**Title: Factors Associated with the Utilization of Modern Family Planning Methods: A cross-sectional study on functional difficulties and dysfunctional women using nationally representative data**

**CHAPTER I**

**INTRODUCTION**

**1.1 Introduction**

Family planning plays a vital role in promoting reproductive health and overall well-being among individuals and communities (WHO, 2023b). It empowers individuals to manage their reproductive health and avoid unintended pregnancies by providing access to services and information (Program et al., 2009). However, individuals with disabilities encounter various obstacles in accessing these services, resulting in unintended pregnancies, diminished control over their reproductive health, and reduced quality of life. Family planning methods, also referred to as birth control, contraception, anticonception, or fertility control, encompass a range of techniques or devices aimed at preventing unwanted pregnancies (Alhusen et al., 2021). While birth control has historical roots, effective and safe methods emerged predominantly in the 20th century (Kantorová et al., 2020).

This research endeavors to address the significant gap in understanding attitudes towards and utilization of family planning among individuals with disabilities. By conducting this study, we aim to offer valuable insights into this crucial matter. The outcomes will play a pivotal role in shaping evidence-based interventions aimed at overcoming the obstacles encountered by people with disabilities in accessing family planning services and information. This, in turn, will contribute to enhancing reproductive health outcomes within this demographic. The global disability action plan outlined by the World Health Organization (WHO) underscores the importance of addressing disability as a priority issue in public health, human rights, and development spheres. Disability is inherently linked to human rights concerns, as individuals with disabilities often face disparities and endure various rights violations, including violence, abuse, discrimination, and a lack of autonomy (WHO, 2023a). The UN Convention on the Rights of Persons with Disabilities (UNCRPD) signifies a fundamental shift by adopting a human rights-centered approach to disability and advocating for an accessible and inclusive society that encompasses everyone. Article 25 of the Convention ensures that individuals with disabilities have the right to access the same caliber of free or affordable healthcare services and programs as other individuals, encompassing sexual and reproductive health (SRH) (UN, 2006).

Research endeavors into the reproductive health of women with disabilities gained momentum in the 1990s after a conference sponsored by the National Institutes of Health (NIH) on the reproductive health of individuals with physical disabilities (Mosher et al., 2017). Over time, there has been a burgeoning body of evidence regarding family planning specifically tailored to women and girls with disabilities, with this body of evidence deemed to be of medium size (Fraser & Corby, 2019). Various factors, including individual, environmental, attitudinal, and institutional factors, influence the accessibility and adoption of family planning among women and girls with disabilities (Kassim & Ndumbaro, 2022).

Individuals with disabilities, often marginalized within society, frequently encounter exclusion from family planning (FP) education, primarily due to the erroneous assumption that they are not sexually active (Mekonnen et al., 2020). Perceptions surrounding disability can significantly shape one's life experiences and opportunities, influencing the ability to seek, access, and utilize maternal health services. Numerous studies have highlighted that stereotypical beliefs and misunderstandings regarding the sexual and reproductive lives of persons with disabilities serve as barriers to accessing sexual and reproductive health (SRH) services (Babik & Gardner, 2021). A comprehensive comprehension of the contraceptive care experiences among women within specific disability subgroups can inform targeted initiatives aimed at better addressing the diverse needs of women within the extensive and heterogeneous disability population.

Presently, there is limited understanding regarding the contraceptive care encounters encountered by women with varying types of disabilities. Individuals with disabilities encounter various obstacles when attempting to access family planning services and information, resulting in unintended pregnancies, a lack of autonomy over their reproductive health, and diminished quality of life. This unequal utilization underscores the necessity for additional research aimed at comprehending the attitudes towards and utilization of family planning among individuals with disabilities.

**1.2 Justification of the Study**

The demographic makeup of a nation holds significant importance, as both overpopulation and underpopulation can present challenges for a country. Individuals within a nation must possess knowledge of family planning methods to effectively manage population dynamics. This study primarily aims to investigate the awareness of and utilization rates of different family planning methods among women with disabilities.

