ORIGINAL ARTICLE

Unmet Need of Family Planning among Married Women

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ABSTRACT

Objectives: To determine the prevalence of unmet need of family planning among married women and to enumerate the reasons of unmet need among married women.
Study design: Descriptive Cross Sectional.
Place and duration of study: Sakrand Town, Sindh. April 1st to June 30th 2011.
Methods: This was a cross sectional study conducted on 97 married women at Sakrand Town, Sindh.
Results: It was found that married women in town Sakrand had unmet need for contraception higher i.e. 42.26%.
Conclusions: The study found married women of town Sakrand were facing different barriers in the taking up of contraception. Mostly the barriers were at community level e.g. lack of education and awareness, excessive work, family pressure. Religious barriers were the most common among all.
Keywords: Family planning, contraceptive prevalence rate, married women.

INTRODUCTION

The recent data on unmet need in the Pakistan Demographic and Health Survey 2006-7 shows high and research suggests a new framework to analyze and address the issue differently[1]. The recent data on unmet need reveals that the services and programs fail to meet the demand and leave an unmet need of 25%[2]. Unmet need tends to develop until service facility catches up with the demand for less births and longer birth intervals. After that, extra gains in service convenience consecutively decrease unmet need[3].

World Health Organization encourages the practices of family planning and enabling women to avoid unwanted pregnancies in achieving the Millennium Development Goal[4]. Family planning and reproductive health programs have contributed seriously to fertility decline in the developing countries[5]. Improving the utilization of successful family planning contributes to dropping the load of reproductive ill health by declining mortality and morbidity of unnecessary pregnancies. Ever increasing recent family planning method use requires the population's extensive comprehensive interventions and mutual demand of significant information. At the similar time importance has been laid on the interventions aiming at countering negative perceptions of modern contraceptive methods[6].

According to the latest Pakistan Demographic and Health Survey the infant mortality rate is 78 per thousand live births and maternal mortality ratio is 276 per 100,000 live births meaning that in Pakistan one in every 89 women still dies of maternal causes[7]. Inspite of having a massive primary health care infrastructure, the primary health care system is underutilized and provides partial services to the rural and peri-urban populations[8]. Conducting study not only on socio demographic factors but also taking into consideration the economic, political and environmental determinants of health seeking behaviors would therefore be important[9]. The administration must play part for stewardship responsibility and empower in family planning programs strategies and services and use them as one of the crucial poverty-reduction strategies in the state[10]. The population growth rate has decreased from a record high of 3.7% per year in 1960s to 1.9%. The maternal and infant mortality in Pakistan is still high[11]. The use of safe and important methods of family planning allows couples to decide the number and spacing of their pregnancies. Increasing new family planning technique use requires society wide complex interventions and combined requirement of relevant information[12].

The population policy of Pakistan envisages achieving population stabilization in 2020 by declining the annual rate of population growth from 1.9% to 1.3% and TFR at 2.1. This mark requires exhausting hard work to make the perception of small family a usual environment through a keenly planned statement and education promotion. Consideration on immediate determinants of fertility mostly breast feeding and prolonging birth space will not make conflict from the community because these concepts are in accordance with Islamic injunctions and knowledge[13]. The critical importance of reproductive rights to the paradox of population policies in the 21st century argued that reproductive rights go on to be under risk, even some

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15 years after the milestone ICPD in Cairo declared the significance of a satisfying and safe sex life, the potential to have children and the right to choose on the timing, number and spacing.

Family planning programs help millions of people providing reproductive health care that save lives, it also enables women to limit births to their healthiest childbearing years and to avoid giving birth more times than is good for their health. Spacing pregnancies at least two years apart helps women have healthier children and improves the odds of infants survival by about 50%[15]. Unmet need as a concept dates to the 1960s, when researchers first demonstrated a gap in the developing world between women's fertility preferences and their use of contraception[16]. Particularly female sterilization has been promoted consciously, participation of men lagged behind. This lack of involvement of men in family planning has attracted attention since early eighties but has become a focus of attention during the last decade, particularly after the International Conference on Population and development Cairo (1994) and the World Conference on Women at Beijing (1995)[17,18].

