

Contraception Necessitate and Millennium Development Goals

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ABSTRACT

Aim: To survey frequency for unmet need for family planning among rural women of reproductive age group.

Study design: Descriptive Cross-Sectional Study.

Place and duration of study: Hair village, District Lahore. March 16, 2013 to April 30, 2013.

Methods: This study was carried out to survey frequency for unmet need of contraception among rural women of reproductive age group in Hair village, District Lahore. It was a cross sectional study, conducted from March 16, 2013 to April 30, 2013. The primary tool in this study was predesigned and pretested questionnaire for recording of individual informations from One hundred women of Reproductive Age Group. Data was analyzed using SPSS-20 and Chi Square test.

Results: On the basis of findings of study, it was found that women of Reproductive Age Group in Hair village, District Lahore, had unmet need for contraception was 41%, of which 25% were limiters and 16% were spacers. Only 45% women were contraceptive users. Contraceptive use rate increased significantly $X^2 = 11.00$, $p = .026$ with the advancement of age. Limiters increased significantly $X^2 = 15.67$, $p = .003$ with advancement of age with proportionate decrease of spacers. Women's education exert a powerful influence on unmet need $X^2 = 14.56$, $p = .005$. With increasing level of literacy, significant $X^2 = 28.59$, $p < .001$ increase in the prevalence of spacers with reciprocal decrease in the limiters were noticed. Neither the type of family nor the number of living children was significantly associated with the unmet need for contraception. However the prevalence of spacers had significantly decreased and limiters increased with increase in numbers of living children.

Conclusions: The study found that women of Reproductive Age Group in Hair village, District Lahore, unmet need was higher in more fertile age group (i.e. <30 years), therefore Contraception program should focus more on this age group along with targeting illiterate people in rural areas.

Keywords: Contraception, Millennium Development Goals, Community Participation.

INTRODUCTION

The recent data on unmet need in the Pakistan Demographic and Health Survey 2006–7 shows a high unmet need for contraceptives and research suggests a new framework to analyze and address the issue differently¹. 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. As family size needs reduce, 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 need³.

According to World Health Organization, encouragement of contraception and enabling women to avoid unwanted pregnancies is

fundamental. So World Health Organization's care in humanizing motherly health in achieving the Millennium Development Goal⁴. Family planning and reproductive health programs have contributed seriously to fertility decline in the developing countries⁵. Improving the utilization of successful contraception contributes to dropping the load of reproductive ill health by declining mortality and morbidity of unnecessary pregnancies. Ever-increasing recent contraceptive 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 methods⁶.

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 causes⁷. In spite 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 populations⁸. Conducting study not

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only on socio demographic factors but also taking into consideration the economic, political, and environmental determinants of health-seeking behaviors would therefore be important⁹. The administration must play part for stewardship responsibility and empower in contraceptive programs, strategies, and services and use them as one of the crucial poverty-reduction strategies in the state¹⁰. The estimated population of Pakistan in 2007 was 160 million is growing at 1.9 per cent per annum. The population growth rate has decreased from a record high of 3.7 per cent per year in 1960s to 1.9 per cent. The maternal and infant mortality in Pakistan is still high¹¹. The use of safe and important methods of contraception allows men and women to decide the number and spacing of their pregnancies. Admission to such methods was deemed a primary human right by the 1994 International Conference on Population and Development (ICPD) a forum in which countries dedicated to work toward achieving the target of universal access to reproductive health services, including access to successful contraceptives¹². Increasing new contraceptive technique use requires society wide complex interventions and combined requirement of relevant information. At the same time stress has been laid on the interventions aiming at countering negative perceptions of modern contraceptive methods¹³.

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 knowledge¹⁴. A paper on to have or not to have: 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 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. The right to want whether and when to have children is at threat both from some who look for to increase birth rates through pronatalist policies and from some who seek a return to population control. This is contrasted with the unmet need for family planning in the poorest countries. It calls for health providers to promoter for reproductive rights, affirming that the autonomy of women to organize their fertility is the origin for other important choices¹⁵.

