Unmet Need for Contraception in South Asia: Levels, Trends and Determinants

Fear of side effects and/or other health concerns, religious prohibition, the desire for more children, opposition from husbands, and a lack of knowledge about and/or access to, contraceptive methods are the major barriers to contraception

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"Unmet need for family planning", which refers to the condition of wanting to avoid or postpone childbearing but not using any method of contraception, has been a core concept in international population for more than three decades (Casterline and Sinding, 2000; Freedman, 1987). The importance of the unmet need for family planning or satisfying an individual's reproductive

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aspirations as a rationale for formulating population programmes was further explicitly reiterated by the Programme of Action of the International Conference on Population and Development (ICPD), which states that "Government goals for family planning should be defined in terms of unmet needs for information and services" and that "all countries should, over the next several years, assess the extent of national unmet need for good-quality family planning services (United Nations, 1994). ICPD+5 has called for a 50 per cent reduction in the unmet need for contraception by 2005 and its total reduction by 2015.

Designing effective programmes to reduce unmet need will require, among other things, an assessment of the extent of unintended fertility and, correspondingly, of the amount of unsatisfied demand for fertility regulations, and the proper identification of women with unmet need, in terms of its causes and their socio-economic and demographic characteristics. This paper, covering selected countries of the South Asian region, attempts (a) to examine levels and trends in unmet need for contraception; (b) to identify the socio-economic and demographic characteristics of those women with the highest unmet need for contraception, at the country and regional levels; (c) to delineate the major reasons for not using contraception; and (d) to draw policy and programme lessons in order to meet the unmet need for contraception.

Data and methods

The paper is based on the analysis of secondary data, particularly those collected by Demographic and Health Surveys (DHSs) from 1990/1991 to 1999/2000. The DHSs were based on national probability samples of ever-married women. The paper is also based on information collected from currently married women between the reproductive ages of 15 and 49 years.

The unmet need for contraception was defined in DHSs as currently married pregnant women whose pregnancy was mistimed (that is, they did not want a child so soon) or unwanted (that is, they did not want a child at all), amenorrhoeic women whose last birth was mistimed or unwanted, and women who were neither pregnant nor amenorrhoeic and who either wanted to wait two or more years for their next birth or have no more children, but were not using contraception. Women who wanted to space the next birth or who wanted no more children were referred to as unmet need for spacing births, or spacers,

1/ Infecund women are those who are unable to give birth to a child even if they try.

Table 1. Distribution of married women of reproductive age with unmet and met needs for contraception and total demand for contraception in selected South Asian countries, 1996/1997-1999/2000

(Percentage)

Need for family planning	Bangladesh (1999-2000)	India (1998-1999)	Nepal (1996)	Pakistan (1996-1997)
Percentage of married women of reproductive age with unmet need				
Spacing	8.0	8.3	14.3	13.4
Limiting	7.3	7.5	17.1	24.1
Total	15.3	15.8	31.4	37.5
Met need for contraception (that is, current contraceptive prevalence rate)				
Spacing	15.6	3.5	2.6	5.1
Limiting	38.2	44.7	25.9	18.8
Total	53.8	48.2	28.5	23.9
Total demand for contraception				
Spacing	23.6	11.8	16.9	18.5
Limiting	45.5	52.2	43.0	42.9
Total	69.1	64.0	59.9	61.4
Percentage of demand satisfied				
Spacing	66.1	29.6	15.4	27.6
Limiting	83.9	85.6	60.2	43.8
Total	77.9	75.3	47.6	39.0

Sources: National Institute of Population Research and Training, Ministry of Health and Family Welfare; Mitra and Associates and Macro International Inc., Bangladesh Demographic and Health Survey 2000. International Institute for Population Sciences, National Family Health Survey, 1998-1999, Bombay, India. Ministry of Health, Nepal Family Health Survey, 1996 Report (Kathmandu, 1997). National Institute of Population Studies, and Centre for Population Studies, London School of Hygiene and Tropical Medicine, Pakistan fertility and family planning survey, 1996-1997 (January 1998).

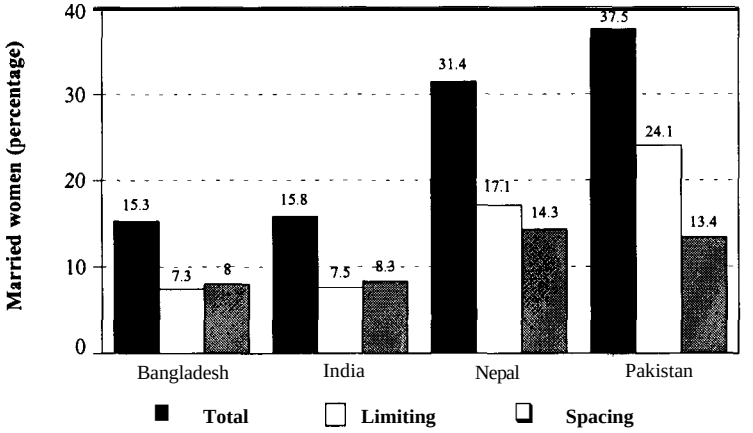
and unmet need for limiting births, or limiters, respectively. Excluded from the category of unmet need were menopausal or infecund[1] women. The flow diagram in the annex illustrates the definition of unmet need, using data collected by the 1996 Nepal Family Health Survey.

