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"Use of Reproductive Health Care Facilities as Family Planning Methods of Married Women" A Study in Char Islands of Islampur Upazila in Jamalpur District.

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Abstract: - Rural women's perceptions and perspectives regarding reproductive health care services rely upon various aspects. This study is aimed at investigating the beliefs and attitudes of rural Bangladeshi women towards reproductive health. This research is also aimed at investigating beliefs and attitudes that shape rural women's understanding and their subsequent decisions about reproductive health. Using reproductive health care services has been shown to promote a woman's sense of autonomy and increase her ability to make decisions in other areas of her life. The current prevalence rate for reproductive health care services use in Bangladesh is 61 percent among currently married women. A cross-sectional study was conducted in a selected hard to reach area (Islampur Upazila under Jamalpur district) of Bangladesh to see the pattern of reproductive facilities use among 365 women of reproductive age (15-49 years). In response of the desired children, 55.9%of the respondents had willingness to have more children in future. The current study revealed that almost all know the names of family planning methods mostly oral pill followed by injection. In the current study about 64.2% respondents were found as current user of contraceptive methods.

Key Words: *Reproductive, Health, Women, Perceptions and Perspective*
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I. INTRODUCTION

Islampur Upazila of Jamalpur district is a char island, which is very remote, and disaster prone area of Bangladesh. According to Bangladesh Bureau of Statistics population census (BBS 2011) the literacy rate of Islampur Upazila of Jamalpur district is 32.4%[1], which is very poor in compare with other area of Bangladesh and reproductive knowledge of the community people is inadequate. Most of the people of char island community of Jamalpur district are fishermen, small farmers, and day labors. Flood, flash flood, draught, river erosion, cold wave, scarcity of safe water, lack of sanitation and knowledge on hygiene promotion, improper knowledge on menstrual hygiene management, lack of safe motherhood services (antenatal & postnatal checkup, safe delivery, neonatal care and nutrition of pregnant and lactating mothers) and family planning services are the major problems. Mainly women are the victim of social customs, polygamy, evacuation, superstition and mal-nutrition.[2] In char island community people are neglected and victimized by different diseases relevant to reproductive health behavior and practices as well as by the social prejudice and that resulting the poor people of the mentioned areas are bound to go again to traditional services providing by the Hujur and Kobiraj (Traditional healers) and the reproductive health services remain neglected and unattended to them. During delivery they have to go to traditional attendant because of found no way.

The practice of family planning helps in reducing the rates of unintended pregnancies, of maternal and child mortality and of induced abortion. In addition, using contraceptives has been shown to promote a woman's sense of autonomy and increase her ability to make decisions in other areas of her life. Data collected over three decades reveal an astounding fact.[3] The county saw fewer intakes of skilled people to deal with birth measures either in cities or at villages and yet, the rate of maternal mortality has still fallen. The probable explanation to this is that expecting mothers were given proper treatment and care when emergencies were raised. The constant presence of midwives in local hospitals also helped to reduce down the possibilities of the mother's and the newborn child's death.

[1] Bangladesh Bureau of Statistics population census (BBS 2011)
[2] Verbal communication with officials of Civil Surgeon Office, Jamalpur
[3] Regional committee for the eastern Mediterranean-Moving towards the MDGs: investing in maternal and child health. Paper presented to the 51st session on 3-6 October 2004, Cairo, Egypt.

Locally, it has been seen that women who have had the privilege of attending school for a period of about eight or so years had only about 33% possibility of dying, during the nine month model of pregnancy or with the forty-two days of giving birth, in comparison to that women who has never been to school.[4] Now, if this woman with no education went and had abortion done, then, her chances of losing her life would be higher by no more than 11 times in contrast to the educated woman. It is expected that the country may shortly be one of those who have successfully managed to bring down the mortality rate within a decade, in case of expecting mothers, by the staggering percentage of 50, through the fulfillment of the Millennium Development Goal (MDG)-5 by 2015. To be able to achieve this feat, Bangladesh needs to bring down the Maternal Mortality Ratio (MMR) to 143 for every one lac of live births within this time model. Whether this is an achievable target or not, only time can tell but, so far the picture is really looking promising for Bangladesh, it really has come a long way to tackle the unfortunate existence of maternal mortality.

The current prevalence rate for contraceptive use in Bangladesh is 61 percent among currently married women.[5] Also the World Bank measured contraceptive prevalence in Bangladesh is 61.20 in 2011.[6] Worldwide, about one third of women with an urgent need for family planning is pregnant or has recently given birth.[7] The provision of quality family planning services in the postpartum period significantly reduces maternal and child mortality and morbidity, as well as prevent the risk of unwanted pregnancies and unsafe abortion.[8] In many countries, postpartum family planning services are not well integrated into existing health services, and most health delivery services do not address women's needs after pregnancy, including the provision of family planning counseling and contraception.[9]

