১০১.	আপনি কি মাসিক নিয়মিতকরণ সম্পর্কে জানেন?	হ্যাঁ .....1 না 2	|___|	
১১০২.	আপনি কি জানেন কোথা থেকে মাসিক নিয়মিতকরণ সেবা পাওয়া যায়? (*একাধিক উত্তর হতে পারে)*	মেডিকেল কলেজ হাসপাতাল .....A জেলা হাসপাতাল .....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র .....D মা ও শিশু কল্যাণ কেন্দ্র .....E কমিউনিটি ক্লিনিক .....F স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র .....G বেসরকারী হাসপাতাল/ক্লিনিক .....H এনজিও ক্লিনিক .....I প্রাইভেট ক্লিনিক .....J সিএসবিএ .....K অন্যান্য (নির্দিষ্ট করুন) X	|___| |___| |___|	
১১০৩.	আপনি কি জানেন কোন সময়ে গর্ভবতী হওয়ার ঝুঁকি সবচেয়ে বেশি? (*একাধিক উত্তর হতে পারে)*	*মাসিক শুরু হওয়ার পূর্বে .....01* *মাসিক শুরু হওয়ার সময়ে .....02* *মাসিক শুরু হওয়ার শেষে .....03* *দুই মাসিকের মর্ধবর্তী সময়ে .....04* *কোন নির্দিষ্ট সময় নেই .....05* *জানি না 06*	|___| |___|	
১১০৪.	আপনি কি জানেন, গর্ভকালীন সময়ে কতবার চেকআপ করাতে হয়?	হ্যাঁ .....1 না 2	|___|	
১১০৫.	একজন গর্ভবতী মায়ের কি কি যত্ন নেয়া দরকার বলে আপনি মনে করেন? (*একাধিক উত্তর হতে পারে)*	নিয়মিত ওজন নেয়া .....A বাড়তি খাবার দেয়া .....B ভারী কাজ না করা .....C প্রয়োজনীয় বিশ্রাম নেয়া .....D প্রয়োজনে আয়রন ট্যাবলেট খাওয়া .....E প্রয়োজনে ভিটামিন এ ক্যাপসুল খাওয়া .....F টিকা নেয়া .....G অন্যান্য (নির্দিষ্ট করুন) X	|___| |___| |___|	
১১০৬.	আপনি জানেন কি, কোথায় সন্তান প্রসব করানো মা ও শিশুর জন্য নিরাপদ?	বাড়িতে .....01 স্বাস্থ্য সেবা কেন্দ্রে 02	|___|	
১১০৭.	প্রসব পরবর্তী সময়ে একজন মায়ের কি কি যত্ন নেয়া দরকার বলে আপনি মনে করেন? (*একাধিক উত্তর হতে পারে)*	বাড়তি খাবার দেয়া .....A তরল খাবার খাওয়া .....B পুষ্টিকর খাবার .....C ভারী কাজ না করা .....D প্রয়োজনীয় বিশ্রাম নেয়া .....E প্রয়োজনে আয়রন ট্যাবলেট খাওয়া .....F প্রয়োজনে ভিটামিন এ ক্যাপসুল খাওয়া .....G টিকা নেয়া .....H অন্যান্য (নির্দিষ্ট করুন) X	|___| |___|	
১১০৮.	আপনার মাসিক সংক্রান্ত কোন সমস্যা হয়েছিল কি?	হ্যাঁ .....1 না 2	|___| →	 ১১১০
১১০৯.	হ্যাঁ হলে, কোথা থেকে চিকিৎসা নিয়েছিলেন? (*একাধিক উত্তর হতে পারে)*	মেডিকেল কলেজ হাসপাতাল .....A জেলা হাসপাতাল .....B উপজেলা স্বাস্থ্য কমপ্লেক্স .....C ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র .....D মা ও শিশু কল্যাণ কেন্দ্র .....E	|___| |___|	