Findings

Level of unmet need

Table 1 and figure 1 examine the level of unmet need as well as the spacing and limiting components in selected countries of South Asia. The data reveal a high level of unmet need for contraception among currently married

Figure 1. Percentage distribution of currently married women of reproductive age with unmet need for contraception by components in selected South Asian countries, 1996/1997-1999/2000



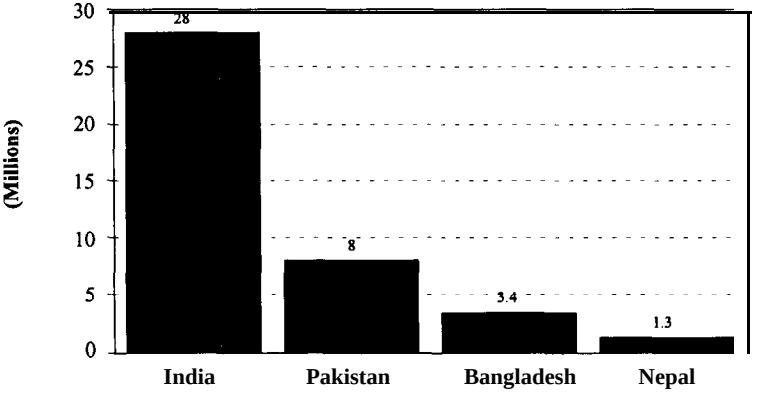
women in South Asia. At least one in five currently married women in the countries surveyed want to stop or delay childbearing, but are not using contraception. However, the level of unmet need for contraception varies considerably across the countries, ranging from 15.3 per cent in Bangladesh to 15.8 per cent in India, 31.4 per cent in Nepal and 37.5 per cent in Pakistan. In other words, nearly two in five currently married women in Pakistan, one in three in Nepal, and one in six in Bangladesh and India are in need of contraception for the purpose of spacing or limiting births. The high unmet need in Pakistan and Nepal can, to a great extent, be attributed to the high demand for limiting births (17-24 per cent), which exceeds the unmet need for limiting births in Bangladesh and India by 128-230 per cent.

Estimated number of women with unmet need

For the purpose of programme planning, an estimate is also made of the number of women in the reproductive age group with unmet need in each country.[2] This provides valuable information on the number of potential users of family planning services and helps programme managers to plan appropriate

2/ An estimate of the number of women with unmet need is obtained by multiplying the number of women in the reproductive age group with the total unmet need for contraception. Data on the number of women in the reproductive age group are taken from World Contraceptive Use, 1998 (wall chart), United Nations, 1999.

Figure 2. Number of currently married women of reproductive age with unmet need for contraception in selected South Asian countries, 1996/1997-1999/2000

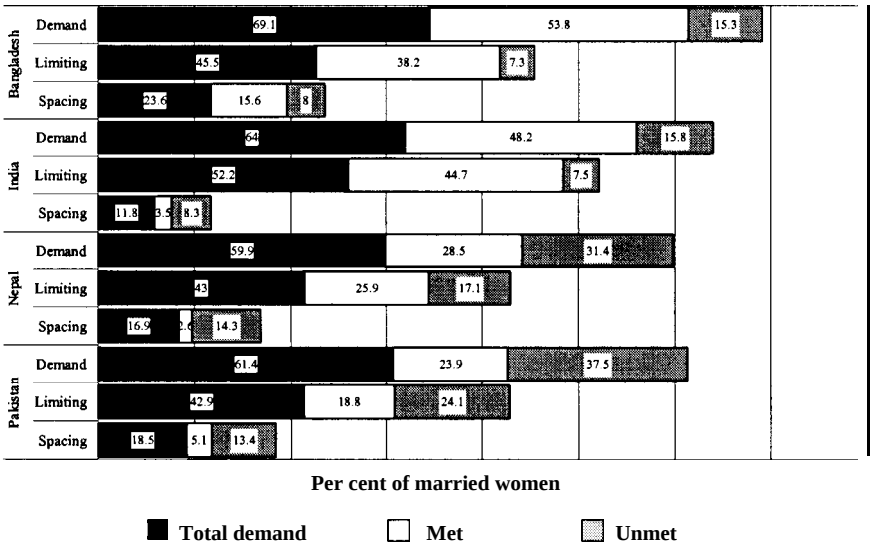


strategies to meet potential demand. In the South Asian countries covered by this paper, nearly 41 million women would like to postpone their next birth for two or more years or to stop childbearing, but are not using contraception. In India alone, around 28 million women have an unmet need for contraception, compared with 8 million in Pakistan, 3.4 million in Bangladesh and 1.3 million in Nepal (figure 2). This paper provides a conservative estimate of the number of women with an unmet need for contraception. The number would have been much higher if (a) the estimate had included the unmet need for contraception among individuals who were not living in marital union, and (b) the definition of unmet need had been broadened to include those women dissatisfied with their current methods of contraception, those who were using less efficacious contraceptive methods or those who sought services other than contraception, such as menstrual regulation or treatment of infecundity.

