**PRACTICE OF FAMILY PLANNING METHODS AMONG ELIGIBLE COUPLES IN THE SLUMS OF DHAKA**

**Dr. Shahnaz Parvin**

**PG-11-45-19-003**

**State University of Bangladesh**

**Guide:** Dr. Abu Jamil Faisal

**Submission Date:**

**PRACTICE OF FAMILY PLANNING METHODS AMONG ELIGIBLE COUPLES IN THE SLUMS OF DHAKA**

**Dr. Shahnaz Parvin**

**PG-11-45-19-003**

**176, Inusbag, Dakkhin Khan, Uttara, Dhaka**

**+8801923366603**

[**parvinshahnaz4@gmail.com**](mailto:parvinshahnaz4@gmail.com)

**Place of Study:** Selected urban slums in Dhaka North City Corporation (DNCC)

**Type of Study:** Cross-Sectional Study

**Duration:** Four months

**Start Date:** 1st September

**Completion Date:** 31st December

**Signature of Investigator:**

**TABLE OF CONTENTS**

**CHAPTER- 1 Page: 7-14**

Introduction

1.1 Introduction

1.2 Justification of the study

1.3 Research question

1.4 Study Objectives

1.4.1. General Objective

1.4.2. Specific objectives

1.5 List of Variables

1.6 Operational definitions

**CHAPTER- II. Page: 15-19**

Review of literature

**CHAPTER- III. Page: 20-23**

Methodology

3.1 Study design

3.2 Study area

3.3 Study population

3.4 Selection criteria

3.4.1. Inclusion criteria

3.4.2. Exclusion criteria

3.5 Study period and duration

3.6 Sample Size

3.7 Sampling technique

3.8 Data collection method and instruments

3.9 Data management plan

3.10 Data Analysis Plan

3.11 Ethical issues

**CHAPTER IV. Page: 24-39**

Result

**CHAPTER V. Page: 40-43**

Discussion

**CHAPTER V. Page: 44**

Conclusion & Recommendation

**CHAPTER- VI. Page: 45-47**

References

**ANNEXURE-1 Page: 48-49**

Curriculum Vitae.

**ANNEXURE-2 Page: 50-52**

Informed consent

Questionnaire

**List Of Tables**

**Table No. Name of Table Page No.**

1. Distribution of the respondents by age (n=180)
2. Distribution of the respondents by religion (n=180)
3. Distribution of the respondents by sex (n=180)
4. Distribution of the respondents by wife’s occupation (n=180)
5. Distribution of the respondents by Husband’s occupation (n=180)
6. Distribution of the respondents by Wife’s education (n=180)
7. Distribution of the respondents by Husband’s education (n=180)
8. Use of contraception by age of the respondents (n=180)
9. Use of contraception by religion of the respondents (n=180)
10. Use of contraception by wife’s occupation of the respondents (n=180)
11. Use of contraception by husband’s occupation of the respondents (n=180)
12. Practice of family planning by education of the women (n=180)
13. Use of contraception by Husband’s education of the (n=180)
14. Use of contraception by Family type of the respondents (n=180)
15. Knowledge of contraceptive use and method (n=180)
16. Practice of family planning by age of the women (n=180)
17. Use of contraception by religion of the respondents (n=180)
18. Practice of family planning by the occupation of the family of the women (n=180)
19. Use of contraception by husband’s occupation of the respondents (n=180)
20. Practice of family planning by education of the women (n=180)
21. Use of contraception by Husband’s education of the (n=180)
22. Practice of family planning by type of family of the women (n=180)

**List Of Figures**

**Figure No. Name of Figure Page No.**

1. Location of selected slums
2. Distribution of the respondents by Family type
3. Prevalence of contraceptive use among participants
4. Distribution of contraceptive method use
5. Source of contraceptive collection
6. Self-reported reasons for not using contraceptives

**CHAPTER-I**

1. **Introduction:**

Family planning programs in Bangladesh have generated much interest among researchers and policymakers globally because of their outstanding success in increasing the contraceptive prevalence rate (CPR)—even in the context of a Muslim-majority country characterized by higher poverty, a lower literacy rate, and a lower level of women’s autonomy [1]. The CPR in Bangladesh has increased to 62.4% in 2014 from a mere 8.0% in 1975 [2]. The remarkable increase in the CPR has not only contributed to the decline of the total fertility rate (TFR) to 2.3 children per woman in 2014, from 6.3 children per woman in 1975, but it has also facilitated large declines in maternal mortality and infant mortality in Bangladesh [1]. However, over the last few years, the increasing trend in CPR in Bangladesh has stalled and, consequently, the declining trend in TFR has also become stagnant at 2.3 children per woman from 2011 to 2017 [1].

To slow population growth and further improve maternal and child health, the Government of Bangladesh has a target to increase CPR by 75% by 2021, thus achieving the below replacement level of fertility (i.e., less than 2.1 children per woman) [3]. However, within the current context, the latter has become a daunting challenge. To maintain the increasing trend of CPR by addressing barriers to contraceptive usage, the Government of Bangladesh needs to adopt an evidence-based pragmatic approach in its family planning programs.

Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk [4]. It has been estimated that meeting women's need for modern contraceptives would prevent about one-quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives a year [5]. Assessing the potential demand for contraceptive services is an important component of family planning program management. The need to control the increasing population to mitigate the adverse impact of population growth on economic development was recognized by the planners since the very beginning of planning in the country [6].

However, there is a discrepancy between rural and urban areas, as well as between rich and poor population [7]. Around 148 million people live in Bangladesh with the majority below the level of poverty [8]. More than one billion people globally live in urban slums or informal neighborhoods according to the United Nations Human Settlements Program (UN-Habitat) [9]. Slums are often characterized by unsafe, unhealthy, unstable, and overcrowded homes with no secure land tenure and limited or no access to basic infrastructures and services, including water, toilets, electricity, and transportation [1]. In all low-income countries, 43% of the aggregated urban population lives in slums [10]. Living in slums is a risk factor for various adverse health outcomes such as unsafe sex, unsafe water, indoor smoke from solid fuels, and tobacco and alcohol consumption [11]. In the same city, slum dwellers share a greater burden of such health outcomes than non-slum dwellers do [1]. As the population living in informal urban neighborhoods continues to globally expand in megacities, targeted urban health intervention strategies are urgently needed.

Increasing landlessness and underemployment in the rural areas are the main factors to cause constant migration of the rural poor to the urban sector and the percentage of urban population has increased from 8.8 percent in 1974 to 18 percent in 1991 [12]. With the expansion of the urban centers and increase in the urban population, the number of slums and slum dwellers is rapidly increasing. The slum dwellers are largely the distressed migrants from the rural areas and, more importantly, most of them live below the poverty line. The slum dwellers do not have sufficient access to education, employment, and health facilities of the formal sector: The health and nutritional status and contraceptive use of the urban poor are even worse than that of the rural poor.