সেকশন ১১: কিশোরী প্রজনন সংক্রান্ড়				
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**CODES**	**SKIP**
		কমিউনিটি ক্লিনিক .....F স্যাটেলাইট ক্লিনিক/ইপিআই সেবা কেন্দ্র .....G বেসরকারী হাসপাতাল/ক্লিনিক .....H এনজিও ক্লিনিক.....I প্রাইভেট ক্লিনিক .....J সিএসবিএ.....K অন্যান্য (নির্দিষ্ট করুন).....X	|___|	
১১১০.	আপনি কি যৌনবাহিত রোগ সম্পর্কে জানেন?	হ্যাঁ .....1 না 2	|___|	
১১১১.	কিশোরী স্বাস্থ্যের প্রজনন সমস্যা এবং কিশোরী স্বাস্থ্যের জন্য সেবাগুলো সম্পর্কে আপনি কিভাবে জেনেছেন? *(একাধিক উত্তর হতে পারে)*	বাংলাদেশ বেতারের মাধ্যমে.....A এফ এম রেডিও/কমিউনিটি রেডিও/অন্যান্য সম্প্রচার কেন্দ্রের মাধ্যমে .....B বাংলাদেশ টেলিভিশনের মাধ্যমে (বিজ্ঞাপন/ স্ক্রলের মাধ্যমে) C টেলিভিশনের প্রাইভেট চ্যানেলের মাধ্যমে (বিজ্ঞাপন/ স্ক্রল) ..D পরিবার পরিকল্পনা কর্মী/স্বাস্থ্যকর্মীর মাধ্যমে .....E এনজিও কর্মীর মাধ্যমে .....F পত্র-পত্রিকার মাধ্যমে/ ত্রৈমাসিক পরিক্রমা/ নিউজ লেটার.....G বন্ধুবান্ধব/আত্মীয়-স্বজনের মাধ্যমে.....H বিলবোর্ড/নিয়নসাইন/ট্রাইভিশন ইত্যাদিও মাধ্যমে .....I পোষ্টার/লিফলেট/ফ্লাইয়ার/ব্রশিউর/বুকলেট/ফেষ্টুন মাধ্যমে....J পল্লীগান/ফুটবল টুর্নামেন্ট/মেলা ইত্যাদিও মাধ্যমে .....K ওয়ার্কশপ/সেমিনারের মাধ্যমে .....L উঠান বৈঠকের মাধ্যমে .....M সন্তুষ্ট উপকারভোগীর মাধ্যমে.....N স্বল্পদৈর্ঘ্য চলচিত্র/ টিভি ড্রামা (নাটক) .....O অডিও ভিজ্যুয়াল ভ্যানে চলচ্চিত্র প্রদর্শনের মাধ্যমে .....P নিজেই জেনেছি/বই পুস্তক পড়ে.....Q ইন্টারনেটের মাধ্যমে.....R মোবাইল মেসেজের মাধ্যমে .....S অন্যান্য (নির্দিষ্ট করুন).....X	|___| |___| |___| |___| |___| |___|	

আপনার মূল্যবান সময় ও সাক্ষাৎকারটি দেওয়ার জন্য আন্তরিক ধন্যবাদ

Annex 3: Research Team

List of Researchers

SL	Name	Designation
1.	**Mohammad Bellal Hossain** Associate Professor	Team Leader
2.	**Dr. Mohammad Mainul Islam** Associate Professor	SBCC/Population Health Specialist
3.	**Dr. Md. Kamrul Islam** Associate Professor	Demographer
4.	**Mohammad Sazzad Hasan** Lecturer	Statistician

List of Supervisors:

SL	Name	Designation
1.	Motaleb Hossain	Supervisor
2.	Md Kamal Uddin	Supervisor
3.	Haddiuzzaman	Supervisor
4.	Nurul Islam	Supervisor
5.	Aoulad Hossain	Supervisor
6.	Shariful Islam	Supervisor
7.	Abdus Salam	Supervisor
8.	Akram Hossain	Supervisor