The research landscape regarding the attitudes and utilization of family planning among individuals with disabilities is notably deficient, and this study aims to rectify this gap by offering valuable insights into this significant issue. Moreover, there exists limited research concerning contraceptive care for individuals living with disabilities, alongside a dearth of clinical guidelines for contraceptive methods suitable for individuals with diverse disabilities and conditions (Verlenden et al., 2019). A growing body of literature acknowledges the historical denial of sexual and reproductive health (SRH) rights to individuals with disabilities.

The Federal Ministry of Health (FMOH) has initiated a needs assessment aimed at enhancing family planning (FP) programs for individuals with disabilities. The insights garnered from this study will serve as a foundation for crafting evidence-based interventions to overcome the obstacles hindering individuals with disabilities from accessing family planning services and information. Consequently, the study will contribute to enhancing reproductive health outcomes for this demographic, including heightened accessibility to family planning services and information, reduced occurrences of unintended pregnancies, and bolstered agency over their reproductive health. In essence, investigating the attitudes towards and utilization of family planning among individuals with disabilities is imperative for addressing the disproportionate challenges they encounter in accessing these services, bridging the existing research gap on this matter, and guiding the development of evidence-based interventions to ameliorate reproductive health outcomes.

**1.3 Operational Definitions**

**Family planning:**  Family planning refers to the management of childbirth and the spacing between pregnancies, predominantly through the utilization of contraception or voluntary sterilization methods.

**Exposure to mass media:** Exposure to mass media quantifies the percentage of women aged 15-49 who engage with newspapers, magazines, radio, or television at least once a week.

**Contraceptive prevalence rate:** Contraceptive prevalence rate indicates the proportion of currently married women aged 15-49, or those with married partners, utilizing any form of contraceptive method (modern or traditional).

**Functional difficulties:** Functional difficulties pertain to women aged 18-49 experiencing impairments necessitating assistive devices, encountering challenges across various domains such as vision, hearing, mobility, self-care, communication, and memory.

**Person with disabilities:** Person with disabilities, as per the Convention on the Rights of Persons with Disabilities, specifically includes individuals with long-term impairments, while the World Health Organization's mandate encompasses all individuals experiencing disability, irrespective of duration.

**1.4 Research Question (s)**

* Does the educational level exhibit a noteworthy correlation with the utilization of contemporary family planning techniques among individuals with disabilities?
* Is there a substantial variance in the adoption of modern family planning methods between urban and rural communities comprising individuals with disabilities?
* What is the prevalence rate of modern family planning utilization among individuals with disabilities?

**CHAPTER II**

**LITERATURE REVIEW**

According to the World Health Organization (WHO), approximately 15% of the global population, totaling roughly one billion individuals, live with disabilities. Among them, nearly 200 million encounter significant challenges in their daily functioning. Looking ahead, disability is anticipated to become a more pressing issue due to its escalating prevalence. Factors contributing to this include aging populations and the heightened susceptibility to disability among older individuals, alongside the global surge in chronic health conditions like diabetes, cardiovascular disease, cancer, and mental health disorders. The United Nations Development Program reports that the majority of persons with disabilities, approximately 80%, reside in developing nations (WHO, 2011).

The World Report on Disability, a collaborative effort between the World Bank and WHO, suggests that the actual number of children, adults, and elderly individuals living with disabilities in Ethiopia is around 15 million, representing approximately 17.6% of the population (WHO, 2011; World Bank, 2011). Regional-level studies conducted in Ethiopia further illustrate that the proportion of individuals living with disabilities in the Oromia, Amhara, and SNNP regions is 12.7%, 14.0%, and 16.8%, respectively. Ahumuza et al. discovered a prevalent societal misconception among individuals with disabilities in Uganda, revealing that there's a belief that people with disabilities don't require sexual and reproductive health (SRH) services or information (Ahumuza et al., 2014). Consequently, the healthcare system has tended to exclude individuals with disabilities from seeking and accessing SRH services.

A study was conducted to investigate the initial experiences of women with various types of disabilities when seeking contraceptive care, revealing the necessity for tailored actions to address their awareness needs. For instance, offering a paper pamphlet to a visually impaired woman is not conducive and may even pose harm to women with disabilities. Heightened focus on addressing the reproductive healthcare requirements of women with disabilities is crucial for enhancing healthcare equity and standards (Horner-Johnson et al., 2021b).