II. LITERATURE REVIEW

Bangladesh is well into the third phase of demographic transition, having shifted from a high mortality-high fertility regime to a low mortality-low fertility one. The uniqueness of demographic transition in Bangladesh is evident from the fact that while worldwide low-income country's population grew at an average annual rate of 2.1% between 1990 and 1997; the population of Bangladesh grew only at the rate of 1.6%. In Bangladesh also the unmet need is as higher as 24%.3 unmet needs does not necessarily mean that family planning services are not available.[10] The World Health Organization reports that an estimated 94 per cent of the population of the world lives in countries with policies that favor family planning. Despite this, five of every six couples of reproductive age do not use adequate measures of fertility regulation. Gender inequalities in patriarchal societies ensure that men play a critical role in the decisions on family matters. The present study was undertaken to study the nature of acceptance of contraceptive practices and the psychosocial determinants. Methods: This was a community based cross sectional descriptive study. The anticipated prevalence of contraceptive practices among the 206 women in the age group of 15-49 years was 50%. Considering a margin of error of 10%, with finite correction and 10% of non-response and 95% CI, the sample size was calculated. 90 married women in the reproductive age group of 15-49 years residing at the village were studied after drawing the sample with simple random sampling method. A cross-sectional descriptive study using a self-administered questionnaire was conducted among 1996 medical students in their fifth year of study at 11 medical colleges in the state of Dhaka, Bangladesh.[11] A few students had experienced training in abortion care. There were misconceptions about modern family planning methods and the impact of sex education. Attitudes towards reproductive health services were mainly positive, premarital counseling was supported and the influence of traditional values and negative provider attitudes on services was recognized. Gender, area of upbringing and type of medical college did not change the results.[12]

This study explored the prevalence of use and knowledge and attitudes towards family planning among rural Jordanian women. A descriptive study was conducted with 807 ever-married women aged 15-49 years in a

[4] http://www.ssc.wisc.edu/cde/cdewp/84-31.pdf Prevalence and determinants of contraceptive practices in rural area of Bangladesh(

[5] https://dhsprogram.com/pubs/pdf/FR265/FR265.pdf-BDHS,2011

[6] Worldbank.org/indicator/SP.DYN.CONU.ZS-Contraceptive prevalence (% of women ages 15-49)

[7] Robey B, Ross J, Bhushan I. Meeting unmet need: new strategies. Population Rep J. 1 996 Sep; 43:l-35.

[8] Rivera R, Solis JA. Opinion: improve family planning after pregnancy. Network, 1997; 17(4):4-6.

[9] Wolf M, Benson J. Meeting women's needs for post-abortion family planning: report of a Bellagio technical working group. IntJGynaecol Obstet. 1994; 45(Suppl): Sl-S33.

[10] Unmet need of family planning among rural women in Bangladesh-Ferdousi SK1, Jabbar MA2, Houque SR3, Karim SR4, Mahmood AR5, ARA 1, Khan NR1

[11] International journal of medical research and health sciences, Maharashtra, India

[12] Petro-Nustas W. Men's Knowledge of and Attitudes Toward Birthspacing and Contraceptive Use in Jordan. International Family Planning Perspectives; Volume 25, Number 4, December 1999

household survey of 29 villages in the southern region of Jordan.[13] The most common family planning methods ever used were oral contraceptive pills (31.1%); intrauterine device (24.8%) and withdrawal (19.5%). Of the women interviewed, 37% were currently using contraception. Being pregnant (11%) and breastfeeding (10%) were the most reported reasons for not using contraceptives. This study shows poor awareness regarding some vital aspects of postpartum methods and, in particular, that there is little effort to educate fathers. Sri Lankan men play an important role in decisions regarding family planning tools. Improvement of education regarding postpartum methods could contribute to reducing the high abortion rate in Sri Lanka.[14]

Another study conducted by Olamijulo.et all on Knowledge and practice of reproductive health services among married women attending the antenatal clinic in Lagos University Teaching Hospital.[15] A Semi-structured questionnaire was administered to 151 married women attending the antenatal clinic in LUTH to collect data on their socio-demographic characteristics, knowledge of family planning methods, pre-pregnancy contraceptive use and their anticipated post-partum contraceptive choices. The study showed that the mean age of the women was 29.9 years and the mean Parity was 1.1. Majority (90.7%) of the women were married. Ten women (6.6%) felt that they had poor knowledge about reproductive health while the rest had fair to excellent knowledge. The prevalence of family planning methods use before current pregnancy was 57.6% and the male condom was the method used in 56 cases (64.4%). Their major (54%) source of contraceptive commodity was the chemist/pharmacy. Sixty (69%) women stopped using contraceptive because they wanted to get pregnant. Sixty-eight (45.0%) women planned to use contraceptives after delivery and the male condom (55.9%) was the most preferred method of post-partum contraception. There is no statistical association between age, religion, parity and educational attainment and desire for family planning tools.

Rahman and Nazneen discussed in detail efforts made by Bangladesh Government to control its population through planned efforts since 1953. Covering persistent setbacks and reasons there of in governmental efforts, the authors highlight shifts in policies and strategy. The [government family planning] program provides a wide range of contraceptive choice to eligible couples in a manner as acceptable and convenient as possible to the client. The program is totally voluntary and the government is firmly opposed to coercion or pressure on couples to accept family planning. As a strategy, the program has integrated health and [family planning] while various ministries have attempted to encourage the acceptance of low-fertility behavior through socio-economic incentives and educational motivation program."[16]