* 1. **Justification of the Study:**

More than one billion people globally live in urban slums or informal neighborhoods according to the United Nations Human Settlements Program (UN-Habitat) [9]. Slums are often characterized by unsafe, unhealthy, unstable, and overcrowded homes with no secure land tenure and limited or no access to basic infrastructures and services, including water, toilets, electricity, and transportation. In all low-income countries, 43% of the aggregated urban population lives in slums [10]. Living in slums is a risk factor for various adverse health outcomes such as unsafe sex, unsafe water, indoor smoke from solid fuels, and tobacco and alcohol consumption [11]. In the same city, slum dwellers share a greater burden of such health outcomes than non-slum dwellers do [1]. As the population living in informal urban neighborhoods continues to globally expand in megacities, targeted urban health intervention strategies are urgently needed. To our knowledge, there is little evidence of the study on contraceptive use patterns among slum dwellers in Bangladesh. The studies conducted on fertility and contraceptive use are confined to micro level and DHS data and focused mainly on rural women or national level. Little attention has been paid on contraceptive behavior among slum dwellers, where 35% of the urban people of Bangladesh live [13]. The principal contribution of this study is to drive up the understanding of contraceptive use and method choice among urban poor living in the slums.

In Bangladesh, the size of the slump population is growing at an alarming rate. In the line of urbanization, the slum population increasingly living in Dhaka city. According to a recent report, Dhaka city has more than 5,000 slums inhabited by an estimated four million people [14]. There are 1,639 slums with 4,99,011 population under Dhaka North City Corporation (DNCC) [15]. Bangladesh's high rate of growth of slums and population living in slums has serious economic, social, and public health consequences. Although the government has a structured health and family planning service delivery system for the rural poor, it does not have any comparable infrastructure for the urban poor.

Nongovernmental organizations (NGOs) are the primary service providers for the urban poor population. However, some studies report that "NGO services are often selective, less than optimum, and their coverage is incomplete" [16]. The informal sector in urban areas is not yet fully urbanized. Those who live in the slums are largely distressed migrants from rural areas, most of whom live below the poverty line and maintain the outlook and values of their rural heritage [17]. They do not have sufficient access to the education, employment, and health facilities of the formal sector to attain any higher standard of living. Infant and maternal mortality rates are higher than the national rates, and around one-third of the people in the slum communities are thought to be ill at any time [18]. All these factors are likely to adversely affect the contraceptive behavior of those who live in the slums. These factors possibly also help to explain why urbanization has had little effect on the declining fertility in Bangladesh.

However, very little is currently known about reproductive behavior and family planning in the urban slums. To launch an effective family planning intervention, it is imperative to understand the determinants of family planning practice for the people who live there. The main purpose of the analysis presented in this paper is to learn more about the determinants of family planning choices among women living in the slums in Bangladesh.

* 1. **Research Question:**

What is the prevalence of contraceptive practices among eligible couples in slum areas of Dhaka?

* 1. **Study Objectives:**
     1. **General Objective:**

To determine the contraceptive practices among eligible couples in Dhaka slums.

* + 1. **Specific Objectives:**
* To find out the proportion of eligible couple currently using family planning methods.
* To study the knowledge about family planning methods among couples of reproductive ages (15-49 years).
* To find out the sociodemographic situation in Dhaka slums.
* To find out the factors including socio-demographic variants for adoption/non-adoption of family planning practice.
  1. **List of Variables:**

**Independent variables**

**Demographic Variables:**

* Respondents Age
* Respondents Sex
* Type of family

**Socio Economic Variables:**

* Education level of wife
* Education level of husband
* Religion
* Working status of wife
* Working status of husband

**Family planning variables:**

* Knowledge about family planning methods
* Distribution of contraceptive methods
* Source of contraceptive collection
* Reason for not using contraceptive

**Outcome variable**

* Contraceptive use
  1. **Operational Definitions:**
* **Family Planning:** Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility. A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.
* **Contraceptive:** Contraception is defined as the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures. Thus, any device or act whose purpose is to prevent a woman from becoming pregnant can be considered a contraceptive.
* **Eligible Couple:** a currently married couple wherein the wife is in the reproductive age (i.e. 15 -49 year of age)**.**
* **Slum and Urban Slum:** A slum is usually a highly populated urban residential area consisting mostly of closely packed, decrepit housing units in a situation of deteriorated or incomplete infrastructure, inhabited primarily by impoverished persons. Urbanslumsare settlements, neighborhoods, or city regions that cannot provide the basic living conditions necessary for their inhabitants, or slum dwellers, to live in a safe and healthy environment.
* **Reproductive Health:** Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health implies that people can have a satisfying and safe sex life and that they can reproduce and the freedom to decide if, when, and how often to do so [19].
* **Reproductive Age:** Women of reproductive age refer to all women aged 15–49 years.
* **Unmet Need for Family Planning:** Women with unmet needs are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior [20].

**CHAPTER-II**

**REVIEW OF LITERATURE**

Family planning in which the major component is the use of contraceptive methods is a key constituent of health services and it benefits the health and well-being of women, men, children, families, and their communities. The widespread adoption of family planning represents one of the most dramatic changes of the 20th century. The growing use of contraception around the world has given couples the ability to choose the number and spacing of their children and has tremendous lifesaving benefits. Yet despite the impressive gains, contraceptive use is still low and the need for contraception is high in some of the world’s poorest and most populous places [1]. Contraception has been the single most important intervention to reduce the burden of unwanted pregnancy as well as to promote healthy living among young adults.

Globally, contraceptive prevalence is estimated at 63 percent in 2011. In developing countries, 55 million unintended pregnancies occur every year due to women not using contraceptive methods; another 25 million occur as a result of incorrect inconsistent use of contraceptive methods and method failure [2]. If contraception were accessible and used consistently and correctly by women who want to avoid pregnancy, maternal death would decline by 25-35%. Abortion is a direct indicator of unintended pregnancy and around 35 million abortions occur in developing countries each year and approximately 20 million of these are unsafe abortions; which claim the lives of 67,000 women as a result of related complications, these deaths represent 13-25% of all pregnancy-related mortality. Further, the levels of unwanted fertility too have been quite high in India among all and particularly among married young women. A recent study reported that the prevalence of contraceptive method choice was relatively similar across slum and non-slum settlements. 34.3 % of women in slum communities and 28.1 % of women in non-slum communities reported using short-term methods. Slightly more women living in the non-slum settlements reported the use of long-term methods, 9.2 %, compared to 3.6 % in slum communities [14].

The landmark International Conference on Population and Development (ICPD) of 1994 called for greater recognition of complexities and differences in the family planning needs and preferences of couples and individuals. Hence both women and men must have access to information and a wide range of safe and effective family planning methods that will enable them to exercise freedom of choice. Existing evidence indicates that restricted contraceptive choice often leads to poor uptake and low contraceptive prevalence [21]. Over the years, contraceptive prevalence rates have grown exponentially in Kenya from 9.7 % in 1984 to 46 % in 2008-09 and recently to 58 % in 2014 among married women. However, unmet needs for family planning and unintended pregnancy remain persistently high, suggesting underlying barriers to effective contraception. According to the 2008–09 Kenya Demographic and Health Survey (DHS), 42 % of married women described their current pregnancy as unintended [22]. The 2014 Kenya DHS reports that the unmet need for family planning is 18 % among married women [23].

A study conducted in Bangladesh revealed that among respondents aged 15-20) around 8.6% prefer an oral pill, 2.5% prefer an IUD, 6.2% prefer a condom (husband’s method) and 4.9% prefer an injectable. Of respondents aged (21-25) around 19.8% prefer oral pills, 3.7% prefer IUDs, 6.2% prefer condoms (husband’s method) and 7.4% prefer injectables. Respondents age (above 25) around 21.0% prefer oral pills, 1.2% prefer IUD, 1.2% prefer condom (husband’s method) and 17.3% prefer injectable [13]. In total, around 49.4% prefer an oral pill, 7.4% prefer IUD, 13.6% prefer a condom and 29.6% prefer injectable. National Population Policy 2000 visualizes a general approach access to several methods of contraception and fertility regulation. It is anticipated that if this policy is fully implemented India’s population in 2010 will be 1107 million instead of 1162 million [24]. According to National Family Health Survey (NFHS)-3, the prevalence of modern methods of contraceptive use is 48.5% and all methods 56% in India, and in urban areas, the prevalence of modern methods of contraceptive use is 55.8%, which is still below the expected rate of 60% to have stable population [25].