According to Ethiopia's inaugural national survey on fertility and family planning conducted in 1990, merely 4% of women of reproductive age were utilizing some form of family planning methods, with less than 3% opting for modern contraceptives. Over a decade, between 1990 and 2000, the contraceptive prevalence rate (CPR) doubled, reaching an estimated 8.2% by 2000. Subsequently, there was a remarkable and rapid escalation in CPR after 2000, with a subsequent Ethiopian Demographic and Health Survey (EDHS) in 2005 reporting a twofold increase in CPR, reaching 14.7%. This upward trajectory persisted, and by 2014, contraceptive prevalence had surged to 42% (Yirga Tejeji & Berhane Assefa, 2017).

In Nepal, a study encompassing 293 young individuals aged 15-30 with visual, hearing, or physical impairments revealed that merely 38% of respondents perceived the closest sexual and reproductive health (SRH) service center as physically accessible and accommodating to disabilities. The characteristics indicative of physical accessibility and disability friendliness included the provision of facilities such as ramps, railings, elevators, appropriate toilets, availability of sign language interpreters, provision of written materials in Braille or large text, and centers situated on the ground floor with sufficient space for movement (Kassa et al., 2016).

Research conducted in Uganda observed that individuals with disabilities frequently experienced extended waiting times at healthcare facilities to obtain family planning services, primarily because of insufficient healthcare staff. The study highlighted that while lengthy queues are prevalent, particularly in public health centers in Uganda, the lack of accommodation for individuals with physical disabilities posed a barrier to accessing sexual and reproductive health services (Ahumuza et al., 2014). A cross-country investigation spanning Ethiopia, Uganda, and Rwanda revealed that conversations regarding sexuality matters between parents and young individuals with disabilities were notably infrequent. Merely 22% of respondents reported having discussed topics related to sex and family planning with their parents (Kassa et al., 2016).

In culturally conservative settings, discussing sexuality, especially for younger and unmarried girls, can be considered taboo. Research conducted in Jordan with parents of adolescents aged 12-18 with Down's Syndrome revealed cultural barriers to addressing topics such as masturbation, sexuality, and family planning. These discussions were deemed particularly shameful for parents when involving girls. Studies have shown that women with disabilities are at least twice as likely as those without disabilities to experience rape, sexual abuse, and intimate partner violence (IPV), with male partners being the most common perpetrators. Misconceptions about asexuality can contribute to instances of IPV and other forms of violence going unnoticed. For instance, research conducted alongside young people with disabilities in Senegal highlighted a heightened vulnerability to sexual violence and consequently a higher risk of unintended pregnancies, particularly among young girls with hearing impairments (Van Der Heijden, 2014).

A review of seven significant sexual and reproductive health (SRH) policy and practice documents sourced from the Ghanaian government and NGOs concluded that the attention directed towards addressing the SRH needs of individuals with disabilities has been superficial. There is a recognized need for additional guidance and research to ensure the provision of disability-friendly services and information (Mprah et al., 2014). For instance, a qualitative study involving young individuals aged 18-24 with physical, visual, and hearing impairments in Senegal identified financial constraints as a prominent barrier to accessing SRH services. It recommended the implementation of financial assistance or voucher programs to enable young people with disabilities to access SRH services either free of charge or at subsidized rates (Burke et al., 2017).

A systematic examination of evidence regarding contraceptive awareness and utilization among women with intellectual, physical, or sensory disabilities from affluent nations revealed merely six intervention studies. Among these, five reported enhancements in contraceptive awareness and usage following the interventions (Horner-Johnson et al., 2019).

A recent scoping study commissioned by DFID revealed that individuals with disabilities are often overlooked in monitoring and evaluation (M&E) activities, including those related to family planning programming. The study identified a deficiency in expertise within the monitoring sector to effectively assess disability inclusion, with many longstanding programs lacking design considerations for inclusion. Consequently, disability remains largely invisible in M&E efforts (Buchy et al., 2017).

**CHAPTER III**

**RESEARCH METHODOLOGY**

**3.1 Study Objectives**

**3.1.1 General Objective**

The primary aim of this assessment was to evaluate the prevalence of modern family planning methods among individuals with disabilities, with a specific focus on age and residential areas.