Level of total demand for contraception

Table 1 also provides an estimate of the total demand for contraception, obtained by adding the total unmet need to the contraceptive prevalence rate. Total demand may be interpreted as the contraceptive prevalence that would have been observed at the time of the survey if the women had previously fully implemented their spacing and limiting preferences (Bongaarts, 1991). The data in table 1 reveal a high level of total demand for contraception in almost all the countries surveyed, with little variation among them. The total demand for contraception varies within a narrow range of 60-64 per cent for most of the

Figure 3. Percentage distribution of currently married women of reproductive age with total demand for contraception, met need and unmet need, selected South Asian countries, 1996/1997-1999/2000

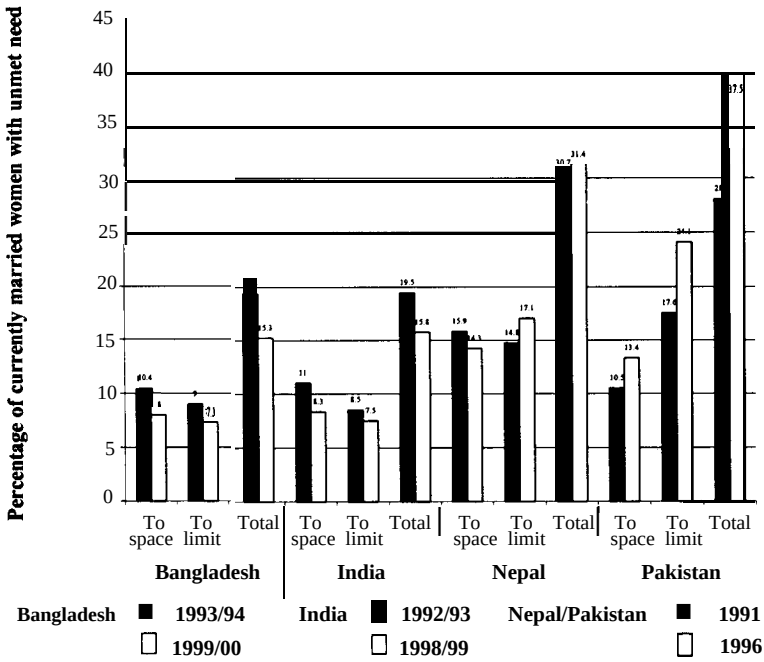


countries surveyed. However, there is substantial variation with respect to the level that is reached in satisfying total demand.

Level of satisfaction in meeting total demand for contraception

The extent to which the total demand for contraception is satisfied is also estimated by dividing the contraceptive prevalence rate by the sum of the total unmet need and prevalence rate. The estimate will provide, on the one hand, a measure of the success achieved by the family planning programme in meeting the demand for contraception while reminding the programme managers of their unfinished task of meeting the need of those whose demand for contraception still remains unrealized. The data in table 1 and figure 3 indicate a big gap between demand and satisfaction. Only 65 per cent of the total potential demand for contraception is currently being satisfied. However, the level of satisfaction varies widely by country in the region. The percentage of the total demand for contraception that is currently satisfied ranges from a high of 75-78 per cent in India and Bangladesh to 48 per cent in Nepal and 39 per cent in Pakistan. It is also important to note that the proportion of satisfied

Figure 4. Level and trend in unmet need for contraception by planning status in selected South Asian countries, 1991 to 1999/2000



demand for limiting births far outweighs the proportion of satisfied demand for spacing births in all countries covered by this survey (figure 3). This may reflect, among other things, programme emphasis on terminal rather than spacing methods. It calls for ensuring greater accessibility of spacing methods and popularizing them, particularly among young couples who have not yet achieved their desired family size and are in need of contraception for spacing births. The findings indicate that most countries in the region need to substantially improve their programme efforts to enhance the contraceptive use rate (for example, at least 28-33 per cent in Bangladesh and India, and 110-157 per cent in Nepal and Pakistan, respectively) in order to meet the total demand for contraception.