Women’s education, exposure to mass media, current work status husband’s working status, age of marriage, decision-making rights, and religious restriction are the important determinants of contraceptive use among slum women. The study revealed that on the aspect of contraceptive method choice women were the program makers. More than one-third of the total women had the self-confidence to make such decisions despite their husband’s disapproval. One of the important findings is that a large proportion of slum women (45%) would like to decide jointly about the number of children they should have. But they could not place birth. Nearly half (48.4%) of their first children were born accidentally. The study found a significant relationship between respondents’ age and in deciding family size [13]. The duration of the marriage of the respondent also emerged as one of the important determinants of deciding family size. Kabir, Islam, and Bapari (2017) the study conducted through a quantitative sample survey, this research conducted in Kamlapur, Karwan Bazar, and kamrangirchor area in Dhaka city, All the women of a slum areas in Dhaka city are population [26].

Studies on this topic have been limited. So far reviewed, not that much work is found. The purposive sampling technique used in the present study. Firstly, three slums of Dhaka city were selected purposively. This study has been conducted to unveil the scenario of using contraception in the slum area of Dhaka city. The study has found that slum women are using different types of contraceptives like pills, IUDs, injections, condoms, etc. The studies have found that older women in Bangladesh usually opt for traditional methods, and young women prefer modern contraceptive methods. The study also shows that they suffer from different types of problems including weakness, increasing weight, vomiting, menstrual problems, etc.

It can be said that programmatic efforts alone will not be enough to expedite the improvement of the position of urban slum women. The study findings finally recommended that efforts should be made to enough greater participation of women with their husbands in all family decisions.

The financial status and gender-related characteristics greatly influence the reproductive health of females. A theory was formulated to explain fertility as an aspect of the so-called new-home economics approach. This approach proposed that the value of time increases as a result of investment in human capital. Based on the household income hypothesis, it is identified that the fertility rate is likely to increase as income rises. The rise in income also increases the desire for goods that further compete with the family resources depending on the number of children. Moreover, women associated with activities that generate income have greater access to contraceptives, which decreases the chances of conception. The women who are involved in decision-making tend to have higher age during marriage, reduced use of contraceptives, and access to abortion as a safety measure for the sake of their health.

**CHAPTER-III**

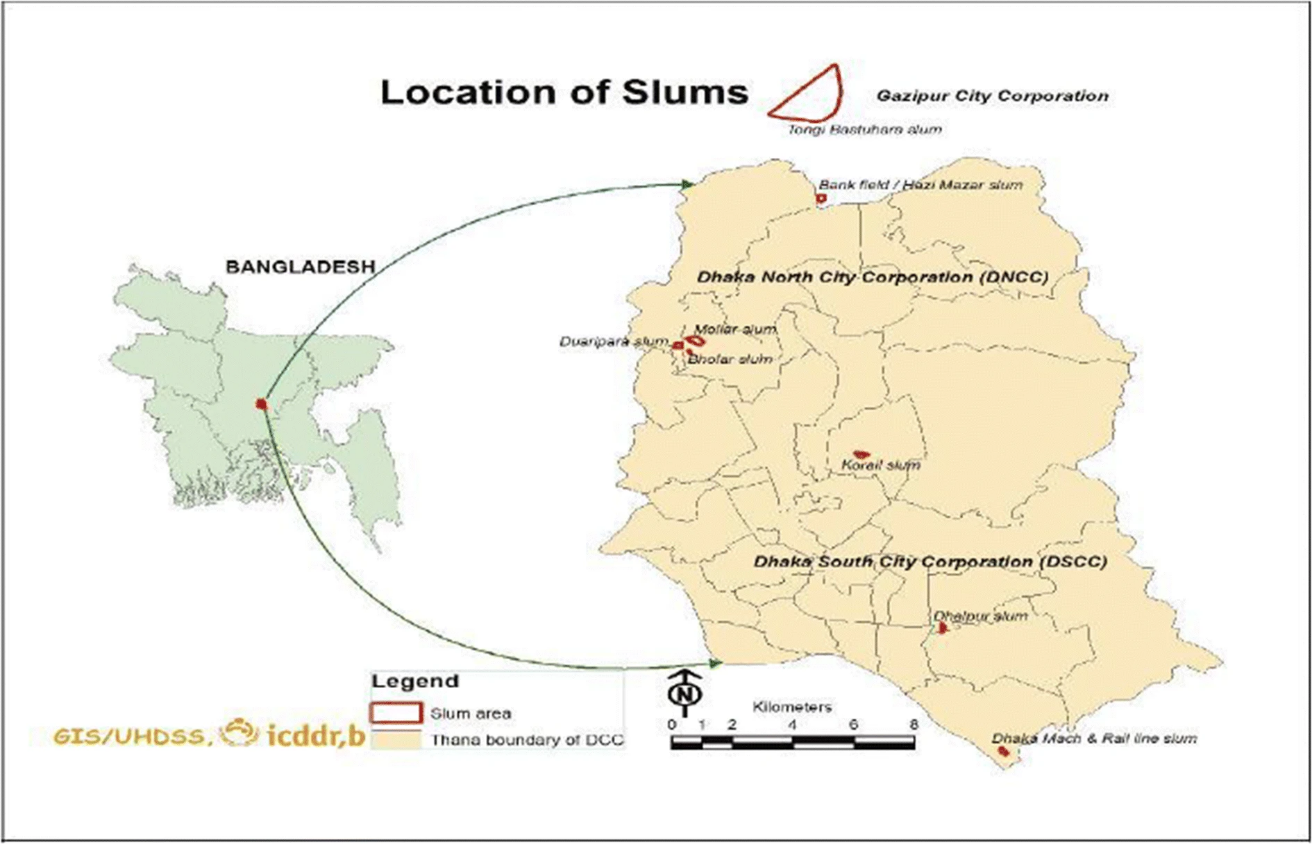
**METHODOLOGY**

**3.1 Study Design:**

This study was conducted as a cross-sectional study.

**3.2 Study Area:**

The study areas were selected conveniently. We selected two urban slums (Vasanteck and Basila) in the North City corporation of Dhaka city.



**Figure 1: Location of selected slums**

**3.3 Study Population:**

All couples of a selected slum in the North City corporation of Dhaka

**3.4 Selection Criteria:**

**3.4.1. Inclusion Criteria:**

* + 1. Participants (couple) age group 15-49 years of old
    2. Participants who gave the consent for this study

**3.4.2. Exclusion Criteria**

* + - * 1. Participants with psychiatric disorders
        2. Participants had a history of hysterectomy

**3.5 Study Period and Duration:**

This study was carried out from February to May 2021.

**3.6 Sample Size:**

We calculated the sample size using the following standard formula:

Where

n= desired sample size

z= standard normal deviation; usually set at 1.96 with 95% confidence interval

p= 21. 6%= 0.216 [13]

q= 1-p= 1-0.216= 0.784

d= degree of accuracy required at a 5% level of precision.