**3.1.2 Specific Objectives**

* To evaluate the prevalence of modern family planning methods among individuals with disabilities.
* To examine the disparity in the utilization of modern family planning methods between urban and rural populations of individuals with disabilities.
* To pinpoint factors that could potentially impact the utilization of modern family planning methods among individuals with disabilities, including educational attainment and residential location.

**3.2 Conceptual Framework**

**Dependent Variable**

**Independent Variables**

Functional difficulties

(Yes and No)

Modern contraceptive methods (Yes and No)

**Socio-demographic variables**

* Geographic Area (Urban and Rural)
* Administrative Division (Barisal, Chattogram, Dhaka, Khulna, Rangpur, Rajshahi, Mymensingh, and Sylhet)
* Age Group (15-49 years)
* Educational Attainment (None, Primary, Secondary, and Higher)
* Number of Children Living in Household (<=2 and >2)
* Ethnicity of Household Head (Bengali and Other)
* Wealth Index Quintile (Poor, Middle, and Rich)
* Religious Affiliation (Islam and Other)
* Gender of Household Head (Male and Female)
* Household Size (<=4 and >4)
* Access to Mass Media (Yes and No)
* Educational Level of Husband/Partner (None, Primary, Secondary, and Higher)

**Cofounders**

**3.3 Study Design**

The MICS survey employs a two-stage cluster sampling approach, randomly selecting households with children under the age of five. The 2019 MICS was conducted with a sample of 61,242 households, achieving a response rate of 99.4%. It offers a comprehensive overview of the health status of children and women across the seven administrative divisions of Bangladesh: Dhaka, Chittagong, Sylhet, Rajshahi, Rangpur, Barisal, and Khulna. Districts were identified as the primary sample strata for sample selection during the second stage of the survey (MICS (2019) Bangladesh 2019 MICS Report).

**3.4 Target Population & Sample Population**

Among the households surveyed, a total of 68,711 women aged between 15 and 49 years were identified. Out of this group, 64,378 women were effectively interviewed, resulting in a response rate of 93.7% within the surveyed households.

**3.5 Study Site & Area**

Bangladesh ranks among the most densely populated nations globally and grapples with widespread poverty. The majority of its terrain is characterized by low-lying, flat areas with alluvial soil. The country experiences a tropical climate dominated by seasonal monsoons, featuring mild winters and hot, humid summers. With a mean elevation of 85 meters above sea level, Bangladesh's fertile delta is frequently affected by natural calamities like floods, cyclones, tidal bores, and droughts.

**3.6 Study Period**

The data collection process involved 33 teams, each consisting of four interviewers, one measurer, and a supervisor. Fieldwork commenced on January 19, 2019, and concluded on June 1, 2019. Tablet computers equipped with the Windows 10 operating system were utilized for data collection. A Bluetooth application facilitated field operations, allowing for the transfer of assignments and completed questionnaires between supervisor and interviewer tablets.

**3.7 Sample Size**

In the MICS 2019 survey, the population of Bangladesh was sampled using the list of Enumeration Areas (EAs) derived from the Population and Housing Census conducted in Bangladesh in 2011.

4,333 women were excluded from the sample as they did not meet all the criteria for inclusion.

The survey was effectively conducted among a total of 61,242 households, achieving a response rate of 99.4 percent.

A total of 64,400 households from 3,220 Enumeration Areas (EAs) were chosen, with selection probabilities proportional to the size of each EA.

3,158 households were excluded from the sample due to not meeting all the criteria for inclusion.

Among the households surveyed, a total of 68,711 women aged between 15 and 49 years were identified.

Out of these, 64,378 women were effectively interviewed, resulting in a response rate of 93.7 percent within the surveyed households.

13,257 women were excluded from the sample because they were either unmarried or ineligible to utilize any form of contraceptive methods.

1,016 women were excluded from the sample because there was no information available regarding their functional difficulties.

Dysfunctional

n = 48633

Functional Difficulties

n = 1472

50,105 women between the ages of 18 and 49 have information available regarding their functional difficulties.

51,121 women between the ages of 15 and 49 were currently married and eligible to utilize various forms of contraceptive methods.

**3.8 Inclusion Criteria**

1. Married women within the reproductive age range of 18-49 years who have disabilities.
2. Individuals who express a willingness to take part in the study.

**3.9 Exclusion Criteria**

1. Individuals who decline to participate in the study.
2. Unmarried women within the reproductive age range.
3. Data will not be gathered from widows and divorced women.