III. JUSTIFICATION OF STUDY

More than 200 million women in developing countries would like to delay pregnancy of married life, but many of them still rely on traditional and less effective methods of family planning or use no method at all.[17] Population of Bangladesh stands at more than 162 million at present with Total Fertility Rate- TFR 2.7, the country will have 180 million people within next ten years.[18] The family planning Prevalence Rate-CPR is only 61% among currently married women.[19] The population growth rate among the educated people has come down at a considerable extent, but the rate among the underprivileged, who continue to constitute a big majority, is double as the rate of educated group. Since the poor people have no stable income (some practically live hand to mouth), they normally want more children as security and support in old age. They are also pertinent to get married early and produce children that they can’t educate or even support. Gender preferences may have significant implications for a couple’s fertility behavior. Additional population of Bangladesh creates impact on economy, education, land, etc. Women typically do not consider fertility decisions in isolation. They have partners whose preferences need to be accommodated. Those who do not use any family planning method may lack access or face barriers to using family planning. Reproductive health facilities use is an effective primary prevention strategy for reducing maternal mortality. The use of effective family planning could avert 90% of abortion-related and more than 20% of obstetric-related mortality globally.[20] Abortion incidence is inversely associated with the level of family planning use, especially where the fertility rates are able.

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13 Knowledge, attitudes and practices towards family planning among women in the rural southern region of Jordan. Mahadeen AI1, Khalil AO, Hamdan-Mansour AM, Sato T, Imoto A.

[14] Senanayake S, Kariyawasam V, Knowledge, attitudes and practices regarding postpartum contraception among 100 mother-father pairs leaving a Sri Lankan maternity hospital after childbirth. Vol. 51, No. 1, March 2006.

[15] *Knowledge and practice of contraception among pregnant women attending the antenatal clinic in Lagos University Teaching Hospital. Niger J Med. 2012 Oct-Dec;21(4):387-93.*

[16] Okonofua F. Need to intensify safe motherhood interventions in Africa. Afr J Reprod Health. 2003;7(3):7-12.

[17] World Health Organization-WHO population report 2007

[18.] http://ijmrhs.com/psychosocial-determinants-of-contraceptive-use-among-women-of-reproductive-age-in-a-rural-area-of-maharashtra/India

[19] Bangladesh demography of health survey BDHS 2011

[20] Nigeria Demographic and Health Survey 2008

Furthermore, Char Island communities are very remote and isolated where reproductive health facilities as family planning method is not available and service providers are not frequently provided their services to the community people, as a result use of reproductive health facilities is so poor in island communities.[21] This study will be assist to explore the status of married women (aged 15-49 years) in regard of their use of reproductive health facilities as family planning methods and to find out factors that affect the use of reproductive health service as family planning methods in char islands of Islampur Upazila of Jamalpur district in Bangladesh.

1.1 Operational Definitions

Reproductive Health: Reproductive health right is a condition in which reproduction is accomplished in a state of complete physical, mental and social wellbeing and not merely as the absence of disease or disorders of the reproductive processes. But the overall situation is quite drastic in Bangladesh where women's reproductive health rights are always ignored which has been depicted in this study and discussed. In case of family planning, the concept of male involvement in family planning is broad in nature. It is important that cultural, demographic, social and economic factors play an important role in shaping marriages in society, as well as family planning. The study results ensured that the respondents were less considered to take family planning options and in this way their reproductive health rights, as well as their basic rights were violated continuously. Family planning acceptance has the greatest effects on the total number of family members. In those families who had more family members the reproductive health rights were less considered due to economic limitations and the mentality among their family members. Thus, family planning acceptance had played an important role and for this the respondents had a limited number of children. [22]

Possession of modern facilities is a very important issue for a society, and a society with enough modern facilities is more developed and people enjoy their reproductive health rights. The facilities, which make a new man and are intended to be different from traditional styles, are known modern facilities such as TV, radio, etc. Mass media such as radio and television can create awareness about issues affecting the daily life, family planning programs, poverty alleviation programs, gender issues, human rights issues, etc. Consequently, modern facilities had played a vital role to ensure the reproductive health rights of the respondents.

Current Family Planning practices: The conscious effort of couple to regulate the number and spacing of births. Family planning usually suggests the use of contraceptive methods to avoid pregnancy, but also includes efforts of couples to regulate their fertility. Family planning methods utilization refers to use of any form of either modern or traditional family planning methods to avoid or delay pregnancy. Current use of family planning method referred to respondents who responded positively for use of family planning methods at time of the survey to delay or avoid pregnancy. Family planning method queries included male and female condoms (restricted to those reporting “Always” use), injections, oral contraceptive pills, diaphragm, intrauterine devices (IUD), female tubal ligation, hysterectomy, and male partner sterilization. In assessing the contraceptive method profile, dual protection was defined as use of both a barrier family planning method (male condom) and use of a hormonal or permanent contraceptive method or devices used to prevent pregnancy and helps women plan if and when they want to have a baby, like-Oral contraceptive pill, Male condom, female condom, vaginal contraceptive ring, contraceptive patch, implant etc.

Modern family planning method: Short-term modern contraceptive methods distributed by CBDs i.e. condoms, pills and inject able.

Traditional family planning method: These consist of periodic abstinence and withdrawal.

Determinants: The factors that influence family planning practice are multifaceted and challenging. Associated with socio-demographic, socio-cultural, socio economic, source of information and family planning factors. For instance, according to different study findings socio-demographic and economic, obstetric and media exposure related factors were found to contribute on the use of modern reproductive health services.

Attitude: Attitude is an expression of favor or disfavor toward a person, place, thing, or event.

Income: Income means total earning of both male and female of the family.

Respondents: Respondents mean women of reproductive age group in the community.