So, the calculated sample size was 260. However, we could not collect the required sample because of the coronavirus pandemic. Finally, we could manage 180 samples for our study.

* 1. **Sampling Technique:**

We used a random sampling method for study area selection Then for respondent’s selection the study was conducted a simple random sampling from eligible couples from selected urban slums.

* 1. **Data Collection Method and Instruments:**

A semi-structured questionnaire was used for collecting data from the respondents. After developing questionnaire, it was pretested among the people of similar to the study population other than the study area to identify the potential problems of the questionnaire. After pretesting the questionnaire was finalized.

* 1. **Data Management Plan:**
* Initially data were checked for completeness and correctness. Then it was corrected to exclude missing or inconsistent data.
* Corrected and completed data then entered into the computer.

**3.10 Data Analysis Plan:**

* The data were analyzed by using the Statistical Package for the Social Sciences (SPSS)
* Descriptive data were analyzed by simple frequency distribution (count and percentage)
* Cross tabulations were tried to find the relationship between dependent and independent variables. Statistical significance was set at a 95% confidence interval.
* Data were presented using frequency tables, graphs, and charts.
  1. **Ethical Issues:**

Approval from the Ethical Review Committee of the State University of Bangladesh was taken. Written informed consent was taken from the respondents before enrolling in the study. Confidentiality was maintained strictly and Respondents had every right to withdraw themselves from the study at any time during the data collection.

**CHAPTER-IV**

**RESULTS**

A total of 180 couples participated in our study with a response rate was 92.3%. Table 1 shows the frequency distribution of the participants by age categories. The majority (37.8%) of the study couples were from <18 years, 31.1% from ≥39 years, and only 17.2% and 13.9% were from 29-38 years and18-28 years of old, respectively.

**Table 1: Distribution of the respondents by age (n=180)**

|  |  |  |
| --- | --- | --- |
| Age Group | Frequency | Percentage (%) |
| <18 Years | 68 | 37.8 |
| 18-28 Years | 25 | 13.9 |
| 29-38 Years | 31 | 17.2 |
| ≥39 Years | 56 | 31.1 |
| Total | 180 | 100.0 |

The majority were Muslim 92.8%, 5% of women were Hindu, 0.6% were Christian, and 1.7% were from other religions (Table 2).

**Table 2: Distribution of the respondents by religion (n=180)**

|  |  |  |
| --- | --- | --- |
| Religion | Frequency | Percentage (%) |
| Muslim | 167 | 92.8 |
| Hindu | 9 | 5.0 |
| Christian | 1 | 0.6 |
| Others | 3 | 1.7 |
| Total | 180 | 100.0 |

The majority were Male 62.8%, and 56.7% were female in this study (Table 3).

**Table 3: Distribution of the respondents by sex (n=180)**

|  |  |  |
| --- | --- | --- |
| Sex Group | Frequency | Percentage (%) |
| Male | 112 | 62.8% |
| Female | 78 | 56.7% |
| Total | 180 | 100.0 |

The majority of participants were housewives 78.3%, 12.8% of women were self-employed, and 8.9% were workers (Table 4).

**Table 4: Distribution of the respondents by wife’s occupation (n=180)**

|  |  |  |
| --- | --- | --- |
| Wife’s occupation | Frequency | Percentage (%) |
| Housewife | 141 | 78.3 |
| Self-employed | 23 | 12.8 |
| Worker | 16 | 8.9 |
| Total | 180 | 100.0 |

The majority of participants were Self-employed 56.1%, followed by 35.6% were office workers, 5.6% were Rickshaw pullers, and 2.8% were Daily laborers (Table 5).

**Table 5: Distribution of the respondents by Husband’s occupation (n=180)**

|  |  |  |
| --- | --- | --- |
| Husband’s occupation | Frequency | Percentage (%) |
| Rickshaw puller | 10 | 5.6 |
| Self-employed | 101 | 56.1 |
| Office worker | 64 | 35.6 |
| Daily labor | 5 | 2.8 |
| Total | 180 | 100.0 |

The majority of wives’ education was primary 56.7%, followed by 27.8% were less than primary educated, 11.1% were secondary, and a lower were 2.8% were no education (Table 6).

**Table 6: Distribution of the respondents by Wife’s education (n=180)**

|  |  |  |
| --- | --- | --- |
| **Wife’s education** | **Frequency** | **Percentage (%)** |
| No education | 08 | 4.4 |
| Less than primary | 50 | 27.8 |
| Primary | 102 | 56.7 |
| Secondary | 20 | 11.1 |
| Total | 180 | 100.0 |

The majority of husbands’ education was primary 62.8%, followed by 22.2% were less than primarily educated, 13.9% were secondary, and a lower was from 1.1% were no education (Table 7).

**Table 7: Distribution of the respondents by Husband’s education (n=180)**

|  |  |  |
| --- | --- | --- |
| **Husband’s education** | **Frequency** | **Percentage (%)** |
| No education | 02 | 1.1 |
| Less than primary | 40 | 22.2 |
| Primary | 113 | 62.8 |
| Secondary | 25 | 13.9 |
| Total | 180 | 100.0 |

The majority in this study (67.2%) were participants from the nuclear family, whereas, 32.8% came from extended families (Figure 2).

**Figure 2: Distribution of the respondents by Family type (n=180)**

The prevalence of contraceptive use among the study couples was found to be 44%, whereas, 56% were non-user (Figure 3).

**Figure 3: Prevalence of contraceptive use among participants (n=180)**

Table 8 shows the percentage of contraceptive use among the participants. The majority of the participants used contraceptives who were less than eighteen years old (52.94%). Followed by, 51.61% of users from 29-38 years, and 35.71% from greater equal than 39 years. Only 28.0% were from less than 18 years old contraceptive users.

**Table 8: Use of contraception by age of the respondents (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Age in years** |  |  |  |
| <18 | 36 (52.94) | 32 (47.06) | 68 (37.8) |
| 18-28 | 07 (28.0) | 18 (72.0) | 25 (13.9) |
| 29-38 | 16 (51.61) | 15 (48.39) | 31 (17.2) |
| ≥39 | 20 (35.71) | 36 (64.29) | 56 (31.1) |

Table 9 shows the percentage of contraceptive use among the participants. The majority of the participants used contraceptives who were Hindu (44.44%). Followed by, 44.31% of users from the Muslim religion, and 100% from the Christian religion.

**Table 9: Use of contraception by religion of the respondents (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Religion** |  |  |  |
| Muslim | 74 (44.31) | 93 (55.69) | 167 (92.8) |
| Hindu | 04 (44.44) | 05 (55.56) | 9 (5.0) |
| Christian | 01 (100) | 00 | 1 (0.6) |
| Others | - | 03 (100) | 3 (1.7) |

Table 10 shows the percentage of contraceptive use among the participants. The majority of the participants used contraceptives who were housewives (46.80%). Followed by, 34.78% of users were self-employed, and 31.25% were workers.

**Table 10: Use of contraception by wife’s occupation of the respondents (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Wife’s occupation** |  |  |  |
| Housewife | 66 (46.80) | 75 (53.20) | 141 (78.3) |
| Self-employed | 08 (34.78) | 15 (65.22) | 23 (12.8) |
| Worker | 05 (31.25) | 11 (68.75) | 16 (8.9) |

Table 11 shows the percentage of contraceptive use among the participants. The majority of the participants used contraceptives whose husbands' occupations were rickshaw pullers (52.94%). Followed by, 44.55% of users' husbands were self-employed, and 39.06% of contraceptive users' husbands were office workers. Day labor wives use contraceptives only 20%.