The Islamic Republic of Pakistan celebrated its Golden Jubilee in 1997, 50 years after the partitioning of United India from the British Raj. For Pakistan, this was also a time to review the health and population status of its people. In Pakistan, during the 1940s, population growth rates initiate to go faster as health improvements prolonged life anticipation and birth rates remained elevated. In 1947, at the time of freedom, Pakistan's population was 31 million. By 1995 it had escalated to 140 million Family planning programmes were started in the 1950s and 1960s by private and government institutions. Donors such as World Bank and the UN along with the government of Pakistan funded the programmes for family planning (FP). For years these institutions focused only on women as it was thought that FP was the preserve of women, therefore the audience was 100% female. According to United Nations projections, the Pakistan population will grow to over 380 million by the year 2050, surpassing the United States, Indonesia, Brazil, and Russia to become the world's third largest country behind India and China, the highest population growth rate for any large Asian nation¹⁶.

Contraception programs help millions of people, providing reproductive health care that saves lives, avoids unintended pregnancies, and offers more choices, contraception benefits individuals and countries in many ways. Among the most important ways are: Saving women's lives by avoiding unintended pregnancies could prevent about one-fourth of all maternal deaths in developing countries. Especially, using contraception helps avoid unsafe abortions to end unintentional pregnancies. 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. Saving children's lives. Spacing pregnancies at least two years apart helps women have healthier children and improves the odds of infants' survival by about 50%¹⁷.

Around 200,000 maternal morbidities take up to half the total can be prevented through effective family planning and literature is evident that eleven women die each day from pregnancy and birth complications so most of these deaths can also be prevented by contraception. Proper birth spacing reduces by half the risk of death for newborns and infants. More than 7,800 infant deaths can be prevented yearly through contraception. Poor women and infants carry the most risk of death and disability from lack of access to reproductive health services, so contraception is a cost-effective public health measure¹⁸.

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 contraception¹⁹.

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 (ICPD), Cairo (1994) and the World Conference on Women at Beijing (1995)^{20,21}.

New perspectives on men have emerged from an evolution in thinking about reproductive health with ICPD programme of action laying down a holistic concept of reproductive health. With the expansion of the definition of reproductive health to include "right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice" following ICPD (1994), focus for most of the reproductive health component shifted has from women to couples²².

An Indian study revealed that unmet need for contraception was 11% for married men and 17.5% for married women. The difference was seen both in unmet need for spacing (M-3.5% vs. F-6%) as well as limiting family size (M-7.5% vs. W-11.5%). Overall, unmet need for contraception was significantly higher for married women compared to married men²³.

Unmet need for contraception is particularly high in Sub-Saharan Africa, where little progress has been made. Within every region, however, some countries and sub regions stand out as clear targets for assistance. 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 their region; Vietnam (5%) and Colombia (6%) respectively.

An estimated 113.6 million women in the developing world have an unmet need for contraception 105.2 million married women (of whom 55.4 million wish to space births and 49.8 million wish to limit further childbearing) and 8.4 million unmarried women. In addition, an estimated nine million women in other regions have an unmet need: 4.6 million in Russia, 3.6 million in Eastern Europe. Thus, a total of 122.7 million women in developing countries and the former Soviet republics have an unmet need for contraception. Asia contains 61 million married women with unmet need, or 58% of the total for the developing world, reflecting the inclusion of several countries with very large populations (India, Indonesia, Pakistan and Bangladesh). Sub-Saharan Africa contains 24 million (22% of the total), mostly

because of the large populations of Nigeria, Ethiopia, South Africa and the Democratic Republic of the Congo. Latin America contributes 11 million married women with unmet need (11%), nearly half of whom live in Mexico and Brazil. North Africa and the Middle East account for only about eight million (8%), and the Central Asian republics, with their smaller populations, have a total of 1.1 million (1%). The proportion of currently married women with unmet need in various regions of the developing world in 2000 ranges from 11% to 24%. Sub-Saharan Africa's figure of 24% is about half again the average for the developing world overall (17%); other regional figures range from 11% in the Central Asian republics to 14% in Latin America and 16% in North Africa and the Middle East and in Asia²⁴.