Trend in unmet need

The data in figure 4 show a mixed trend in unmet need and the total demand for contraception by its components. In Bangladesh and India unmet

Table 2. Estimated total fertility rate using regression equation TFR = 7.178 - 0.0682 CPR + e

Country	Current total fertility rate (TFR)	Current contraceptive prevalence rate (CPR)	Unmet need	Total demand for contraception	Estimated TFR if total demand for contraception satistied
	(A)	(B)	(C)	(B+C)	
Bangladesh	3.3	53.8	15.3	69.1	2.46
India	2.9	48.2	15.8	64.0	2.81
Nepal	5.6	28.5	31.4	59.9	3.09
Pakistan	5.3	23.9	37.5	61.4	2.99

Sources: National Institute of Population Research and Training, Ministry of Health and Family Welfare; Mitra and Associates and Macro International Inc., Bangladesh Demographic and Health Survey 2000. International Institute for Population Sciences, National Family Health Survey, 1998-1999, Bombay, India. Ministry of Health, Nepal Family Health Survey, 1996 Report (Kathmandu, 1997). National Institute of Population Studies, and Centre for Population Studies, London School of Hygiene and Tropical Medicine, Pakistan fertility and family planning survey, 1996-1997 (January 1998).

need has declined, while in Nepal and Pakistan it has increased. In India and Bangladesh, the unmet need for family planning among currently married women declined by 19-21 per cent between the early and late 1990s. This decline was also noticed among both spacers and limiters of births. In Nepal, the unmet need for contraception increased, albeit modestly, by 2 per cent, while in Pakistan it increased considerably by 33 per cent between the early and late 1990s. This increase was noticed among both spacers and limiters of births in Pakistan. In Nepal, the unmet need for contraception for spacing and limiting of births showed an opposite trend, in which the former declined while the latter increased. The increase in unmet need for contraception in Pakistan and Nepal may be attributed to greater reproductive preference for smaller family size and the increased availability of family planning services, among other factors.

Demographic impact

The question of whether unmet need for family planning is high enough in South Asian countries to have a significant impact on fertility if that need is satisfied is investigated using a simple regression model (TFR = 7.178 - 0.0682 CPR + e), developed by Bongaarts (1990). The result in table 2 shows that a significant demographic impact would follow for a majority of the South

Asian countries surveyed if all women who wished to limit or postpone births became contraceptive users. For example, the total fertility of Bangladesh, Nepal and Pakistan would be greatly reduced, from 3.3 to 2.5 births (24 per cent), 5.6 to 3.1 births (45 per cent) and 5.3 to 3.0 births (43 per cent), respectively, if the unmet need for contraception was satisfied. Only in the case of India would the corresponding decline be marginal: from 2.9 to 2.8 births (3 per cent). These countries would become 15 to 30 per cent closer to replacement-level fertility of 2.1 births per woman (table 2) if women with unmet need for contraception became contraceptive users.

Co-variates of unmet need for contraception: who has unmet need?

The magnitude of unmet need for contraception varies substantially according to the demographic and social characteristics of women, the most prominent of which are age, number of living children, residence and education. Also, the characteristics of women with unmet need who are interested in spacing differ from those interested in limiting births. Examination of co-variates of unmet need will enable the identification of women with greater unmet need and their characteristics. This information will provide valuable inputs to the formulation of targeted strategies for meeting the demand for contraception of women with varying needs.

Age

The data in table 3 show a negative association between age and unmet need for contraception for all of the South Asian countries surveyed, except Pakistan. In Pakistan, age shows a positive relationship with unmet need for contraception. The relationship between age and unmet need becomes sharper and uniform across all the countries when unmet need is divided into its spacing and limiting components. Age shows a negative relationship with unmet need for spacing and a positive relationship with limitation of births. This indicates a concentration of unmet need for spacing and limiting births among younger and older women, respectively. This is to be expected because younger women will still want to have more children, while older women have achieved their desired number of children.

Number of living children

The relationship between the number of living children and the level of unmet need assumes the same pattern as that of age, in which women with

Table 3. Percentage distribution of currently married women with unmet need for contraception by background characteristics in selected South Asian countries, 1996/1997-1999/2000