**Table 11: Use of contraception by husband’s occupation of the respondents (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Husband’s occupation** |  |  |  |
| Rickshaw puller | 08 (80.0) | 02 (20.0) | 10 (5.6) |
| Self-employed | 45 (44.55) | 56 (55.45) | 101 (56.1) |
| Office worker | 25 (39.06) | 39 (60.94) | 64 (35.6) |
| Daily labor | 01 (20.0) | 04 (80.0) | 5 (2.8) |

Table 12 shows the percentage of contraceptive use among the participants. The majority of the participants used contraceptives who had less than primary education (56.0%). Followed by, 42.15% of users who had secondary education, 37.5% had no education level, and only 25.0% were tertiary level education.

**Table 12: Practice of family planning by education of the women (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Chi-square test and p-value** |
| **Yes** | **No** |  |
| **Education** |  |  |  |
| No education | 03 (37.5) | 05 (62.5) | X2= 2.300  p = 0.317 |
| Primary | 28 (56.0) | 22 (44.0) |
| Secondary | 43 (42.15) | 59 (57.85) |
| Tertiary | 05 (25.0) | 15 (75.0) |

Table 13 shows the percentage of contraceptive use among the participants. The majority of the participants used contraceptives whose husbands had no education and less than primary education (50%). Followed by, 45.13% of users whose husbands' highest education level was primary, and 28.0% were 28%.

**Table 13: Use of contraception by Husband’s education of the (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Husband’s education** |  |  |  |
| No education | 01 (50.0) | 01 (50.0) | 02 (1.1) |
| Less than primary | 20 (50.0) | 20 (50.0) | 40 (22.2) |
| Primary | 51 (45.13) | 62 (54.87) | 113 (62.8) |
| Secondary | 07 (28.0) | 18 (72.0) | 25 (13.9) |

Table 14 shows the percentage of contraceptive use among the participants. The majority of the participants used contraceptives who were from the nuclear family (46.28%) and Only 38.98% were from joint family.

**Table 14: Use of contraception by Family type of the respondents (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Family type** |  |  |  |
| Nuclear | 56 (46.28) | 65 (53.72) | 121 (67.2) |
| Joint | 23 (38.98) | 36 (61.02) | 59 (32.8) |

Figure 4 shows the percentage of types of contraceptive use among the participants. The majority of the participants used Tubal ligation contraceptives (53.16%). Followed by, 44.30% of oral contraceptive users, and only 2.53% were condom users.

**Figure 4: Distribution of contraceptive method use**

Approximately 88.9% of the study couples have heard about family planning (Table 15). Those, who have heard about family planning, majority of them, i.e., 58 (36.25%) knew oral contraceptive pill only, followed by 54 (33.75%), who knew OCP and tubal ligation both. OCP, condoms, and tubal ligation were known to 10 (6.25%) and only 7 (4.375%) of them knew about OCP, Condoms and Cu-T.

**Table 15: Knowledge of contraceptive use and method (n=180)**

|  |  |  |
| --- | --- | --- |
| **Variables** | **Yes** | **No** |
| Heard about contraceptives | 162 (88.9%) | 28 (11.0%) |
| Method |  |  |
| Oral contraceptives only | 54 (33.75%), | 126 (66.25%) |
| Tubal ligation, Condom | 10 (6.25%) | 170 (93.75) |
| OCP, Condom, Cu-T | 7 (4.37%) | 173 (95.63) |

Figure 5 shows the majority i.e., 51 of the study couples obtained family planning materials from government health centers, followed by 43% of couples, who procured it from medicine shops and only 6% procured it from private clinics.

**Figure 5: Source of contraceptive collection**

We found the commonest reason for not practicing family planning was the desire for a son (70%) and the rest were fear of adverse effects (25%) and some non-specific reasons (5%) (Figure 6).

**Figure 6: Self-reported reasons for not using contraceptives**

Table 16 shows the relation between contraceptive users and the age of the participants. From the chi-square test, they haven’t any statistically significant association at a 5% level of significance (X2 = 7.096, p-value >0.05).

**Table 16: Practice of family planning by age of the women (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Chi-square test and p-value** |
| **Yes** | **No** |  |
| **Age in years** |  |  |  |
| <18 | 36 (52.9) | 32 (47.06) | X2 = 7.096  p = 0.069 |
| 18-28 | 07 (28.0) | 18 (72.0) |
| 29-38 | 16 (51.61) | 15 (48.39) |
| ≥39 | 20 (35.71) | 36 (64.29) |

Table 17 shows the relationship between contraceptive users and the religion of the participants. From the chi-square test, they showed a statistically significant association at a 5% level of significance (X2 = 11.011, p-value <0.05).

**Table 17: Use of contraception by religion of the respondents (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Religion** |  |  |  |
| Muslim | 74 (44.31) | 93 (55.69) | X2 = 11.011  p = 0.009 |
| Hindu | 04 (44.44) | 05 (55.56) |
| Christian | 01 (100) | 00 |
| Others | - | 03 (100) |

Table 18 shows the relation between contraceptive users and the occupation of the participants. From the chi-square test, they haven’t any statistically significant association at a 5% level of significant (X2 = 2.300, p-value >0.05).

**Table 18: Practice of family planning by occupation of family of the women (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Chi-square test and p-value** |
| **Yes** | **No** |  |
| **Occupation** |  |  |  |
| Housewife | 66 (46.80) | 75 (53.20) | X2 = 2.300  p = 0.317 |
| Self-employed | 08 (34.78) | 15 (65.22) |
| Worker | 05 (31.25) | 11 (68.75) |

Table 19 shows the relation between contraceptive users and the husbands’ occupation of the participants. From the chi-square test, they showed a statistically significant association at a 5% level of significance (X2 = 15.212, p-value <0.05).

**Table 19: Use of contraception by husband’s occupation of the respondents (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Husband’s occupation** |  |  |  |
| Rickshaw puller | 08 (80.0) | 02 (20.0) | X2 = 15.212  p = 0.019 |
| Self-employed | 45 (44.55) | 56 (55.45) |
| Office worker | 25 (39.06) | 39 (60.94) |
| Daily labor | 01 (20.0) | 04 (80.0) |

Table 20 shows the relationship between contraceptive users and the participants' education level. From the chi-square test, they showed a statistically significant association at a 5% level of significance (X2 = 20.199, p-value <0.05).

**Table 20: Practice of family planning by education of the women (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Chi-square test and p-value** |
| **Yes** | **No** |  |
| **Education** |  |  |  |
| No education | 03 (37.5) | 05 (62.5) | X2= 20.199  p = <0.001 |
| Primary | 28 (56.0) | 22 (44.0) |
| Secondary | 43 (42.15) | 59 (57.85) |
| Tertiary | 05 (25.0) | 15 (75.0) |

Table 21 shows the relationship between contraceptive users and the husband’s education level of the participants. From the chi-square test, they showed a statistically significant association at a 5% level of significance (X2 = 14.214, p-value <0.05).