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 million²⁵.

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 condition²⁶.

Unmet need for contraception is one of several frequently used indicators for monitoring of contraception programs, and was recently added to the MDG goal of improving maternal health. The indicator unmet need for contraception is defined as the proportion of married women who do not want any more children but are not using any form of family planning (unmet need for contraception for limiting) or currently married women who want to postpone their next birth for two years but are not using any form of contraception (unmet need for contraception for spacing)²⁷.

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 planning²⁸.

PATIENTS & METHODS

This was a Cross sectional (Descriptive) study, conducted from March 16, 2013 to April 30, 2013 among rural women of reproductive age group in Hair village, District Lahore. A total of One hundred women of Reproductive Age Group were approached for interviewing after fulfilling selection criterion as inclusion criteria: women of reproductive age & exclusion criteria: women of reproductive age; having debelating illness & mental disability. These respondents were selected through Convenience Sampling. The primary tool in this study was pre-designed and pretested questionnaire for recording of individual information's; data was entered in SPSS - Ver. 20.0 and analyzed by using proportions & univariate analysis (Chi Square test).

RESULTS

On the basis of findings of study, it was found that women of Reproductive Age Group in Hair village, District Lahore, had unmet need for contraception was 41%, of which 25% were limiters and 16% were spacers. Only 45% women were contraceptive users. Contraceptive use rate increased significantly $X^2 = 11.00$, $p = .026$ with the advancement of age. Limiters increased significantly $X^2 = 15.67$, $p = .003$ with advancement of age with proportionate decrease of spacers. Women's education exert a powerful influence on unmet need $X^2 = 14.56$, $p = .005$. With increasing level of literacy, significant $X^2 = 28.59$, $p = <.001$ increase in the prevalence of spacers with reciprocal decrease in the limiters were noticed. Neither the type of family nor the number of living children was significantly associated with the unmet need for contraception. However the prevalence of spacers had significantly decreased and limiters increased with increase in numbers of living children. The major reasons for unmet need were opposition from husband & family members (34%) and lack of information regarding the different methods of contraception (29%).

DISCUSSION

In the current study; unmet need for contraception was found to be higher (i.e., 41%, of which 25% were limiters and 16% were spacers.) among study respondents. International & regional literature shows regional figures of total Unmet Needs 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 17.4²⁵.

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 their region Vietnam (5%) and Colombia (6%), respectively²⁰. According to a source which identifies that the unmet need for contraception remains persistently high in several countries where one fifth or more of married reproductive-aged non-contracepting women report wanting to space or limit births e.g., Myanmar (20%), Laos (40%), Cambodia (25%) and Nepal (24%). These five countries alone account for nearly 20 million women with unmet need and another eight with available data (e.g., Indonesia, Philippines, Vietnam, Bangladesh, India, Kazakhstan, and Mongolia) contribute an additional 58.3 million women.

Unmet need varies widely as well, where data are available. 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 men & women, where the women 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 million²¹. 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 condition²².

CONCLUSION

People are facing different barriers at individual, family, community and system levels in the practice of contraception 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 contraception.

RECOMMENDATIONS

The following are recommendations to buck up issue as:

- Use of contemporary contraceptives should be augmented and also the obtainable misapprehension about contraception may be dealt with throughout premeditated communiqué, in this perspective electronic and print media approximating TV, FM radio and newspapers/magazines should be utilized.
- There is need of competence construction of contraception services providers enabling the contraception services providers to effectively promote and deliver services in the communities. This can be accomplished through providing enabling environment to the contraception services providers for different modern contraception methods like injections and surgeries via update itinerary and workshops.
- Involvement of religious leaders of all sectors.
- Sensible supply and adequate stockpile of up-to-the-minute contraceptives.
- Community and other pressure groups should be involved to battle at ample to shrink these concerns.

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