Background characteristics	Unmet need for contraception											
	Bangladesh (1999-2000)			India (1998-1999)			Nepal (1996)			Pakistan (1996-1997)		
	To space	To limit	Total	To space	To limit	Total	To space	To limit	Total	To space	To limit	Total
Age												
15-19	18.3	1.7	20.0	25.6	1.6	27.1	38.9	1.6	40.5	22.4	0.6	23.0
20-24	13.2	4.9	18.1	18.4	5.9	24.4	28.8	9.0	37.8	25.9	7.1	33.0
25-29	6.7	9.5	16.2	8.1	10.5	18.6	12.9	21.6	34.6	19.6	18.1	37.7
30-34	4.2	10.3	14.5	3.1	11.1	14.1	5.3	27.0	32.3	10.6	24.1	34.7
35-39	I.5	11.8	13.3	1.1	9.1	10.2	2.3	26.8	29.1	3.8	35.8	39.5
40-44	0.6	9.3	9.9	0.2	5.5	5.7	0.8	21.4	22.2	1.8	43.0	44.7
45-49	0.0	4.6	4.6	0.1	3.0	3.1	0.1	9.1	9.2	0.8	51.8	52.6
Number of living children												
0				13.8	0.2	14.1	22.9	0.2	23.1			
1				20.6	2.6	23.2	32.0	3.4	35.4			
2				7.9	7.1	15.0	18.2	13.8	32.1			
3				4.1	7.8	11.9	9.2	20.1	29.3			
4				2.9	9.7	12.5	3.2[a/]	30.3[a/]	33.5[a/]			
5				2.4	14.2	16.6						
6+				2.0	20.5	22.5						
Residence												
Urban	6.3	6.1	12.4	6.7	6.7	13.4	7.4	14.3	21.7	11.8	24.2	36.0
Rural	8.4	7.6	16.0	8.9	7.8	16.7	14.9	17.4	32.3	14.0	24.1	38.1
Education												
No education	6.9	9.7	16.6	7.8	8.5	16.2	12.7	18.4	31.1	13.3	26.2	39.5
Primary	8.6	8.3	16.9	9.2	6.1	15.2	21.1	15.0	36.2	14.6	20.3	34.8
Secondary +	8.5	3.9	12.4	8.8	6.3	15.1	19.0	8.8	27.8	12.9	15.9	28.8
Total	8.0	7.3	15.3	8.3	7.5	15.8	14.3	17.1	31.4	13.4	24.1	37.5

Sources: National Institute of Population Research and Training, Ministry of Health and Family Welfare; Mitra and Associates and Macro International Inc., Bangladesh Demographic and Health Survey 2000. International Institute for Population Sciences, National Family Health Survey, 1998-1999, Bombay, India. Ministry of Health, Nepal Family Health Survey, 1996 Report (Kathmandu, 1997). National Institute of Population Studies, and Centre for Population Studies, London School of Hygiene and Tropical Medicine, Pakistan fertility and family planning survey, 1996-1997 (January 1998).

a/ Refers to 4 and above.

fewer living children are more interested in contraception for spacing than women with high parity. The latter are more concerned with limiting births (table 3).

Place of residence

In all the South Asian countries covered by this paper, the unmet need for contraception is generally higher in rural areas than in urban areas. This may be attributed, among other factors, to the higher availability of contraceptive services and the preference for smaller families in urban areas. The overall finding of a higher need for contraception in rural areas also holds for the unmet need to space births across all the South Asian countries surveyed, and for limiting births, except in Pakistan. The data show no variation between rural and urban areas of Pakistan with regard to unmet need for limiting births (table 3).

Female education

Examination of the relationship between female education and the level of unmet need shows the following pattern: in all of the countries included in the survey, unmet need for family planning is lower among women with secondary and higher education than among women with little or no education (table 3). However, the overall pattern of the relationship between education and unmet need changes when unmet need is divided into spacing and limiting components. In all of the countries under study, the unmet need for limiting births is more concentrated among women with little or no education, while the unmet need for spacing is more concentrated among women with primary education followed by those with secondary education, except in Pakistan. In Pakistan, both spacers and limiters tend to be more concentrated among women with little or no education. The finding of a relatively higher concentration of spacers among women with higher education and a greater number of limiters among women with little or no education may be attributed, among other factors, to their age differences. Since women with higher education are relatively younger than women with little or no education, the former will therefore be more interested than the latter in spacing births. Moreover, the former are more knowledgeable than the latter about method mix and sources of contraceptives.

Differences among women with unmet need

Women with unmet need do not form a homogeneous group. Several important differences exist among women with unmet need that deserve

Table 4. Composition of unmet need for contraception by pregnancy status and contraceptive intention in selected South Asian countries

(Percentage)

Country	Pregnant or amenorrhoeic	Who have never used contraception	Who intend to use contraception
Bangladesh (1993-1994)[a/]	22.0	51.0	79.0
Nepal (1996)[b/]	26.5	78.0	76.0
Pakistan (1990-1991)[a/]	26.0	82.0	26.0

a/ Demographic and Health Surveys, quoted in *Population Reports*, vol. XXIV, No. 1, September 1996, Johns Hopkins University School of Public Health, Centre for Communication Programs.

b/ Aryal, R.H and T.B. Dangi (1997). "Attitudes towards family planning and reasons for non-use among women with unmet need for family planning in Nepal", in *Insights on Family Health Issues in Nepal* (Kathmandu, Ministry of Health).

consideration from a programmatic viewpoint. These differences include whether unmet need is for limiting or spacing of births, the pregnancy or exposure status, the previous use of contraception and the intention to use contraception in the future.

Limiting versus spacing

The classification of unmet need into two components (the need for spacing and the need for limiting births) has important family planning programme implications. This will provide valuable information to programme managers that will be helpful in selecting the appropriate method mix for meeting the demand of potential users of contraception, that is, whether they are interested in spacing or limiting births.

Data show no systematic distribution pattern of the components of unmet need across the South Asian countries covered by this study. The unmet need is higher for limiting than spacing births in Nepal and Pakistan, while in India and Bangladesh it is the reverse (table 1).