Rich Households:

- Possess solid and stable houses that are usually renovated every 15 years
- Have transportation, either a motorbike or a bicycle or both and local vehicle
- Own a television

[21] A statement through verbal conversation with the officials of Civil Surgeon Office, Jamalpur

[22] Bangladesh demography of health survey BDHS 2011

• Can send their children to school
• Never lack money even after the harvest has been eaten or sold
• Are able to save money
• Have gardens with useful plants and trees

Medium Households:
• Have a stable house that usually does not need renovating for ten years
• Own a TV and/or a radio
• Have enough food all year round
• Can send their children to school
• Have wells or easy access to water

Poor Households:
• Live in unstable houses, often made with mud
• Have no TV or radio
• Aren't able to save money
• Some have children who can't go to school, or have to leave school prematurely
• Usually have enough food until the next harvest, although sometimes lack food for one to two months per year
• Are unable to utilize surrounding natural resources to their benefit Very Poor Households
• Live in very unstable houses that often need to be rebuilt every two to three years
• Have no wells or easy access to fresh water

Variables
Socio-demographic characteristics

- Age
- Sex
- Education
- Income per month/wealth quintile
- Having more than two children
- Religious belief
- Husband's approval
- Media exposure
- Occupation
- Family members

Reproductive Health Related Factors

- Use of family planning methods
- Types of contraceptives
- Advantages of reproductive
- Side effects of contraceptives.

Factors behind the unmet need

- Age at marriage
- Age at first childbirth
- Contraceptives availability
- Pregnancy-wanted/unwanted
- Cost of contraceptive (affordable/ Non-affordable)

Research Question:

- What is the prevalence and determinants of reproductive health as family planning method practices among married women (15-49 years) in char area?

1.2 Objectives of the Study
General objective:
To determine the prevalence of family planning practices among married women of reproductive age group (15-49 years) and to find out the determining factors affecting family planning use among this group
Specific objectives:

- To determine the prevalence of family planning methods among married women of reproductive age group in char island of Islampur Upazila
- To assess the socio-cultural factors (husband's approval, and spouse communication) related to the use of family planning method among these women
- To determine the association between socio–demographic factors (e.g. discussion with husband, education, fertility preference) and the use of family planning among women of reproductive age group

1.3 Methodology of the Study

Study area
The study will be conducted in a selected char island community of Jamalpur District, Bangladesh.

Study period and duration
Study period will be 1 month, December 2015

Study population
The study population will be the married women at reproductive age (15 to 49 years) group living in char islands of Islampur Upazila of Jamalpur district

Study design
Descriptive cross sectional study will be adopted for study.

Sample size
The sample size for this study will be determined by the following equation.
The formula for calculating sample size is:

$n = z2pq / d^2$
Where,
n = desired sample size
Z = standard normal deviate usually at 1.96 which corresponds to 95% confidence interval
p = 0.61 (contraceptive prevalence of currently married women is 61 % in- BDHS 2011)
q=l-p= 1-0.61- 0.39
d = level of error 5% = 0.05
Hence, desired sample size, $n = \{(1.96)^2 * 0.6 I* 0.39\} / (0.05)^2 = 365$

1.4 Sampling technique:
Primarily one union selected randomly and then one village selected from the list of the union randomly. After selecting the village, respondents have been selected randomly from the couple list, which have been collected from family planning department.

2. 1 Selection criteria:
Inclusion criteria
- All married women at reproductive age group (15 to 49 years) living in the selected villages of selected unions of Islampur Upazila under Jamalpur district
- Those married women who are willing to participate in the study

Exclusion criteria:
- Infertile women
- Physically or mentally severely ill to participate in the study

2.2 Data collection methods
Data will be collected through interview by using a semi-structured questionnaire. The questionnaire will be designed in 'Bengali' and also be pre-tested and finalized with necessary corrections and modifications as considering the pre-testing feedback if any.

2.3 Data management and analysis
Data will be checked thoroughly for consistency and completeness when these will be collected. Collected data will be cleaned, edited and verified on daily basis to avoid any error or inconsistency. Incomplete or erroneous

data will be discarded. After that coding and classification will be done and then data will be entered in the SPSS version 16 data sheet.
The analysis will be carried out with the help of SPSS. Frequency tables with mean and standard deviation will be created. Moreover chi square test will be performed to examine the association between socio-demographic variables with other determinants. Descriptive statistics will be computed for all categorical variables.

2.4 Ethical Issues
To maintain the ethical standard, an approval will be taken from Ethical Review Committee of State University of Bangladesh. Verbal informed consent from the study population will be obtained prior to the interview. Confidentiality of the respondents will be maintained. Respondent will preserve the rights to refuse and withdraw from the interview at any time.

IV. RESULT OF THE STUDY

3.1 Data analysis and presentation as below;

The demographic characteristics of the respondents are presented in Table 1. The study population consisted of 365 women (aged 15-49 years), all of which were recruited Degrirchar village of Char Putimari union. Char Putimary union is under Islampur Upazila of Jamalpur district. The women averaged 30.8 years of age (range 18-49 years). The majority (23.6%) interviewed was aged between 30 and 34 years. Of the respondents, a small number (n=7, 1.9%) belonged to less than 20 years. The table shows that almost half (51.5%) of the participants were illiterate. Of the literate, the majorities (27.9%) were educated up to Primary level, and only 0.8% reached up to Higher Secondary Certificate (HSC) level. All the (100.0%) respondents were Muslim. The table also shows the distribution of ages at which participants had their first marriage. The majority (47.1%) of participants had their first marriage when they were less than 18 years old. Over one quarter (43.0%) of the women had their marriage when they were aged between 18 and 20 years. The table illustrates an unequal distribution of economic status of the respondents. Nearly half (49.3%) of the respondents classified themselves as middle class group.