**3.10 Sampling Technique**

A two-stage, stratified cluster sampling method was employed to select the survey sample. The sampling frame utilized was derived from the 2011 Bangladesh Census of Population and Housing. In the first stage, primary sampling units (PSUs) were chosen, which consisted of enumeration areas (EAs) defined for the census enumeration. Subsequently, a household listing was conducted in each sampled EA, and a sample of households was selected in the second stage.

**3.11 Data Collection Tools**

The MICS survey employs Computer-Assisted Personal Interviewing (CAPI) technology. The data collection application utilized the CSPro (Census and Survey Processing System) software, Version 6.3, which included a specialized data management platform dedicated to MICS.

**3.12 Data Management & Analysis Plan**

Data collection will involve conducting face-to-face interviews. Before commencing data collection, permission will be sought from each couple involved. The purpose of the study will be thoroughly explained to the respondents. Interviews will be conducted with the respondents in the slum area. Ethical assurance will be provided to the respondents, guaranteeing that no part of the interview will be disclosed to any unauthorized individuals under any circumstances.

**Data Preparation:** Clean and preprocess the MICS data to ensure its suitability for analysis, including addressing missing values, outliers, and any other irregularities.

**Descriptive Statistics:** Compute descriptive statistics for the variables of interest, such as mean, median, standard deviation, and frequency distributions. This aids in understanding the data distribution and identifying any anomalies.

**Inferential Statistics:** Utilize inferential statistical tests to examine hypotheses. For Hypothesis 1, potential tests include chi-square or logistic regression to explore the association between education level and the use of modern family planning methods. For Hypothesis 2, options may include independent samples t-test or ANOVA to assess differences in modern family planning method usage between urban and rural populations.

**Interpretation of Results:** Interpret the outcomes of statistical tests, considering factors such as p-values, effect sizes, and confidence intervals. Typically, a p-value below 0.05 suggests statistical significance, indicating a less than 5% likelihood that the findings are attributable to chance.

**3.13 Quality Control & Quality Assurance**

Before collecting data from respondents, an amicable atmosphere is established, and the objectives of the data collection are communicated to the respondents. Throughout the data collection process, efforts are made to engage with respondents using the local Bangla language.

**3.14 Ethical Considerations**

Written authorization will be obtained from the relevant authority and the respondent before initiating data collection. The investigator will explain to the respondents about the study's objectives before commencing data collection.

**3.15 Expected Outcomes**

We anticipate that there will be a notable correlation between the use of contraception and women experiencing functional limitations. Our hypothesis posits that women with functional limitations are more susceptible and may struggle to fulfill their contraceptive needs compared to women without such limitations.

**3.16 Work Plan**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activities** | **Jan**  **2024** | **Feb**  **2024** | **Mar**  **2024** | **Apr**  **2024** | **May**  **2024** | **Jun**  **2024** | **Jul**  **2024** | **Aug**  **2024** |
| **Designing the Study** |  |  |  |  |  |  |  |  |
| **Review of Literature** |  |  |  |  |  |  |  |  |
| **Development & approval of proposal** |  |  |  |  |  |  |  |  |
| **Development of Data Collection Tools** |  |  |  |  |  |  |  |  |
| **Pre testing Questionnaire** |  |  |  |  |  |  |  |  |
| **Data Collection, Entry & Analysis** |  |  |  |  |  |  |  |  |
| **Report Writing** |  |  |  |  |  |  |  |  |
| **Submission & Approval of Thesis** |  |  |  |  |  |  |  |  |
| **Printing, Binding and Submission** |  |  |  |  |  |  |  |  |

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# APPENDICES

# APPENDIX-A

# CONSENT FORM

Hello, I'm (your name), representing the Bangladesh Bureau of Statistics (BBS). Our current initiative involves assessing the conditions of children, families, and households. I'd like to discuss various aspects of your health and related topics. Typically, this interview lasts around 45 minutes. Additionally, we're conducting interviews with mothers regarding their children. Please rest assured that all information provided will be kept strictly confidential and anonymous. If there's any question you prefer not to answer or if you wish to conclude the interview at any point, please feel free to inform me. Shall we begin?

