**THESIS ON**

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

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**CHAPTER-I**

**INTRODUCTION**

* 1. **Introduction:**

Family planning programs in Bangladesh have generated much interest among researchers and policy makers 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 [3,4,5]. However, over the last few years, the increasing trend in CPR in Bangladesh has become stalled and, consequently, the declining trend in TFR has also become stagnant at 2.3 children per woman from 2011 to 2017 [6,7].

In order to slow population growth and further improvement in maternal and child health, the Government of Bangladesh has a target to increase CPR 75% by 2021, thus achieving the below replacement level of fertility (i.e., less than 2.1 children per woman) [8]. However, within the current context the latter has become a daunting challenge. To maintain the increasing trend of the CPR by addressing barriers of contraceptive usage, the Government of Bangladesh needs to adapt 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 [9]. 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 [10]. Assessing the potential demand for contraceptive services is an important component of family planning program management. The need to control increasing population so as to mitigate the adverse impact of population growth on the economic development was recognized by the planners since the very beginning of planning in the country [11].

However, there is a discrepancy between rural and urban areas, as well as between rich and poor population [12]. Around 148 million people live in Bangladesh with majority below the level of poverty [13]. More than one billion people globally live in urban slums or informal neighborhoods according to the United Nations Human Settlements Program (UN-Habitat) [1]. 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 [1]. 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 [2]. 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, 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 [14]. With the expansion of the urban centers and increase in the urban population, the number of slums and slum dwellers are 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.

**1.2 Justification**

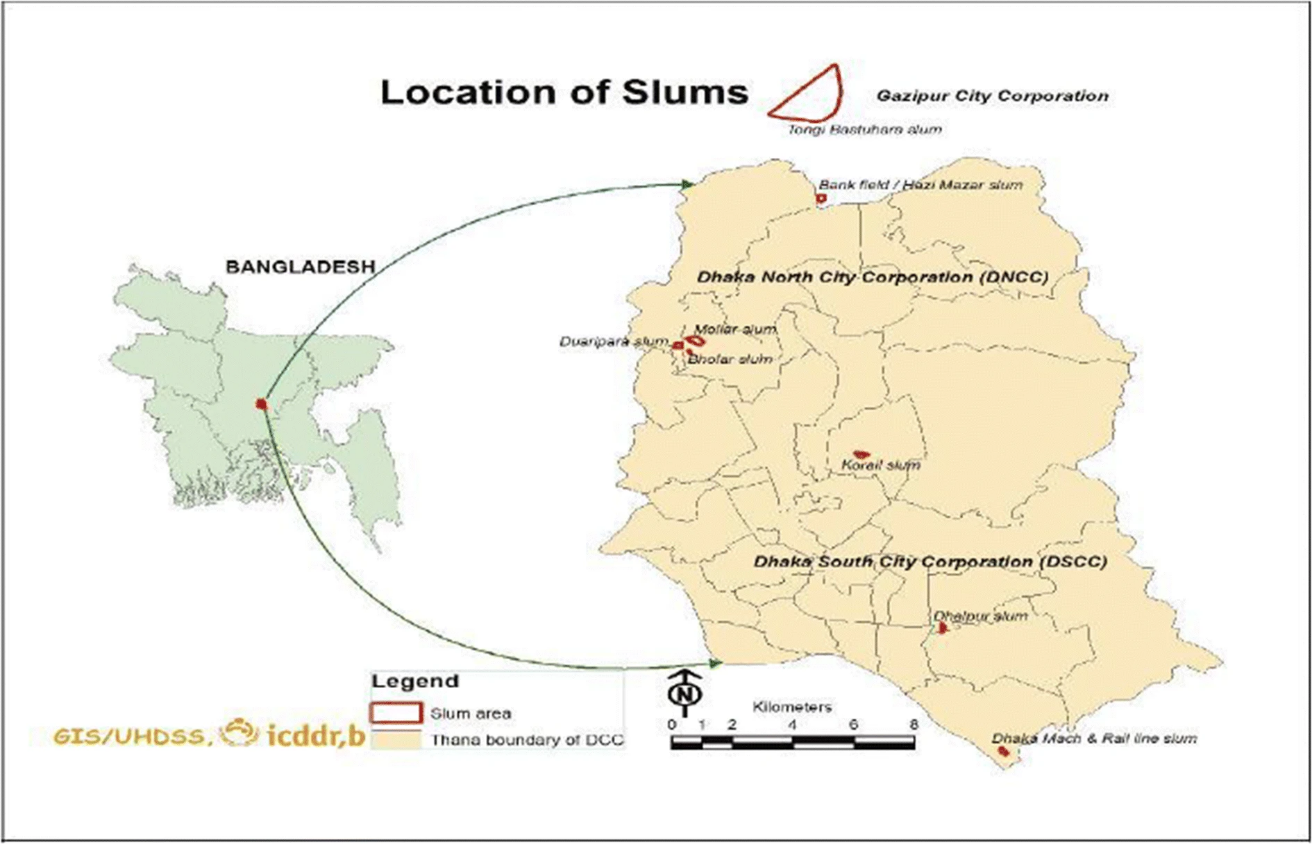
More than one billion people globally live in urban slums or informal neighborhoods according to the United Nations Human Settlements Program (UN-Habitat) [1]. Slums are often characterized by unsafe, unhealthy, unstable, and overcrowded homes with no secure land tenure and limited or no access to basic infrastructures and services, including water, toilets, electricity, and transportation [1]. In all low-income countries, 43% of the aggregated urban population lives in slums [1]. 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 [2]. 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 pattern 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. The principal contribution of this study is to driving 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 number of slum population increasingly living in Dhaka city. According to recent report, Dhaka city has more than 5,000 slums inhabited by an estimated four million people [15]. There are 1,639 slums with 4,99,011 population under Dhaka North City Corporation (DNCC) [16].