Table 1: Demographic characteristics of the respondents (n=365)

Variables	Number	Percent
Age (in year)		
<20	7	1.9
20-24	72	19.7
25-29	85	23.3
30-34	86	23.6
35-39	41	11.2
40-44	54	14.8
45-49	20	5.5
Mean= 30.4 years, SD= 7.6, Range = 31 (18-49 years)		
Self-classification of economic status		
Poor	168	46.0
Middle class	180	49.3
Rich	17	4.7
Education		
No education (illiterate)	188	51.5
Primary complete	102	27.9
Primary incomplete	46	12.6
Secondary complete	6	1.6
Secondary incomplete	12	3.3
HSC compete	3	0.8
Bachelor complete	4	1.1
Masters complete	4	1.1
Religion		
Islam	365	100.0
Income generating activities (IGA)?		
Yes	130	35.6
No	235	64.4
Age at marriage (in year)		

Less than 18	172	47.1
18-20	157	43.0
21-23	28	7.7
24-26	8	2.2
Mean = 17.4 years, SD = 2.6, Range= 13 (12 -25 years)		
N	**365**	**100.0**

Table 2 presents the occupation of the respondents. The respondents in this sample reported diversified job categories. More than three-quarter (87.7%) of participants interviewed in this survey were a housewife, with only 7.1% of the sample reported being day laborer. Some (3.0%) participants were involved in service work. Small proportions (1.1%) of the participants interviewed in this survey were involved in business.

Table 2: Occupation of the respondents

Occupation	Number	Percent
Business	4	1.1
Agriculture	4	1.1
Service	11	3.0
Housewife	320	87.7
Day laborer	26	7.1
Total	**365**	**100.0**

Table 3 shows the monthly family income of the respondents. The majority (25.5%) of respondents had a monthly income ranging between Tk. 5,000 and Tk. 6,999, followed by 19.7% whose income is ranged between 3,000 and 4,999. On average, these women earned about 7,427 tk per month (range = Tk. 1,000-25,000; SD= 4,341).

Table 3: Monthly family income of the respondents

Monthly income (in taka)	Number	Percent
1,000-2,999	22	6.0
3,000-4,999	72	19.7
5,000-6,999	93	25.5
7,000-8,999	62	17.0
9,000-10,999	51	14.0
11,000-12,999	19	5.2
13,000-14,999	-	-
15,000+	46	12.6
Mean = 7,427.39, SD = 4,341.64, Range = 24,000 (1,000-25,000)		
Total	**365**	**100.0**

The majority (72.9%) of the respondents came under nuclear family system, and nearly a quarter (27.1%) stated that they came from join families (Table 4). Nearly 35.0% of the respondents said that they had quite a large number of members comprising 4 members in the family. Twenty-seven percent of the respondents stated that they had a family composed of 5 members. Some respondents (0.8%) reported having 9 members in their family. The proportion of respondents reported to have only 1 member is low (1.1%) in this sample.

Table 4: Family composition of the respondents

Variables	Number	Percent
Type of family		
Nuclear	266	72.9
Join	99	27.1
Number of family members		
1	4	1.1
2	-	-
3	70	19.2
4	127	34.8
5	99	27.1
6	37	10.1
7	18	4.9

8	7	1.9
9	3	0.8
Mean = 5		

Table 5 shows the distribution of children who died. Less than a quarter (21.9%) of the sample stated that at least one of their children passed away. When asked about the reasons of their child's death, nearly half of the sample (36.3%) claimed that the baby died during the labor and birth. Nearly one third (28.8%) said the death resulted after delivery. Twenty percent said that the baby died in the first year of life.

Table 5: Distribution of respondents by died children

Number of alive children	Number	Percent
Any child passed away? (n=365)		
Yes	80	21.9
No	285	78.1
When the child passed away (n=80)		
During delivery	29	36.3
After delivery	23	28.8
Within one year after birth	16	20.0
Within 5 years after birth	8	10.0
Other	4	5.0
Total	80	100.0

Table 6 provides information with regard to women's awareness on contraceptive methods. As can be seen from the table, more than three quarter of the sample (85.2%) heard of any contraceptive method. Oral pill was the most commonly cited contraceptive method (100.0%) among the women that they have heard of. The next most commonly cited contraception was injection (91.6%), followed by withdrawal (72.7%) and tubectomy (22.5%). Permanent methods such as implant (2.8%) and vasectomy (7.1%) were rarely mentioned in the sample.

Table 06: Knowledge about Family planning methods among the respondents

	Number	Percent
Have you ever heard of any FP methods that women can use to avoid pregnancy? (n=365)		
Yes	311	85.2
No	54	14.8
*If yes, which methods of contraception have you heard about? (n=311)**		
Pill	311	100.0
Injection	285	91.6
Implant	8	2.8
Condom	226	72.7
Withdrawal	19	6.7
Vasectomy	22	7.1
Tubectomy	70	22.5
Tubal ligation	64	20.6
Wash (menstruation regulation)	10	3.2
Emergency contraception	27	8.7
Sterilization	-	-

*Multiple responses

In the survey, women were asked about the sources from where they heard about family planning method (Table 7). The majority of women (89.3%) mentioned Family Planning Worker as the source of family planning services, followed by TV (39.2%). Only 14.5% of women mentioned radio as the source of family planning services.