**Table 21: Use of contraception by Husband’s education of the (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Total (n, %)** |
| **Yes** | **No** |
| **Husband’s education** |  |  |  |
| No education | 01 (50.0) | 01 (50.0) | X2= 14.214  p = <0.001 |
| Less than primary | 20 (50.0) | 20 (50.0) |
| Primary | 51 (45.13) | 62 (54.87) |
| Secondary | 07 (28.0) | 18 (72.0) |

Table 22 shows the relation between contraceptive users and the types of families of the participants. From the chi-square test, they haven’t any statistically significant association at a 5% level of significance (X2 = 0.858, p-value >0.05).

**Table 22: Practice of family planning by type of family of the women (n=180)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Contraception User** | | **Chi square test and p-value** |
| **Yes** | **No** |  |
| **Family type** |  |  |  |
| Nuclear | 56 (46.28) | 65 (53.72) | X2 = 0.858  p = 0.354 |
| Extended | 23 (38.98) | 36 (61.02) |

**CHAPTER-V**

**DISCUSSION**

In this study, the prevalence of contraceptive use was found to be 43.9%. A study conducted in India found it to be 52.7% among rural people. Lower literacy levels may be the reason for the low prevalence of contraceptive use among them. On the other hand, the study population which comprised of rural and urban mix, permanent settlement, and slum and of better literacy level showed a higher contraceptive prevalence rate in neighboring countries. In this study, only 4.4% of the ladies were illiterate whereas previous studies found it to be 68.26%, 26%, and 15.7% [27]. This may be due to poor literacy rates in Bangladesh, Nigeria, and Ethiopia respectively.

In our study, 37.5% of illiterate ladies were practicing family planning whereas another study found it to be 20.7%. In this study, 56% of the primary educated ladies were practicing family planning whereas Roumi et.al. (2010) found it to be 35.8%. In our study, 25% of graduate or higher-educated ladies were practicing family planning but Roumi et. al. (2010) found it to be 3.9%. All these may be due to the lower literacy status of the ladies in that study [28].

A previous study suggests that older women were less likely to use traditional and short-term methods than those under 25 years but more likely to use long-term methods [29]. Our results support these findings that younger women were more likely to use contraceptives than older women. This could be a possible indication that older women want to stop childbearing and are therefore more likely to use long-term methods which are more effective as opposed to younger women who want to use contraception to space and hence more likely to use reversible or short-term methods. Although young women are increasingly initiating sex early, they are more disadvantaged in terms of contraceptive use as they receive no sex and contraceptive education [21].

In the present study, tubal ligation (female sterilization) was adopted by 53.16% and OCP was used by 44.3% of the couples whereas another study found it to be 30.4% and 9% respectively. In the present study, 80.6% couples had no desire for more children. Sultana et. al. (2007) also found that most respondents had no desire to have more children. As expected, there is a greater risk of experiencing pregnancy for women in marriage which explains their higher likelihood to use either short-term or long-term methods of contraception. Currently, married women are more likely to use short-term and long-term methods of contraception compared to their never/formerly married counterparts. These findings largely confirm those of studies conducted in the Philippines and the US which found contraceptive use to be common in consistent relationships. Our results show that women who reported having at least one child were less likely to use contraceptive methods [21].

Further, our results show that the likelihood of using a long-term method increased with the number of children. This is an indication of the influence of several children ever born on the choice of contraceptive method to adopt. Elsewhere, contraceptive use has been found to increase with parity, where women who had achieved their desired family size used contraceptives to limit births [30]. Women with three or more three children were more likely to use long-term methods but less likely to use traditional or short-term methods compared to those with fewer children. Number of surviving children is a key determining factor in contraceptive use. Women who achieve the desired family size are therefore more likely to use long-term methods of contraception [31].

Women working outside the home or those in formal employment were more likely to use contraception than those in self-employment. The increased likelihood of using traditional and long-term methods is partly attributed to the cost and benefit of childbearing and rearing. As is already documented elsewhere, childbearing and rearing are incompatible with employment outside the home. Additionally, engagement in productive employment increases women’s bargaining power which may result in higher contraceptive uptake [32]. Women from rich households were less likely to use long-term methods. Similarly, a previous study in Bangladesh found that women from rich households were found to be less likely to use permanent/long-term methods like sterilization for fear of the side effects or their mode of operation [33].

Variations in contraceptive use by age require public health interventions designed to reach the youngest age group, such as CHW, social media, and peer-to-peer interventions. Addressing stigma is equally crucial, as PMA data reported that nearly half of women believe that adolescents who use contraception are promiscuous [11]. In addition, providers tend to have a negative attitude regarding the provision of FP services to youth. One study reported that some health workers were not comfortable giving contraceptive methods to adolescent girls as they were perceived to be “children” [34]. A study reported the citation: “Sometimes when you go, they look at your body and feel that you are not old enough. They ask a lot of questions, like, ‘Who sent you?’ They also say, ‘You are too small’, and send you away” [35]. Adolescents have also stated that health professionals were unsupportive and did not seriously regard the problems they faced. Consequently, adolescents were not given a chance to discuss their sexual- and reproductive health issues [36].

Slum-focused and CHW-mediated FP programs were designed to respond to the fact that informal neighborhoods are generally more likely to be served by informal providers. Such providers are frequently unregulated and deliver low-quality services at a greater cost than that of government services [11]. Because most FP programs are managed by the government, the urban poor, particularly those living in slums, is the subgroup most likely to be impacted by interruptions in public contraceptive services. The significant interaction between household wealth and slum settlement as a predictor of modern contraceptive use indicates that there is heterogeneity between the two groups. In the present study, 50.63% of couples obtained family planning materials from government health centers whereas Pande (2002) found it to be 82% [28]. The present study revealed that 88.9% of couples have heard about family planning, whereas Abraham et. al. (2010) found it to be 96% [28].

**CHAPTER-VI**

**CONCLUSION &**

**RECOMMENDATION**

The study concludes that contraception prevalence in the study area is lower than the findings of another study in Bangladesh. As the public health care delivery system was found to be the major source of obtaining family planning materials, it needs to be strengthened in terms of quality and accessibility. Desire for a son was identified as an important barrier to contraception and despite a high rate of desire to limit family size less than half of the couples were currently using contraception. Hence apart from improving the quality and accessibility of RCH services at the primary level, better opportunities for girl children should also be created so that daughters are also equally preferred as sons. Social mobilization and behavior change communication may be helpful to eliminate the prevailing conception, that ‘male offspring are more dependable than female’ so that a greater number of couples may like to adopt family planning practices and that too without apprehension. The present study has the limitation of generalizability to this slum population only. There is a need to research the reasons for the low contraceptive use in non-slum settings. Equally important is researching other forms of family planning interventions, including outreach services, which could be feasible, acceptable, and effective in non-slum areas.

**CHAPTER-VII**

**REFERENCES**

1. **Kamrul Islam M, Rabiul Haque M, Hema PS**. Regional variations of contraceptive use in Bangladesh: A disaggregate analysis by place of residence. *PLoS ONE* PLOS, 2020; **15**Published online: 2020.doi:10.1371/JOURNAL.PONE.0230143.

2. **NIPORT**. *Bangladesh Demographic and Health Survey 2014. National Institute of Population Research and Training (NIPORT), Mitra and Associates and ICF International. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF Internationa*. 2016.

3. *Seventh Five Year Plan FY2016 – FY2020 ‘Accelerating Growth, Empowering Citizens’ | ESCAP Policy Documents Managment*. (https://policy.asiapacificenergy.org/node/2443). Accessed 4 July 2024.

4. **Askew I, *et al.*** Family planning saves maternal and newborn lives: Why universal access to contraception must be prioritized in national maternal and newborn health policies, financing, and programs. *International Journal of Gynecology & Obstetrics* John Wiley & Sons, Ltd, 2024; **164**: 536–540.