Pregnancy or exposure status

The unmet need for contraception was also assessed for women who are pregnant or amenorrhoeic women by asking whether (a) their current pregnancy or recent birth was mistimed (that is, the child was either not wanted so soon or was unintended (that is, not wanted at all), and (b) any method of family planning was being used at the time of conception. Table 4 shows that a

sizeable proportion of women with unmet need are pregnant or amenorrhoeic, accounting for at least one fifth of the total in all the South Asian countries included in this study. The finding indicates that unmet need is fairly common among amenorrhoeic women, that is, those who have recently given birth. This finding has significant programme implications. Although such women are not immediately at risk of pregnancy, they may become pregnant sooner than expected if their unmet need for contraception is not met in a timely and adequate way, a fact confiied by studies conducted in several countries. For example, survey data from 33 countries found that 17-22 per cent of pregnancies occurred within nine months of a previous birth (Hobcraft, 1991). Another set of data collected from 25 countries found that, on average, 11 per cent of women intended to have another birth within two years of a previous birth, but that 35 per cent had actually given birth sooner. Those figures confirm that many amenorrhoeic women give birth much earlier than they would like (Westoff and Bankole, 1995). One lesson that can be learnt from these findings is that the unmet need for contraception of amenorrhoeic women should be met in a timely way in order to avoid unwanted births.

Prior use of family planning

As observed elsewhere, the data from selected South Asian countries also confirm that the majority of women with an unmet need have never used contraception. The past use of contraception ranges from a high of 49 per cent in Bangladesh to a low of 18 and 22 per cent in Pakistan and Nepal, respectively.

Intention to use contraception

The data on intention to use contraception in the future are very useful as they enable a fairly robust estimate to be made of potential demand for contraception. There is a close association between intention to use and actual use of contraception. A recent longitudinal study in Morocco revealed that more than 75 per cent of a cohort of women who indicated their intention to use family planning in 1992 actually did so in 1995 (Johns Hopkins University School of Public Health, 1996). The data in table 4 show a high potential demand for contraception among women with unmet need in most countries of the region, except Pakistan. At least three out of four women in Bangladesh and Nepal intended to use contraception in the future. In Pakistan, only one in four intended to use contraception in the future. This could be attributed to the prevailing low level of unmet need and inadequate supply of family planning services in 1990-1991. However, the situation could have changed by

the late 1990s. Unfortunately, no recent comparative data are available for measuring that change over time.

Reasons for not using contraception

This section identifies and discusses the factors inhibiting the use of contraception by married women who are apparently willing to postpone or limit births, by utilizing data collected during the DHS surveys. The reasons for not using contraception are identified for two groups of women with unmet need: (a) women with total unmet need; and (b) women with unmet need who do not intend to use contraception in the future. Proper identification of the reasons why so much demand remains unsatisfied will lead to the formulation of appropriate strategies for meeting the unmet need of potential users.

Reasons for not using contraception: women with total unmet need

The most frequently mentioned reasons cited by women with unmet need for not using contraception in Nepal, as reported in the 1996 DHS, were: (a) a desire for more children (27 per cent); (b) side effects and/or health concerns (22 per cent); (c) infrequent sex and/or not having sex (11 per cent); (d) husband's disapproval (6 per cent); (e) a lack of knowledge and/or sources of, and a lack of access to, contraceptive methods, (12 per cent); (f) religion (3 per cent); and (g) postpartum breastfeeding (7 per cent) (table 5).

In Bangladesh and Pakistan, religion and the partner's opposition were cited as the principal reasons for not using contraception by women with unmet need in the 1990/1991 and 1993 DHSs (Macro International, 1998). A 1997 survey in the province of Punjab, Pakistan revealed that among the eight possible barriers to contraceptive use, the most prevalent was disapproval by the husband, followed by fear of side effects (Population Council, 1997). Opposition by the husband was also identified as a major reason for non-use of contraception in India (Viswanathan, Godfrey and Yinger, 1998).

In Sri Lanka, the principal reasons cited by women with unmet need for non-use of contraception included: (a) health concerns (19.3 per cent); (b) husband's disapproval (14.6 per cent); (c) infrequent sex (13.3 per cent); (d) lack of knowledge (10.4 per cent); (e) religion (3.6 per cent); and (f) lack of access (3.2 per cent) (Bongaarts and Bruce, 1994). In 2000, health concerns were still cited (11 per cent) as the single most important non-biological reason for not using contraception, followed by husband's disapproval (3.9 per cent) and religious opposition (3 per cent), among married non-pregnant women who

Table 5. Percentage distribution of women with unmet need for contraception by main reason for non-use, Nepal 1996