Table 07: Sources of hearing about family planning method (n=311) (Q25 and Q33-36)

Source	Number	Percent
Radio	45	14.5
TV	122	39.2
Husband	19	6.1
Relatives	18	5.8
Family member	61	19.6
Family planning worker	115	37.0
Health worker	28	9.0

Note: Multiple responses.

The respondents were asked if they had experience of any side effects related to using contraceptives. About 26.5% acknowledged having a side effect related to contraceptive use (Table 8). When asked about the side effects associated with contraceptive use, 63.5% had experienced headache and 69.8% had experienced vomiting tendency. Some of the respondent reported having irregular menstruation (31.7%) and over fat (19.0%)

Table 08: Contraceptive as a family planning tools use among women in the last month

	Number	Percent
Who is willing to use contraception in future to avoid pregnancy? (n=365)		
Yes	278	76.2
Yes	87	23.8
Have you used any method to delay or avoid pregnancy in the last 30 days? (n=365)		
Yes	238	64.2
No	127	35.8
Proportion of permanent method and temporary method (n=238)		
Permanent method	88	37.1
Temporary method	150	62.9
Who desired more children in future among the user of contraceptive method? (n=238)		
Yes	155	65.1
No	83	34.9
*If yes, what method have you been using in the last 30 days? (n=238)**		
Pill	150	63
Injection	60	25.2
Implant	4	1.7
Condom	80	33.6
Withdrawal	3	1.3
Vasectomy	9	3.8
Tubectomy	7	2.9
Tubal ligation	8	3.5
Who took decision to use contraceptive method? (n=238)		
Self	94	39.5
Husband	15	6.3
Husband and wife	129	54.2
Have approval of your husband to use contraceptive method? (n=238)		
Yes	235	98.7
No	3	1.3
Have any side effects of these family planning methods? (n=238)		
Yes	63	26.5
No	175	73.5
*What type of side effects (n=63)**		
Headache	40	63.5
Vomiting	44	69.8
Fat	12	19.0

Irregular menstruation	20	31.7

*Multiple responses.

The reasons why a woman might not use family planning services can be complex and challenging. It is important to recognize that these are serious issues and no single product or method is going to meet the needs of every individual. In line with this, questions were asked among women (who heard of any family planning method) to explore the reasons given for not using methods. Table 9 shows the distribution of women according to their main reason for discontinuing family planning services. Around 11% of the women in this survey did not use family planning services because they were pregnant during the time preceding the survey. Around nine percent of women reported that they did not use family planning because their husbands did not allow them. Another 8.4% discontinued because of recent delivery of a child. Around 7.7% discontinued because it created a menstrual problem, and 5.8% because of religious restriction. A small proportion (5.1%) of women reported 'side effect' as their main reason for not using family planning services.

Table 09: Reason for not using family planning mechanisms (n=127)

Reasons	Number	Percent
Currently pregnant	25	19.7
Delivered baby recently	16	12.6
Irregular menstruation	14	11.0
No menstruation	8	6.3
Afraid of side effect	12	9.4
Irregular visit of health worker	8	6.3
Husband doesn't allow	18	14.2
Restricted in religion	18	14.2
Other	8	6.3

Most of women do have side effects from hormonal contraceptive. Hormonal contraceptives (e.g. pill) contain a small amount of man-made estrogen and progestin hormones. These hormones work to inhibit the body's natural cyclical hormones to prevent pregnancy. In this sample, around 20% participants reported at least one side effect (Table 10). The type of side effects reported in this sample varied. Nearly three-quarter (70.8%) of women reported to have headache due to contraceptive use. More than half (62.5%) reported about vomiting as a side effect. A small proportion (16.7%) said contraceptive methods produced changes in their menstrual cycle.

Table 10: Side effects due to contraceptive use as family planning mechanism? (n=238)

Preference	Number	Percent
Currently facing any side effects due to contraceptive use?(n=238)		
Yes	63	26.5
No	175	73.5
*What kind of side effects (n=63)**		
Headache	40	63.5
Bleeding	44	69.8
Vomiting	12	19.0
Fat	20	31.7
Irregular menstruation	63	26.5

*Multiple responses

Questions were asked among the respondents (who used contraceptives in last 30 days) to examine if they had discontinued contraceptives. More than half (69.7%) of the sample claimed that they discontinued the use of contraceptives (Table 11). The women's reasons for discontinuation of contraceptives are illustrated in Table 20. A broad range of reasons was given for not using contraception. The most common reason included the desire to have a child (62.6%). Nearly one third of women (31.9%) stated having health problems. Some respondents reported that their husbands do not want to use contraceptive (1.8%), and they did not have contraceptive (1.8%).

Table 11: Have you ever discontinue reproductive health services use? (n=238)

Preference	Number	Percent
Have you ever discontinued the use of contraceptives?(n=238)		
Yes	166	69.7

No	72	30.3
*Reasons for discontinuation (n=166)**		
Irregular menstruation	31	18.7
Health problem	53	31.9
Lack of contraceptive	3	1.8
For having child	104	62.6
Husband didn't want	3	1.8
Other	4	2.4

*Multiple responses.