# APPENDIX-B

# CONSENT FORM (BENGALI)

হ্যালো, আমার নাম (আপনার নাম)। আমরা বাংলাদেশ পরিসংখ্যান ব্যুরো (বিবিএস) থেকে এসেছি। আমরা শিশু, পরিবার এবং পরিবারের অবস্থা সম্পর্কে একটি জরিপ পরিচালনা করছি। আমি আপনার স্বাস্থ্য এবং অন্যান্য বিষয় সম্পর্কে আপনার সাথে কথা বলতে চাই। এই সাক্ষাত্কারটি সাধারণত প্রায় 45 মিনিট সময় নেয়। আমরা তাদের সন্তানদের সম্পর্কে মায়েদের সাক্ষাৎকার নিচ্ছি। আমরা প্রাপ্ত সমস্ত তথ্য কঠোরভাবে গোপনীয় এবং বেনামী থাকবে। আপনি যদি কোনো প্রশ্নের উত্তর না দিতে চান বা ইন্টারভিউ বন্ধ করতে চান তাহলে অনুগ্রহ করে আমাকে জানান। আমি কি এখন শুরু করতে পারি?

# APPENDIX-C

# QUESTIONNAIRE

Currently, married?

1. Yes 2. No

Are you pregnant now?

1. Yes 2. No

Are you currently doing something or using any method to delay or avoid getting pregnant?

1. Yes 2. No

Have you ever done something or used any method to delay or avoid getting pregnant?

1. Yes 2. No

**The Washington Group Short Set on Functioning (WG-SS)**

VISION

[Do/Does] [you/he/she] have difficulty seeing, even if wearing glasses? Would you

say… [Read response categories]

1. No difficulty

2. Some difficulty

3. A lot of difficulty

4. Cannot do at all

HEARING

[Do/Does] [you/he/she] have difficulty hearing, even if using a hearing aid(s)? Would

you say… [Read response categories]

1. No difficulty

2. Some difficulty

3. A lot of difficulty

4. Cannot do at all

MOBILITY

[Do/Does] [you/he/she] have difficulty walking or climbing steps? Would you say…

[Read response categories]

1. No difficulty

2. Some difficulty

3. A lot of difficulty

4. Cannot do at all

COGNITION (REMEMBERING)

[Do/does] [you/he/she] have difficulty remembering or concentrating? Would you say…

[Read response categories]

1. No difficulty

2. Some difficulty

3. A lot of difficulty

4. Cannot do at all

SELF-CARE

[Do/does] [you/he/she] have difficulty with self-care, such as washing all over or

dressing? Would you say… [Read response categories]

1. No difficulty

2. Some difficulty

3. A lot of difficulty

4. Cannot do at all

COMMUNICATION

Using [your/his/her] usual language, [do/does] [you/he/she] have difficulty

communicating, for example understanding or being understood? Would you say…

[Read response categories]

1. No difficulty

2. Some difficulty

3. A lot of difficulty

4. Cannot do at all

What is your area of residence?

1. Urban 2. Rural

What is your geographic location (Division)?

1. Barisal 2. Chattogram 3. Dhaka 4. Khulna 5. Rangpur 6. Rajshahi 7. Mymensingh 8. Sylhet

What is your age?

Level of Education?

1. None 2. Primary 3. Secondary 4. Higher

Number of living children in the household?

Ethnicity of the household head?

1. Bengali 2. Others

Wealth index quintile of the household?

1. Poor 2. Middle 3. Rich

The religion of household?

1. Islam 2. Others

Sex of household head?

1. Male 2. Female

Household size?

Accessibility to mass media?

1. Yes 2. No

Husband/partner’s education level?

1. None 2. Primary 3. Secondary 4. Higher

# APPENDIX-D

# QUESTIONNAIRE (BENGALI)

 বর্তমানে বিবাহিত?

1. হ্যাঁ 2. না

আপনি কি এখন গর্ভবতী?

1. হ্যাঁ 2. না

আপনি কি বর্তমানে কিছু করছেন বা গর্ভবতী হওয়ার বিলম্ব বা এড়াতে কোনো পদ্ধতি ব্যবহার করছেন?

1. হ্যাঁ 2. না

আপনি কি কখনও কিছু করেছেন বা গর্ভবতী হওয়ার বিলম্ব বা এড়াতে কোনো পদ্ধতি ব্যবহার করেছেন?