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" [17]. 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 [18]. 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 [19]. 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 choice among women living in the slums in Bangladesh.



**1.3 Research Question:**

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

**1.4 Study Objectives:**

**1.4.1 General Objectives:**

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

**1.4.2 Specific Objectives:**

* + 1. To find out the proportion of eligible couple currently using family planning methods.
    2. To study the knowledge about family planning methods among the couple of reproductive age (15-49 years)
    3. To find out the factors including socio-demographic variants for adoption/non-adoption of family planning practice.
    4. To find out the sociodemographic situation in Dhaka slums.

**1.5 Variables**

**Independent variables**

Demographic Variables:

* Age
* Sex
* Marital status

Socio Economic Variables:

* Education level
* Religion
* Working status
* Exposure to media

Health Facility variables:

* Availability/Supply of contraceptives
* Counseling done at the facilities
* Exposure to media

Proximate Determinants:

* Knowledge about family planning methods
* Religious perceptions regarding use of contraceptives
* Husband approval of contraception
* Couple discussion about family planning methods

**Outcome variable**

Contraceptive use

**1.6 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 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 as 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 are 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 its 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 to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to 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. 20

**Unmet Need for Family Planning:** Women with unmet need 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 behaviour.21

**CHAPTER-II**

**LITERATURE REVIEW**

Family planning in which the major component is use of contraceptive methods is a key constituent of health services and it benefits the health and wellbeing 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 high in some of the world’s poorest and most populous places.1 Contraception has been the single most important intervention to reduce burden of unwanted pregnancy as well as to promote healthy living among young adults.

Globally, contraceptive prevalence is estimated at 63 per cent in 2011. In developing countries, 55 million unintended pregnancies occur every year to women not using contraceptive method; another 25 million occur as a result of incorrect inconsistent use of contraceptive method 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 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 use of long-term methods, 9.2 %, compared to 3.6 % in slum communities [21].