Respondents were asked about the sources from which they came to know about family planning methods. Among the respondents whom had used contraceptives during the last one-month, nearly half (48.3%) said that they came to know about family planning from Family Planning Worker (Table 12). About one-fourth (25.6%) mentioned about family members as the source of their family planning facilities. Some respondents mentioned about health worker (11.8%), husbands (7.9%) and relatives (7.6%).

Table 12: How have you known about these family planning methods? (n=238)

Variable	Number	Percent
Radio	**42**	**13.5**
TV	118	37.9
Husband	16	5.1
Relatives	15	4.8
Family member	56	18.0
Family planning worker	110	35.4
Health worker	22	7.1

3.2 Sources of information regarding family planning facilities

Table 13 shows the proportion of women who had received family planning tools for the last one month. Respondents were asked to list the sources from which they collected the family planning tools. Nearly half (45.0%) of respondents collected family planning tools from the health workers, with 38.9% of the sample reporting that they had collected family planning tools from Satellite clinics. Some of the respondents (12.1%) opted for pharmacy services. Village doctors were provided (2.0%). The commonest sources of information on family planning tools were health workers (47.1%), followed by the Satellite Clinic (40.3%). Only about 1.7% reported to have received their information through government hospital. While pharmacy contributed about 9.7% to source of contraceptives, village doctors did not seem to play any part, as shown by the 2.9%. When respondents were asked who collected the family planning tools, the majority (84.0%) said that they themselves collected these. Only 10.9% claimed that their husband collected the family planning tools.

Table 13: Sources from where respondents collected contraceptives (n=238)

Source	Number	Percent
Where did you collect the contraceptives? (n=238)		
Govt. hospital	4	1.7
Health worker	112	47.1
Satellite clinic	96	40.3
Village doctor	7	2.9
Pharmacy	23	9.7
Who collected contraceptives? (n=238)		
Self	200	84.0
Husband	26	10.9
Health worker at own house	12	5.0

V. DISCUSSION:

This study was done to determine the pattern of use of reproductive health services as family planning methods and regarding factors, unmet need of family planning among the women of reproductive age group (15-49 years) of hard to reach area. A total 365 married women of reproductive age group participated in this study. Among the study respondents about half were in the age of 25 - 34 years, one-third was aged between 15-24

years and rest was within 34 – 49 years (Mean 30.4 years). The majority (72.9%) of the respondents came under nuclear family system, and nearly a quarter (27.1%) stated that they came from join families. Nearly 35.0% of the respondents said that they had quite a large number of members comprising 4 members in the family. Twenty-seven percent of the respondents stated that they had a family composed of 5 members. Some respondents (0.8%) reported having 9 members in their family. The proportion of respondents reported to have only 1 member is low (1.1%) in this sample. The mean family size of the respondents of this study is 5. The analysis shows that almost half (51.5%) of the participants were illiterate. Of the literate, the majorities (27.9%) were educated up to Primary level, and only 0.8% reached up to Higher Secondary Certificate (HSC) level, while 14 percent of women have completed secondary or higher education (BDHS 2014). The respondents were mostly housewives and only few were engaged in other occupations like business, agriculture and daily labors. The majority (25.5%) of respondents had a monthly income ranging between Tk. 5,000 and Tk. 6,999, followed by 19.7% whose income is ranged between 3,000 and 4,999. On average, these women earned about 7,427 tk per month (range = Tk. 1,000-25,000; SD= 4,341). Respondents were asked to state about the main source of family income. The main sources of family income among respondents slightly over half (50.4%) of the participants interviewed in this survey stated that their main source of income is agricultural activities, with a quarter (25.2%) of the sample reported being day laborer. Some (12.1%) participants stated that their main source of income is business. A small proportion (11.5%) of the participants mentioned service as the main source of family income. The distribution of children ever born is presented in Table 7. Over one quarter (26.0%) of women reported having two children. Similar proportion (25.2%) of women reported to have one child (who was ever born). In this sample, women were also asked about the number of their children who are still alive. The distribution of children (who are still alive) is presented in the table. The vast majority (30.4%) of women reported having two children who are still alive. Similarly, 29.0% of the women reported having one child who is still alive. The majority (40.3%) of the respondents' first child aged over 10 years. Around 19.2 were aged between 9 to 10 years. The table shows nearly one third (31.8%) of the last child was aged between 1 and 2 years. The age range was 1 to 23 years, and the mean age was 2.8 years. Provided information with regard to women's awareness on reproductive health as family planning methods. As can be seen from the table, more than three quarter of the sample (85.2%) heard of any contraceptive method. Oral pill was the most commonly cited family planning method (100.0%) among the women that they have heard of. The next most commonly cited family planning was injection (91.6%), followed by condom (72.7%) and tubectomy (22.5%). Permanent methods such as implant (2.8%) and vasectomy (7.1%) were rarely mentioned in the sample.

Women in the reproductive age group (15-45 years) represent a distinct population and their reproductive needs are likely unique as well. Table provides information on the family planning methods among the respondents. The table shows that the majority of women (64.2%) in this sample claimed to have used contraceptives to avoid pregnancy. The table also shows that women preferred modern family planning methods on traditional methods. Oral contraceptives (pill) were the most commonly reported contraceptive method (63.0%) among the women. The next most commonly used form of contraception was injection (25.2%), followed by withdrawal (33.6%). The decision to use family planning appears to be an important one. When asked who took the decision to use family planning in the last month, more than half (54.2%) reported that both partners' desires and intentions were associated with family planning methods use. In almost all the cases (98.7%), these women received approval from their husband to use family planning facilities.