Reasons for non-use	Unmet need		
	Spacing	Limiting	Total
Not having sex	2.2	2.5	2.4
Infrequent sex	8.5	7.9	8.2
Menopausal/hysterectomy	0.0	0.0	0.0
Sub-fecund, infecund	0.0	0.1	0.0
Postpartum, breastfeeding	7.7	6.3	6.9
Want more children	47.1	9.4	26.6
Pregnant	3.4	3.7	3.6
Respondent opposed	1.0	2.1	1.6
Husband opposed	2.9	9.1	6.3
Others opposed	0.8	0.8	0.8
Religious prohibition	3.0	3.4	3.2
Knows no method	3.8	4.8	4.4
Knows no source	2.7	3.3	3.1
Health concerns	1.4	9.8	6.0
Fear of side effects	6.8	23.5	15.9
Lack of access	2.7	6.0	4.5
Costs too much	0.1	0.1	0.1
Inconvenient to use	0.4	0.1	0.2
Interferes with body	0.0	0.4	0.2
Others	4.1	6.4	5.3
Don't know	1.3	0.2	0.7
Total	100	100	100
Number of women	1,138	1,366	2,504

Source: Aryal, R.H. and T.B. Dangi (1997). "Attitudes towards family planning and reasons for non-use among women with unmet need for family planning in Nepal", in *Insights on Family Health Issues in Nepal* (Kathmandu, Ministry of Health and Macro International Inc.).

were not currently using a method of contraception and who reported being unhappy if they became pregnant too soon (Department of Census and Statistics, 2001).

Reasons for not intending to use contraception in the future

The group of women who are apparently willing to postpone or limit their births, but are not intending to use contraception in the future, deserve special focus from a programme point of view. The reason for such focus is that they are not likely to respond spontaneously to family planning programme efforts easily, unless their concerns for not intending to use contraception in the

Table 6. Percentage of women with unmet need intending to use contraception in the future, and reasons of those not intending to use contraception by components of unmet need, Nepal 1996

	Components of unmet need		
	Spacing	Limiting	Total
Intend to use	81.0	70.9	75.5
Do not intend to use	19.0	29.1	24.5
Total	100	100	100
Number of women	1,138	1,366	2,504
Do not intend to use owing to:			
Infrequent sex	4.0	8.6	7.0
Menopausal	0.0	0.1	0.1
Want (more) children	35.5	0.2	12.6
Respondent opposed	3.2	5.7	4.8
Husband opposed	5.0	8.8	7.5
Others opposed	1.4	0.0	0.5
Religious prohibition	16.8	10.6	12.8
Knows no method	6.2	3.1	4.2
Knows no sources	4.6	2.2	3.1
Health concerns	1.9	14.3	9.9
Fear of side effects	19.1	32.6	27.8
Lack of access/too far	0.7	1.9	1.5
Interferes with body	0.0	0.4	0.2
Others	0.0	10.8	7.0
Don't know	1.6	0.8	1.0
Total	100	100	100
Number of women	216	397	613

Source: Aryal, R.H. and T.B. Dangi (1997). "Attitudes towards family planning and reasons for non-use among women with unmet need for family planning in Nepal", in *Insights on Family Health Issues in Nepal* (Kathmandu, Ministry of Health and Macro International Inc.).

future are adequately understood and addressed. This calls for a thorough investigation into, and understanding of, the reasons inhibiting currently married women with unmet need from using contraception in the future. Utilizing data from the 1996 Nepal DHS, Aryal and Dangi (1997) looked at the reasons why women with unmet need did not intend to use contraception in the future, and noted the following frequently cited reasons: (a) fear of side effects and/or health concerns (38 per cent); (b) religious prohibition (13 per cent); (c) a desire for more children (13 per cent); (d) husband's disapproval (8 per cent); and (e) a lack of knowledge and/or sources of contraceptive methods, and lack of access to contraceptive methods (9 per cent) (table 6).

Table 6 shows that the principal non-biological reasons given by women with unmet need who do not intend to use any contraceptive method in the future tend to be: (a) health concerns about contraceptives and side effects; (b) desire for more children; (c) husband's disapproval; (d) a lack of knowledge and/or access; and (e) religious opposition.

Programme implications

The research findings clearly point to the need for (a) improving access to, and the quality of, reproductive health and family planning (RH/FP) services; (b) ensuring that the programme is more focused and targeted; (c) enhancing male participation in reproductive health; and (d) undertaking vigorous information, education and communication programmes as major strategies for meeting the existing unmet need for contraception.

Improving the quality and accessibility of reproductive health services would dispel health concerns and reduce the side effects of contraceptives as well as improve the limited choice of methods, particularly spacing methods, which are the two major barriers to the use of contraception. This would involve developing programme strategies that would (a) institutionalize regular follow-up services for the users of contraceptives in order to monitor and manage health-related side effects; (b) provide counselling and accurate information on how to use the method selected, and promote discussions of possible side effects and how to manage them; (c) ensure the local availability of a wider choice of method mix to meet the need of both spacers and limiters of births; and (d) inform women about various choices of contraceptive methods, the possibility of switching methods whenever their needs change, and/or alternative sources of supply. This would require sound training of field workers and the development of effective educational materials.