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 it is imperative that both women and men have access to information and a wide range of safe and effective family planning methods that will enable them exercise freedom of choice [14]. Existing evidence indicates that restricted contraceptive choice often leads poor uptake and low contraceptive prevalence [14]. 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 [15-17]. However, unmet need for family planning and unintended pregnancy remains 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 [15]. The 2014 Kenya DHS reports that unmet need for family planning is 18 % among married women [17]. A study conducted in Bangladesh revealed that respondents age 15-20) around 8.6% prefer an oral pill, 2.5% prefer IUD, 6.2% prefer condom (husband’s method) and 4.9% prefer injectable. Respondents aged within (21-25) around 19.8% prefer oral pill, 3.7% prefer IUD, 6.2% prefer condom (husband’s method) and 7.4% prefer injectable. Respondents age (above 25) around 21.0% prefer oral pill, 1.2% prefer IUD, 1.2% prefer condom (husband’s method) and 17.3% prefer injectable [22]. In total, around 49.4% prefer an oral pill, 7.4% prefer IUD, 13.6% prefer 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 method 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, religious restriction are the important determinants of contraceptive use among slum women. Wahed, Bhuyan, and Rahman (2006) this study conducted on the role of women in decision making on family planning among the slum women in a selected area of Dhaka city [26]. The study revealed that on the aspect of contraceptive method choice women were the program maker. More than one-third of the total women had the self-confidence to take 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 Childs was born accidentally. The study found a significant relationship between respondents’ age and in deciding family size [27]. 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 quantitative sample survey, this research conducted on Kamlapur, Karwan Bazar and kamrangirchor area in Dhaka city, All the women of a slum area in Dhaka city are the population [28].

of the study and each woman is the unit of analysis in this study. The purposive sampling technique used in the present study. Firstly, three slums of Dhaka city were selected purposively. This study has conducted to unveil the scenario of using contraception in the slum area of Dhaka city. The study has found that the slum women are using different types of contraceptives like as pill, IUD, injection, condom etc. The studies have found that older women in Bangladesh usually opt for

traditional methods, and young women prefer modern contraceptive methods. Study also shows that they suffered from different types of problems including weakness, increasing weights, vomiting, menstrual problems etc.

It can be told that programmatic efforts alone will not be enough to expedite the improvement of the position of urban slums 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 the fertility as an aspect of so-called new-home economics approach. This approach proposed that the value of time increases as a result of investment in human capital. On the basis of household income hypothesis, it is identified that the fertility rate is likely to increase as the income rises. The rise in income also increases the desire for goods that further competes with the family resources depending on the number of children (6). Moreover, women associated with activities that generate income have greater access to the 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 sake of their health.

**CHAPTER-III**

**METHODOLOGY**

**3.1Study Design:**

This study was conducted as cross-sectional study.

**3.2 Study Area:**

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

**3.3 Study Population:**

All couples of a selected slum in North city corporation of Dhaka

**3.4 Selection Criteria:**

**3.4.1. Inclusion Criteria:**

* + 1. Partisans (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 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 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 [Ref: <https://doi.org/10.46281/aijssr.v5i3.667>]

q= 1-p= 1-0.216= 0.784

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

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

**3.7 Sampling Technique:**

We used 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.

**3.8 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.

**3.9 Data Management Plan:**

Data were entered in computer using SPSS 13 version. Descriptive statistics and chi-square tests were applied as per applicability.

* 1. **Data Analysis Plan:**
* The data were analyzed by using the Statistical Package for the Social Sciences (SPSS).
* Descriptive data were analyzed be simple frequency distribution (mean, standard deviation, percentage).
* Data were presented using frequency table, graph and chart.

**3.12 Ethical Issues:**

* Approval from Ethical Review Committee of State University of Bangladesh was taken.
* Written informed consent was taken from the respondents before enrolling for 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 the response rate was 92.3%. Table 1 shows the frequency distribution of the participants. The majority (37.8%) of the study couples were from <18 years, 31.1% from ≥39 years and only 13.9% were from 18-28 years of old. The majority were Muslim and 67.2% were from nuclear families, 78.3% women were housewives and 56.1% men were self-employed. About 62.8% men and 56.7% women studied up to primary level.

|  |  |
| --- | --- |
| **Variables** | **Total Participants** |
|
| **Age in years** |  |
| <18 | 68 (37.8) |
| 18-28 | 25 (13.9) |
| 29-38 | 31 (17.2) |
| ≥39 | 56 (31.1) |
| **Religion** |  |
| Muslim | 167 (92.8) |
| Hindu | 9 (5.0) |
| Christian | 1 (0.6) |
| Others | 3 (1.7) |
| **Wife’s occupation** |  |
| Housewife | 141 (78.3) |
| Self-employed | 23 (12.8) |
| Worker | 16 (8.9) |
| **Husband’s occupation** |  |
| Rickshaw puller | 10 (5.6) |
| Self-employed | 101 (56.1) |
| Office worker | 64 (35.6) |
| Daily labor | 5 (2.8) |
| **Wife’s education** |  |
| No education | 08 (4.4) |
| Less than primary | 50 (27.8) |
| Primary | 102 (56.7) |
| Secondary | 20 (11.1) |
| **Husband’s education** |  |
| No education | 02 (1.1) |
| Less than primary | 40 (22.2) |
| Primary | 113 (62.8) |
| Secondary | 25 (13.9) |
| **Family type** |  |
| Nuclear | 121 (67.2) |
| Joint | 59 (32.8) |