The analysis also suggests that the number of children ever born and number of living children influence the use of contraception. Women with no children are likely to use contraceptives than women with more than 5 children whereas women with 1 to 2 children and women with 3-4 children are more likely to use contraceptives than women in the preference category.

The respondents were asked if they had experience of any side effects related to using family planning method. About 26.5% acknowledged having a side effect related to contraceptive use. When about the side effects associated with contraceptive use, 63.5% had experienced headache and 69.8% had experienced vomiting tendency. Finally the determinants of family planning use in char area as presented in this study, have policy and program implications for Bangladesh with similar social, cultural and economic conditions. The national family planning program should intensify not only its information, education and communication programs on family planning to cover particularly the neglected rural areas but also more importantly, adjust them to suit local conditions. In order to win more clients there is need for a continuous dialogue on the various family planning methods between service providers and clients so as to allay some of the client's fears about supposed side effects of family planning. In addition the family planning IEC should target both men and women. Especially emphasis should be put on encouraging men to play a leading role in family planning.

The importance of husband-wife communication in relation to fertility decision-making is also emphasized by these findings. Bangladesh society is largely male dominated, even with regard to female reproductive health, so men's involvement in family planning can therefore hardly be over-emphasized. One of the crucial factors, which have hindered successfully in char area, is minimal male involvement. This is perhaps not unrelated to

male fertility preferences. The establishment of more family planning programs for the men at work places spouses and thereby promotes more discussion on family planning and other health related issues.

3.3 Reproductive characteristics:

The study revealed that about fifty percent (47.1%) of the respondents were married at a <18 years of age. The mean age at marriage was 17.4 years, though the legal age at marriage is 18 years in Bangladesh. Still 80% of Bangladeshi women marry during adolescence[23] Compulsory sex education can help to empower the girls, which is the most effective strategy to prepare them for late marriage, planned and delayed pregnancy[24]. Though around sixty percent of the respondents had 2-3 children. In response of the desired children, sixty two percent of the respondents had willingness to have more children in future. When the respondents were asked about the reasons of willingness to take more children, it was revealed that for about sixty percent the desired number of children yet not filled; thirty percent mentioned that they yet not got any male children yet. Around two-third of the respondents yet not decided about the desired number of children. Study by Kabir and associates showed that 48.7% of rural women want more children in future.

3.4 Practice Related:

In the current study about twenty seven percent respondents were found as current user of family planning methods. By type of family planning methods, Oral pill was found to be most used method and fifteen percent inject able contraceptives. Condom was found used by only 1%. Though these findings contradict the findings of the study Ferdousi and associates where they found 72% of the respondents was using family planning methods according to BDHS 2014, the current use of family planning methods among the currently married Bangladeshi women age 15-49 is 62%. Among the method used, oral pill (27%), IUD (12%) and other (6.4%) were reported When the respondents were asked about the reason of not using any family planning method currently more than one-third respondents told that they don't know about FP method, one-tenth due to pregnancy and recent delivery and another tenth for Irregular visit of health workers. It was reported that among the current users of family planning methods, one-fourth face side effects mostly Headache. Unmet need for family planning was found about 45% while in a study in rural community was found 12%[25] and another study found *22.4%.*[26]Among the respondents of the study one-fifth reported that they discontinued using contraceptive before this current use mostly for more children (75.0%). It was reported that almost three-fourth respondents procure their family planning methods from Government Hospital or Satellite clinic and rest from health workers. In rural areas, more children mean more working hands. A preference for sons or for more sons than daughters has been documented in several countries in the world. Preference for male children is especially prevalent in South Asia, East Asia and North Africa, while in many European and Latin American countries; a balanced sex composition of children is more commonly preferred.

VI. CONCLUSION:

Sixty four percent respondents were found currently use of contraceptives mostly oral pill, condom and injectable. Eighty five percent respondents were found who have knowledge regarding contraceptive methods mostly oral pill and condom. The most alarming situation is that about fifty percent of the respondents were married at less than 18 years of age (mean 17.40 ± 1.107 years). About Seventy percent of contraceptives user found discontinued using FP method. More than twenty percent of the respondents who have died of their child. Fifty five percent of the respondents had willingness to have more children in future. As reasons of no use of contraceptives that they don't know about FP method, mentioned irregular visit of health workers, side effects and so on. Relatives, followed by husband and health workers were found the source of information on family planning methods and collectors. Relatives, followed by husband and health workers were found the source of information on family planning methods. Association between women level of education and frequency of pregnancy- illiterate women lifetime pregnancy frequency is high than literate women.

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VII. RECOMMENDATIONS:

Based on the study finding followings are recommended;

- Promotion of family planning methods using appropriate technologies for illiterate and hard-to-reach women should be ensured.
- Regular visit of health workers especially in hard-to-reach areas should be strictly monitored by appropriate authority should be ensure.
- The results of the analysis show that contraceptive knowledge have to char areas women but contraceptives practices level is not adequate.
- Further study should be conducted with wider sample size and area to verify the findings of this current study.

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