Pakistan, Laos and the Maldives register some of the highest levels of unmet need (33%, 40%, and 37% respectively) in the region and are substantial for Nepal (24%), Cambodia (25%), Myanmar (20%), the Philippines (17%), PDR Korea (16%) and Mongolia (14%). These levels occur among married couples where the wife is not contracepting but desires to space or limit future births and imply continued vulnerability to the risk of an unplanned pregnancy until the need is met. Globally this figure is estimated to be 215 million women, with a predominant share being in the Asia region, and the incidence of unintended pregnancies annually is estimated at 75 million[19].

At the same time it is evident that reducing unmet need to zero or negligible levels is possible and nearly assured where contraceptive prevalence is high, e.g., Vietnam with 5% and Indonesia with 9%. This indicator is one by which MDG 5b's progress is being monitored, and zero tolerance for unmet contraceptive need merits consideration for adoption by all countries fully committed to improving the human condition[20].

The unmet need measure gives an estimate of the proportion of women who might potentially use contraception. Women who are using contraceptives are said to have met need for family planning. The total demand for family planning is made up of the proportion of married women with unmet need and married women with met need for family planning[21].

METHODOLOGY

It was a cross sectional study carried out on married women of Sakrand Town, District Shaheed Benazirabad, Sindh from April 1st 2011 to June 30th 2011, to identify unmet need of family planning and to assess the factors influencing it. All married women from 15-49 years of age were included while women with history of debelating illness, T.B, Asthma, mental disability were excluded from the study. Sampling technique was Convenience Sampling. Sample size was calculated by assuming 50% expected proportion with 7% absolute precision and 95% confidence level.

RESULTS

42.26% of women (41 out of 97) were found to have an unmet need for family planning. Reasons of unmet need of family planning among women: These were reported as reasons by the women respondents about their unmet need of family planning; breakdown of which is as; 59% religious, 13% family pressure, 9% economics, 8% limited mobility, 5% excessive work, 4% transport problems & 2% lack of education.

DISCUSSION

In the current study; unmet need for family planning was found to be higher for married women (42.26%). International & regional literature shows regional figures of total Unmet Need as: 1990-2009 West and Central Africa 25.5, East and Southern Africa 26.5, Middle East/North Africa 13.5, Eastern Europe 11.3, South Asia 21.0, East Asia/Pacific 16.6, Latin America and Caribbean 17.4[18]. Although Nigeria, South Africa and many of their immediate neighbors have unmet need levels below 20%, Ethiopia, Senegal and several other countries on the east and west coasts of Africa have rates around 35%. Other regions too have their trouble spots: The rates for Cambodia (30%) and Haiti (40%), for example, are six times the lowest measured rates in Vietnam (5%) and Colombia (6%), respectively[20].

CONCLUSION

The study found married women of town Sakrand were facing different barriers in the family planning. Mostly the barriers were at community level like lack of education and awareness, excessive work, resistance from family. Religious barriers were the most common among all. Sakrand town has a high unmet need of family planning and low contraceptive prevalence rate. Although there is good knowledge regarding family and modern methods of contraception however there is low utilization of modern contraceptive methods.

People are facing different barriers at individual, family, community and system levels in the practice of family planning services. These included individual level barriers such as female gender, low education, age and experience. However problems are more at community and family level like religious and economic barriers. Family pressure was also a barrier. Religious barriers were the most reported one as main reason in the consideration of family planning.

Recommendations: This study covers the perception of the peoples regarding the barriers faced by them during practice of contraception services. The following are recommendations to overcome the barriers and make the contraception services more accessible and acceptable in the communities:

- Utilization of modern contraceptives should be increased and also the existing misconceptions about contraception may be tackled through strategic communication, in this context electronic and non-electronic media like TV (Urdu/Sindhi/Punjabi/Pashto/Balochi & other channels), local FM radio (Urdu/Sindhi/ Punjabi/ Pashto/Balochi & other) and newspapers (Urdu/Sindhi/ Punjabi & other) should be utilized.
- Involvement of religious leaders e.g. Imam Masjid and other people with strong religious beliefs and religious backgrounds in reproductive health matters so to counter the religious resistance in the community.
- LHW should be highly involved with special incentives to sensitize community to overthrow these barriers by behavioral change communication.
- Enhancing further roles of the existing health system and supporting groups so to reduce and overcome resistance in the community

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