The prevalence of contraceptive use among the study couples was found to be 43.9% (Figure 1).

**Figure 1: Prevalence of contraceptive use among participants (n=180)**

Table 2 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%). Hindu (44.4%), housewife (46.80%) and rickshaw puller (80.0%) were the main group who used contraceptives more than other groups. We found that female participants who had less than primary school education used contraceptives more than other (56/0%). Among male participants, who had less than primary level education used contraceptive more than other education level (50%). Participants who lived in a nuclear family used contraceptive more than (46.28%) who lived in a joint family.

**Table 2: Use of contraception by socio-demographic profile of the study couples (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) |
| **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) |
| **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) |
| **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) |
| **Wife’s education** |  |  |  |
| No education | 03 (37.5) | 05 (62.5) | 08 (4.4) |
| Less than primary | 28 (56.0) | 22 (44.0) | 50 (27.8) |
| Primary | 43 (42.15) | 59 (57.85) | 102 (56.7) |
| Secondary | 05 (25.0) | 15 (75.0) | 20 (11.1) |
| **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) |
| **Family type** |  |  |  |
| Nuclear | 56 (46.28) | 65 (53.72) | 121 (67.2) |
| Joint | 23 (38.98) | 36 (61.02) | 59 (32.8) |

Figure 2 shows the method used among the participants. Tubal ligation was the most widely adopted method (53.16%) followed by oral contraceptive pills (44.30%) and condom was the least popular method (2.53%).

**Figure 2: Distribution of contraceptive method use**

Approximately 88.9% of the study couples have heard about family planning (Table 3). 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, condom and tubal ligation was known to 10 (6.25%) and only 7 (4.375%) of them knew about OCP, Condom and Cu-T.

**Table 3: 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 3 shows the majority i.e., 40 (50.63%) of the study couples obtained family planning materials from government health centers, followed by 34 (43.04%) couples, who procured it from medicine shops and only 5 (6.33%) procured it from private clinics.

**Figure 3: Source of contraceptive collection**

We found the commonest reason for not practicing family planning was the desire for a son and the rests were fear of adverse effects and some non-specific reasons (Figure 4).

**Figure 4: Self-reported reasons for not using contraceptives**

Table 4 shows that age, type of family, occupation, education of the wives etc. had no significant effect in determining family planning practices of the couples.

**Table 4: Practice of family planning by age, type of family, occupation and education of the women**

|  |  |  |  |
| --- | --- | --- | --- |
| **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) |
| **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) |
| **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) |
| **Family type** |  |  |  |
| Nuclear | 56 (46.28) | 65 (53.72) | X2 = 0.858  p = 0.354 |
| Joint | 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 level may be the reason for 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 both and of better literacy level showed a higher contraceptive prevalence rate in neighbor 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%. This may be due to poor literacy rate in Bangladesh, Nigeria and Ethiopia respectively. In our study 37.5% 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% 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 lower literacy status of the ladies in that study. A previous study suggest 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. Our results support these findings that younger women were more likely to use contraceptive 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 hence more likely to use reversible or short-term methods [37, 40]. Although young women are increasingly initiating sex early, they are more disadvantaged in terms on contraceptive use as they receive no sex and contraceptive education [31].