5. **Health FM of**. NIGERIA FAMILY PLANNING BLUEPRINT (SCALE-UP PLAN). Federal Ministry of Health, 2014; Published online: 2014.

6. **Prata N**. Making family planning accessible in resource-poor settings. *Philosophical Transactions of the Royal Society B: Biological Sciences* The Royal Society, 2009; **364**: 3093.

7. **Pateman T**. Rural and urban areas: comparing lives using rural/urban classifications. *Regional Trends 2011 43:1* Palgrave, 2011; **43**: 11–86.

8. *SDGs and Bangladesh: Progress, Challenges and Missing Links | Social Watch*. (https://www.socialwatch.org/node/18286). Accessed 4 July 2024.

9. *— SDG Indicators*. (https://unstats.un.org/sdgs/report/2023/goal-11/). Accessed 4 July 2024.

10. **Arimah BC**. The Face of Urban Poverty: Explaining the Prevalence of Slums in Developing Countries. *Urbanization and Development: Multidisciplinary Perspectives* Oxford University Press, 2011; Published online: 1 January 2011.doi:10.1093/ACPROF:OSO/9780199590148.003.0008.

11. **Akilimali PZ, Tran NT, Gage AJ**. Heterogeneity of modern contraceptive use among urban slum and nonslum women in kinshasa, dr congo: Cross-sectional analysis. *International Journal of Environmental Research and Public Health* MDPI, 2021; **18**Published online: 1 September 2021.doi:10.3390/IJERPH18179400/S1.

12. *(PDF) Rural poverty, migration, and the environment in developing countries:Three case studies*. (https://www.researchgate.net/publication/23721566\_Rural\_poverty\_migration\_and\_the\_environment\_in\_developing\_countriesThree\_case\_studies). Accessed 4 July 2024.

13. **Akter R**. Contraceptive Use among Slum Women in Slums of Dhaka City. *American International Journal of Social Science Research* Centre for Research on Islamic Banking and Finance and Business, 2020; **5**: 29–35.

14. **Rahaman MA, Kalam A, Al-Mamun M**. Unplanned urbanization and health risks of Dhaka City in Bangladesh: uncovering the associations between urban environment and public health. *Frontiers in Public Health* Frontiers Media SA, 2023; **11**: 1269362.

15. *Over 6 lakh slum dwellers in Dhaka: Minister Tazul Islam | undefined*. (https://www.thedailystar.net/city/6-lakh-slum-dwellers-in-dhaka-1757827). Accessed 4 July 2024.

16. **Tithi NR**. *Assessment of Essential Public Services in Slums of Dhaka City*.

17. *(PDF) Informality, Poverty and Politics in Urban Bangladesh: An Empirical Study of Dhaka City*. (https://www.researchgate.net/publication/318982486\_Informality\_Poverty\_and\_Politics\_in\_Urban\_Bangladesh\_An\_Empirical\_Study\_of\_Dhaka\_City). Accessed 4 July 2024.

18. **Lassi ZS, Kumar R, Bhutta ZA**. Community-Based Care to Improve Maternal, Newborn, and Child Health. *Disease Control Priorities, Third Edition (Volume 2): Reproductive, Maternal, Newborn, and Child Health* The International Bank for Reconstruction and Development / The World Bank, 2016; : 263–284.

19. *Reproductive health*. (https://www.who.int/southeastasia/health-topics/reproductive-health). Accessed 4 July 2024.

20. *Unmet need for family planning (%)*. (https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3414). Accessed 4 July 2024.

21. **Ochako R, *et al.*** Contraceptive method choice among women in slum and non-slum communities in Nairobi, Kenya. *BMC Women’s Health* BioMed Central Ltd., 2016; **16**: 1–13.

22. **Kitui J, Lewis S, Davey G**. Factors influencing place of delivery for women in Kenya: An analysis of the Kenya demographic and health survey, 2008/2009. *BMC Pregnancy and Childbirth* BioMed Central, 2013; **13**: 1–10.

23. **Findings Kenya K**. 2014 Demographic and Health Survey. 2013; Published online: 2013.

24. **Hossain S, *et al.*** Contraceptive uses among married women in Bangladesh: a systematic review and meta-analyses. *Journal of Health, Population, and Nutrition* BMC, 2024; **43**: 10.

25. India National Family Health Survey (NFHS-3) Ministry of Health and Family Welfare Government of India.

26. **Kabir MdA, *et al.*** A Study on Using Contraception in Dhaka City: A Scenario from Slum Area. *Asian Journal of Humanity, Art and Literature* ABC Journals, 2017; **4**: 131–140.

27. **Bekele D, *et al.*** Contraceptive prevalence rate and associated factors among reproductive age women in four emerging regions of Ethiopia: a mixed method study. *Contraception and Reproductive Medicine* BMC, 2021; **6**Published online: December 2021.doi:10.1186/S40834-021-00162-9.

28. **Wani RT, *et al.*** Knowledge, attitude, and practice of family planning services among healthcare workers in Kashmir – A cross-sectional study. *Journal of Family Medicine and Primary Care* Wolters Kluwer -- Medknow Publications, 2019; **8**: 1319.

29. **Allen RH, Cwiak CA, Kaunitz AM**. Contraception in women over 40 years of age. *CMAJ. Canadian Medical Association Journal* Canadian Medical Association, 2013; **185**: 565–573.

30. **Wablembo SM, Doctor H V.** Intergenerational Differences in Current Contraceptive Use among Married Women in Uganda. *International Journal of Population Research* John Wiley & Sons, Ltd, 2013; **2013**: 329390.

31. **Kundu S, *et al.*** Prevalence and determinants of contraceptive method use among Bangladeshi women of reproductive age: a multilevel multinomial analysis. *BMC Public Health* BioMed Central Ltd, 2022; **22**: 1–11.

32. **Finlay JE, Lee MA**. Identifying Causal Effects of Reproductive Health Improvements on Women’s Economic Empowerment Through the Population Poverty Research Initiative. *The Milbank Quarterly* Milbank Memorial Fund, 2018; **96**: 300.

33. **Hoq MN, *et al.*** Determinants of Sterilization Birth Control Method in Bangladesh. *Open Journal of Social Sciences* Scientific Research Publishing, 2019; **7**: 31–43.

34. *Contraceptive use among young women in Namibia: Determinants and policy implications*. (https://catalog.ihsn.org/citations/6370). Accessed 4 July 2024.

35. **Wood K, Jewkes R**. Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reproductive health matters* Reprod Health Matters, 2006; **14**: 109–118.

36. **Langhaug LF, *et al.*** Improving young people’s access to reproductive health care in rural Zimbabwe. *AIDS care* AIDS Care, 2003; **15**: 147–157.