The targeted programme approach would help meet demand for contraception by women with the highest unmet need (that is, women with little or no education, rural women, adolescent girls and young women, and amenorrhoeic women). This would require programme-devising services based on a thorough understanding of reproductive health needs and contraceptive choices. As this understanding is as yet very limited, in-depth research studies on the subject, in order to fill gaps and formulate knowledge-based programme strategies, would need to be carried out.

Male involvement in reproductive health will reduce opposition to family planning decisions made by partners. Opposition from husbands is a major

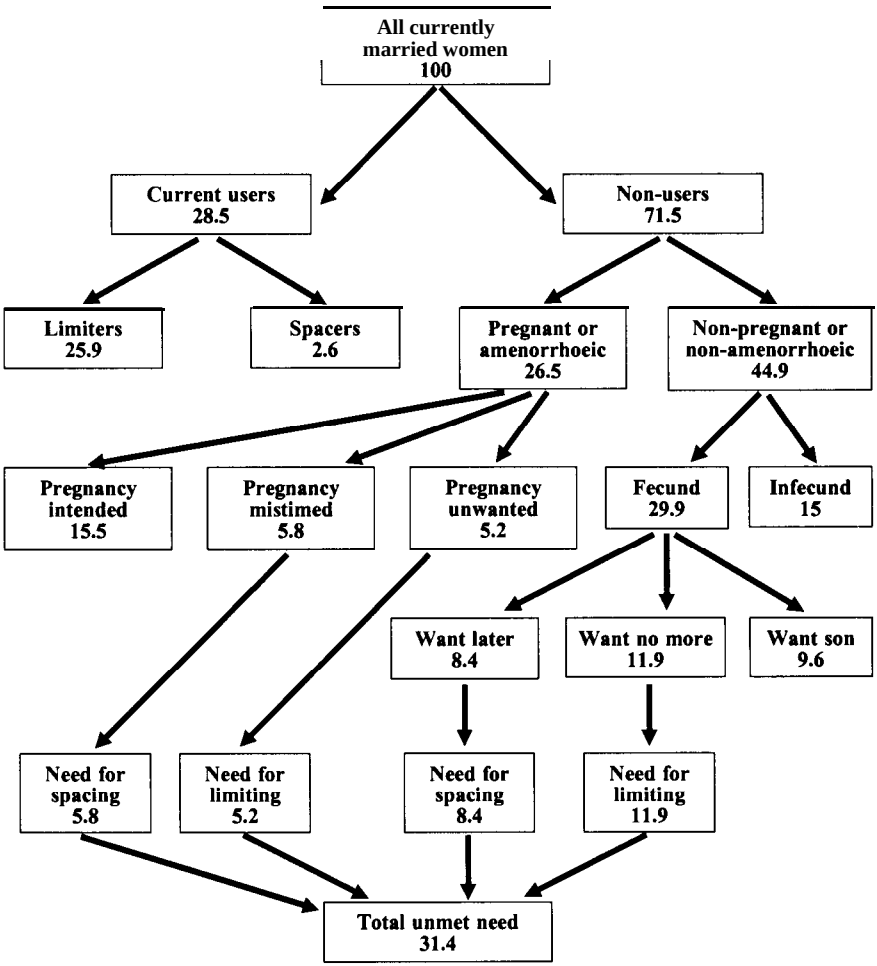
barrier to the use of contraception by wives. Many studies have shown that when men are provided with information about reproductive health services, they are likely to be supportive of their partners' family planning decisions. Hence, family planning programmes should devise services and communication strategies for reaching women and men by (a) conducting male-oriented surveys and research on male perspectives; (b) training programme planners and service providers to give them a better understanding of men's reproductive health needs; (c) emphasizing male-female partnership through better spousal communication; and (d) supporting women's autonomy and reproductive rights. A study conducted in Pakistan in 1999 found that unmet need was somewhat lower among women who had more autonomy in household decision-making, were free to travel to health facilities on their own, and were able to freely discuss family planning with their husbands (Population Council, 1997).

A desire to have more children, opposition from a husband to the use of contraception by his wife, religious prohibition and a lack of knowledge about methods are the major barriers to the use of contraception. To circumvent these barriers, family planning programmes should develop appropriate information, education and communication strategies that would (a) promote the value of the small family; (b) dispel the misinterpretation of religion with regard to birth control; (c) foster interpersonal communication on reproductive health or family planning issues; (d) promote reproductive rights, including the right to choose the number and spacing of children, gender equity and equality; and (e) increase awareness of contraceptive methods.

Annex

Flow diagram for estimation of unmet need for family planning: an example for currently married women in Nepal, 1996

(Percentages)



Source: Aryal, R.H. and T.B. Dangi (1997). "Attitudes towards family planning and reasons for non-use among women with unmet need for family planning in Nepal", in Ministry of Health and Macro International Inc. *Insights on Family Health Issues in Nepal* (Kathmandu).

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