1. হ্যাঁ 2. না

ওয়াশিংটন গ্রুপ শর্ট সেট অন ফাংশন (WG-SS)

ভিশন

[কি/কি] [আপনি/সে/সে] চশমা পরলেও দেখতে অসুবিধা হয়? আপনি কি

বল... [প্রতিক্রিয়া বিভাগ পড়ুন]

1. কোন অসুবিধা নেই

2. কিছু অসুবিধা

3. অনেক অসুবিধা

4. একেবারেই করতে পারবেন না

শ্রবণ

[কি/কি] [আপনি/সে/সে] শ্রবণযন্ত্র ব্যবহার করলেও শুনতে অসুবিধা হয়? হবে

আপনি বলেন... [প্রতিক্রিয়া বিভাগ পড়ুন]

1. কোন অসুবিধা নেই

2. কিছু অসুবিধা

3. অনেক অসুবিধা

4. একেবারেই করতে পারবেন না

গতিশীলতা

[কি/কি] [আপনার/সে/সে] হাঁটতে বা সিঁড়ি বেয়ে উঠতে অসুবিধা হয়? আপনি কিছু বলতে চান…

[প্রতিক্রিয়া বিভাগগুলি পড়ুন]

1. কোন অসুবিধা নেই

2. কিছু অসুবিধা

3. অনেক অসুবিধা

4. একেবারেই করতে পারবেন না

উপলব্ধি (মনে রাখা)

[কি/কি] [আপনার/সে/সে] মনে রাখতে বা মনোযোগ দিতে অসুবিধা হয়? আপনি কিছু বলতে চান…

[প্রতিক্রিয়া বিভাগগুলি পড়ুন]

1. কোন অসুবিধা নেই

2. কিছু অসুবিধা

3. অনেক অসুবিধা

4. একেবারেই করতে পারবেন না

নিজের যত্ন

[করে/করেন] [আপনি/সে/সে] স্ব-যত্ন করতে অসুবিধা হয়, যেমন পুরোটা ধোয়া বা

ড্রেসিং? আপনি কি বলবেন... [প্রতিক্রিয়া বিভাগগুলি পড়ুন]

1. কোন অসুবিধা নেই

2. কিছু অসুবিধা

3. অনেক অসুবিধা

4. একেবারেই করতে পারবেন না

যোগাযোগ

[আপনার/তার/তার] স্বাভাবিক ভাষা ব্যবহার করা, [করেন/করেন] [আপনি/সে/তার] অসুবিধা হয়

যোগাযোগ, উদাহরণস্বরূপ বোঝা বা বোঝা হচ্ছে? আপনি কিছু বলতে চান…

[প্রতিক্রিয়া বিভাগগুলি পড়ুন]

1. কোন অসুবিধা নেই

2. কিছু অসুবিধা

3. অনেক অসুবিধা

4. একেবারেই করতে পারবেন না

আপনার বসবাসের এলাকা কি?

1. শহুরে 2. গ্রামীণ

আপনার ভৌগলিক অবস্থান (বিভাগ) কি?

1. বরিশাল 2. চট্টগ্রাম 3. ঢাকা 4. খুলনা 5. রংপুর 6. রাজশাহী 7. ময়মনসিংহ 8. সিলেট

আপনার বয়স কত?

শিক্ষার স্তর?

1. কোনটিই নয় 2. প্রাথমিক 3. মাধ্যমিক 4. উচ্চতর

পরিবারে জীবিত শিশুদের সংখ্যা?

পরিবারের প্রধানের জাতিসত্তা?

1. বাংলা 2. অন্যান্য

পরিবারের সম্পদের সূচক কুইন্টাইল?

1. দরিদ্র 2. মধ্যম 3. ধনী

গৃহের ধর্ম?

1. ইসলাম 2. অন্যান্য

বাড়ির প্রধানের লিঙ্গ?

1. পুরুষ 2. মহিলা

পরিবারের আকার?

গণমাধ্যমে প্রবেশযোগ্যতা?

1. হ্যাঁ 2. না

স্বামী/সঙ্গীর শিক্ষার স্তর?

1. কোনটিই নয় 2. প্রাথমিক 3. মাধ্যমিক 4. উচ্চতর