**ANNEXURE-I**

**Curriculum Vitae.**

**Dr. Shahnaz Parvin**

176 Inusbag, Dakkhin Khan, Uttara, Dhaka.

Mobile: +880-1923366603

Email: [parvinshahnaz4@gmail.com](mailto:parvinshahnaz4@gmail.com)

**Employment History:**

* Working as Program Specialist in Jhpiego Bangladesh (Johns Hopkins University Affiliate) at Gulshan-2, Dhaka. (January 2022 – Continuing).
* Working as Field Coordinator in Jhpiego Bangladesh (Johns Hopkins University Affiliate) at Gulshan-2, Dhaka. (September 9, 2020 – December 2021).
* Clinical SRH Manager in International Rescue Committee, Rohingya response at Teknaf, Cox’s Bazar (August 26, 2019 – July 31, 2020).
* Medical Officer in Save The Children, Rohingya Response at Cox’s Bazar (April 15, 2018 - August 22, 2019).
* Registered Medical Officer in Maldives Medical and Dental Council, Department-Ministry of Health (December 20, 2016 – December 20, 2017)
* Medical Officer & Consultant Sonologist in Askona Medical Center at Dakkhin Khan, Uttara, Dhaka (April 1, 2015 - November 30, 2016).
* Resident Medical Officer in Taj Genaral Hospital at dakkhin Khan, Uttara, Dhaka (April 1, 2011 – March 31, 2015)
* Medical Officer in Babylon Group at Mirpur Technical, Dhaka (July 1, 2010 – March 31, 2011).

**Academic Qualification:**

1. MPH (Final semester), State University, Dhaka (2020).
2. Diploma in Ultrasonography, State University, Dhaka (2011).
3. MBBS, Sikder Women Medical Collage & Hospital (2008).
4. HSC, BN Collage, Dhaka (1999).
5. SSC, Muslim Modern Academy School, Dhaka (1997).

**Professional Qualification:**

1. Post-Graduation Training Certificate (Gynae & Obs), Medical College for Women & Hospital, Uttara, Dhaka (2015).
2. Post-Graduation Training Certificate (Gynae & Obs), Maternal and Child Health Training Institute, Azimpur, Dhaka (2013)

**ANNEXURE-2**

**Informed consent**

|  |
| --- |
| Rbvev,  Avwg †÷U BDwbfvwm©wU Ae evsjv‡`k Gi Rb¯^v¯’¨ wefv‡Mi QvÎx Wvt kvn&bvR cvifxb| Avwg, Avgvvi gv÷vm© Ae cvewjK †nj&\_ †cÖvMÖv‡gi dvBbvj cix¶vi wimvP© Gi Rb¨ XvKv wefv‡Mi XvKv DËi wmwU K‡c©v‡ikb Gi 10 wU ew¯Íi AvIZvfz³ 15 - 49 eQi eqmx Dchy³ `¤úwZ‡`i cwievi cwiKíbv c×wZ msµvšÍ DcvË msMÖn KiwQ | G Rb¨ Avwg Avcbv‡K wKQz cÖkœ Ki‡Z PvB| Avcwb hw` †Kvb DËi w`‡Z bv Pvb ev A¯^w¯Í †eva K‡ib, Z‡e Avcwb †h †Kvb mgq mv¶vrKvi cÖ`vb eÜ Ki‡Z cv‡ib A\_ev †Kvb cÖ‡kœi DËi †`qv †\_‡K weiZ \_vK‡Z cv‡ib|  Avwg Avcbv‡K Avk¦¯Í KiwQ †h, Avcbvi †`qv DËi ïaygvÎ M‡elYvi Kv‡RB e¨venvi Kiv n‡e Ges m¤c~Y© †Mvcb \_vK‡e|  Avcbvi gZvgZ GB M‡elYvi Rb¨ LyeB ¸iyZ¡c~Y©| ZvB Avwg Avkv KiwQ, G e¨vcv‡i Avcwb Avgv‡K c~Y© mn‡hvMxZv Ki‡eb Ges mKj cÖ‡kœi DËi w`‡q KvRwU‡K mdj Ki‡eb| Avcwb Kx GB M‡elYv m¤c‡K© wKQz Rvb‡Z Pvb?  Zvn‡j, Avwg KB GLb mv¶vrKviwU ïiyKi‡Z cvwi? [1] n¨vu  [2] bv  Avcbvi mw`”Qv, AvMÖn mgq Ges mvnv‡h¨i Rb¨ ab¨ev`| |

|  |  |
| --- | --- |
| 01. µwgK bs . . . . . . . . . . . . . . . . . . .  02. evwoi bvg . . . . . . . . . . . . . . . . . . .  03.evwoi wVKvbv.......................................  05. ‡gvevBj bs . . . . . . . . . . . . . . . . . . . . . . . | 06. mgq . . . . . . . . . . . . . . . Uv (AM/PM)  07. mv¶vrKvi cÖ`vbKvixi bvg  . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . |

**Questionnaires**

**Demographic and Socioeconomic Profile**

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Question** | **Response** | **Skip** |
| 1. | Avcbvi eqm KZ? (c~Y© eQ‡i)  How old are you? (In year) | |  |  | | --- | --- | |  |  |   eQi (Year) |  |
| 2. | Avcbvi wj½ wK?  What is your gender? | [1] cyiyl  [2] gwnjv |  |
| 3. | Avcbvi ag© wK?  What religion do you belong? | [1] Bmjvg  [2] wn›`y  [3] Ab¨vb¨ ............... |  |
| 4. | Avcwb †Kvb †kªYx ch©šÍ †jLvcov K‡i‡Qb? | |  |  | | --- | --- | |  |  |   †kªYx |  |
| 5. | Avcbvi †ckv wK?  What is your occupation? | [1] M„wnYx  [2] PvKzix  [3] LÛKvjxb PvKzix  [4] Mv‡g©›Um kªwgK  [5] A‡b¨i evwo‡Z KvR  [6] ¶z`ª e¨vemvqx  [7] K…wl  [8] w`bgRyi  [9] KviLvbv kªwgK  [10] wf¶ve„wË  [99] Ab¨vb¨ ............. |  |
| 6. | Avcbvi ¯^vgx †Kvb †kªYx ch©šÍ †jLvcov K‡i‡Qb? | |  |  | | --- | --- | |  |  |   †kªYx |  |
| 7. | Avcbvi ¯^vgxi †ckv wK?  What is your husband’s occupation? | [1] w`bgRyi  [2] K…wl  [3] PvKzix  [3] Mv‡g©›Um kªwgK  [4] KviLvbv kªwgK  [5] wiKkv-f¨vb PvjK  [6] ¶z`ª e¨vemvqx  [7] ivRwg¯¿x  [8] WªvBfvi  [9] ev‡mi/KÛv±i/‡nívi  [10] nKvi/‡mjmg¨vb  [11] MvW©  [12] †nv‡U‡j KvR  [13] Kzwj  [14] B‡j±ªwbK †gKvwbK  [15]wiKmv-mvB‡Kj †gKvwbK  [16] †eKvi  [99] Ab¨vb¨............... |  |
| 8. | cwiev‡ii aib? | [1] GKK  [2] †hŠ\_ |  |
| 9. | Avcwb wK cwievi cwiKíbvi c×wZ¸‡jv m¤ú‡K© Rv‡bb? | [1] n¨vu  [2] bv |  |
| 10. | Avcwb wK eZ©gv‡b cwievi cwiKíbvi †Kvb c×wZ e¨envi Ki‡Qb? | [1] n¨vu  [2] bv |  |
| 11. | Avcwb cwievi cwiKíbvi †Kvb c×wZ e¨envi Ki‡Qb- | [১] wcj (OCP)  [২] KbWg  [৩] Bgcø¨v›U  [৪] AvBBD wm wW  [৫] Bb‡RKkb| |  |
| 12. | cwievi cwiKíbv caŸwZ msMªn K‡i‡Qb †Kvb hvqMv †\_‡K? | [1] miKvwi  [2] cªvB‡fU  [3] dv‡g©wm |  |