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 further children. Sultana et. al. (2007) also found that most of the respondents had no desire for having more children. As expected, there is a greater risk to 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 were 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. Further, our results show that the likelihood to use a long-term method increased with the number of children. This is an indication of the influence of number of 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 [35]. 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. Women working outside the home or those in formal employment were more likely to use contraception than those in self-employment. The increased likelihood to use traditional and long-term methods is partly attributed to the cost and benefit of child bearing and rearing. As is already documented elsewhere, childbearing and rearing is incompatible with employment outside the home. Additionally, engagement in productive employment increases women’s bargaining power which may result to higher contraceptive uptake [37]. 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.

ariations 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 [36]. 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” [35]. A study reported the citation as: “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” [37]. Adolescents have also stated that health professionals were unsupportive and did not seriously regard problems they faced. Consequently, adolescents were not given a chance to discuss their sexual- and reproductive-health issues [38,39]. 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 [31]. 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% couples obtained family planning materials from the government health centers whereas Pande (2002) found it to be 82%. Present study revealed that 88.9% couples have heard about family planning, whereas Abraham et. al. (2010) found it to be 96%. We have found that among the couples who have heard about family planning, 36.25% of them knew about OCP, whereas in Reddy et. al. (2003), it was 50%.

**CHAPTER-VI**

**CONCLUSION &**

**RECOMMENDATION**

The study concludes that contraception prevalence in the study area is lower than the finding of other 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 primary level, better opportunities for girl children should also be created so that daughters are also equally preferred as sons. Social mobilization and behaviour 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 planing interventions, including outreach services, which could be feasible, acceptable, and effective in non-slum areas.

**CHAPTER-VII**

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**ANNEXURE-I**

**Curriculum Vitae.**

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**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)

ANNEX-2, Questionnaires

|  |
| --- |
| 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  . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . |

**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. | Avcbvi mšÍvb KqwU?  How many children you have? | |  |  | | --- | --- | |  |  |   wU |  |
| 5. | Avcbvi eZ©gvb kvwiwiK Ae¯’v wK?  Which of the flowing best describe your physical condition? | [1] eZ©gv‡b Mf©eZx  [2] eZ©gv‡b cÖm~Zx  (3) bv |  |
| 6. | Avcbvi cwiev‡ii m`m¨ msL¨v KZ? | |  |  | | --- | --- | |  |  |   Rb |  |
| ৭. | Avcwb †Kvb †kªYx ch©šÍ †jLvcov K‡i‡Qb? | |  |  | | --- | --- | |  |  |   †kªYx |  |
| ৮. | 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¨ ........................ |  |  |
| ৯. | Avcbvi gvwmK Avq KZ? | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |   UvKv |  |
| ১০. | Avcbvi ¯^vgx †Kvb †kªYx ch©šÍ †jLvcov K‡i‡Qb? | |  |  | | --- | --- | |  |  |   †kªYx |  |
| 11. | 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¨........................ |  |  |
| 1২. | Avcbvi ¯^vgxi gvwmK Avq KZ? | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |   UvKv |  |
| 1৩. | cÖwZgv‡m Avcbvi cwiev‡ii †gvU Avq KZ? | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |   UvKv |  |
| 1৪. | Avcwb wK msev`cÎ c‡ob? | [1] n¨vu  [2] bv |  |
| 1৫. | Avcwb wK †iwWI †kv‡bb? | [1] n¨vu  [2] bv |  |
| 1৬. | Avcwb wK †Uwjwfkb †`‡Lb? | [1] n¨vu  [2] bv |  |
| ১৭ | Avcwb wK cwievi cwiKíbvi c×wZ¸‡jv m¤ú‡K© Rv‡bb? | 1] n¨vu  [2] bv |  |
| ১৮. | cwievi cwiKíbv c×wZ e¨env‡i Avcbvi ¯^vgxi AbygwZ Av‡Q wK? | 1] n¨vu  [2] bv |  |
| ১৯. | Avcwb wK eZ©gv‡b cwievi cwiKíbvi †Kvb c×wZ e¨envi Ki‡Qb? | 1] n¨vu  [2] bv |  |
| ২০. | 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| |  |
| 21. | cÖme c~e©eZ©x †mev`vbKv‡j cwievi cwiKíbvi c×wZ m¤ú‡K© Avcwb wK †Kvb Z\_¨ †c‡qwQ‡jb? | 1] n¨vu  [2] bv |  |
| 22. | cÖme cieZ©x †mev`vbKv‡j cwievi cwiKíbvi c×wZ m¤ú‡K© Avcwb wK ‡Kvb Z\_¨ †c‡qwQ‡jb? | 1] n¨vu  [2] bv |  |