Demand for Family Planning in Urban Pakistan.

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Acknowledgements

This working paper uses findings from a baseline survey conducted as part of the first phase of an evaluation of Marie Stopes Society family planning clinics in Pakistan. The evaluation project started in 1999 and is ongoing. This evaluation project is funded by the David and Lucile Packard foundation. Further details of the evaluation are contained in the study report (Evaluation of Marie Stopes Family Planning Programme Pakistan: Report of Phase I), held at Marie Stopes International, London.

Abstract

Objective
This paper explores the demand for family planning services amongst the urban poor in Pakistan.

Methods

A household population survey was conducted amongst 5338 ever-married women in six urban study sites in Punjab and Sindh. In addition, 40 focus group discussions were conducted across the six sites. Interviews were also conducted with community leaders and service providers in each of the sites.

Results
Women reported a high approval of contraceptive use (78%) but a low uptake of modern methods of family planning (21%). Their husband's play an important role deciding whether to adopt a family planning method. Husband's approval increases with parity, particularly after the second child. Some women conceal their use of contraception from their husband.

Just over half of the women stated that their last pregnancy was mistimed or unwanted. 62% of currently married women desire to either space or limit future births. 47% of this demand is currently being satisfied. Total unmet need for family planning was 39%, with unmet need for limiting (23%) being greater than the unmet need for spacing (16%). The unmet need for limiting is greatest amongst older women (35+), those with no formal education and women of parity four and above, whilst unmet need for spacing births is greatest amongst women under 25 years, women with secondary or higher education and those with lower parity.

Conclusions

Although approval of family planning is high across all study sites (78%), there exists a high level of unmet need for family planning. The low levels of contraceptive use and the large numbers of unwanted pregnancies point to the need to provide quality accessible family planning services in these six urban areas. There exists unmet need for both the spacing and limiting of births, and the extent of each of these varies by women's age, parity and education. Family planning services thus need to provide a range of quality methods of family planning that can allow women to either limit or space births, and need to focus services to the individual needs of women with differing socio-demographic characteristics.

Background to the study

Funded by the David and Lucile Packard Foundation, the *Vision 100* project of the Marie Stopes Society (MSS) in Pakistan has the objective of opening 100 new reproductive health clinics in the four provinces of Pakistan over the next ten years. The new services aim to reach communities currently unable to access quality family planning services, particularly low-income men and women. Phase I of *Vision 100* aims to open 13 new clinics, predominantly in urban areas. An important aspect of Phase I is to evaluate the effect of the programme of new clinics on the local population, in terms of contraceptive acceptance and continuation, and to assess the components of the clinic supply environment that influence access to and uptake of family planning services.

An evaluation study is currently being implemented by the University of Southampton (*Opportunities and Choices Programme*), United Kingdom. The evaluation is longitudinal in design. Phase I was conducted in 1999-2000 and comprised a baseline population survey and focus group discussions in each of the six study sites. The MSS clinics then opened and operated for a period of 18-24 months. Phase II is currently underway and involves identifying the impact of the new clinics on the local population. In addition to repeating the population survey and focus group discussions, Phase II will also evaluate the supply environment using; clinical audit, service statistics, observation techniques and exit interviews. This working paper reports on preliminary data analysis of the baseline data collected as part of Phase I of the evaluation.

Data and Methods

Study setting

Pakistan has high levels of fertility and a low contraceptive prevalence. The 1991 Demographic and Health Survey showed that Pakistan had a total fertility rate of 4.9 births per woman. Contraceptive use in Pakistan has typically been low, but more recent surveys indicate that the use of modern methods of family planning is increasing. The 1994-5 Pakistan Contraceptive Prevalence Survey showed that 17.8% of currently married women were using a method of contraception, whilst 12.6% were using a modern method. Contraceptive prevalence rates vary across the country and between urban and rural areas.

This study focuses on urban areas where there is a concentration of low-income households. Data were collected from six cities in Punjab and Sindh provinces. These were Gujranwala, Gujrat, Hyderabad, Larkana, Sargodha and Shikarpur. Each study area within these cities is characterised as a densely populated section of an urban area, which is settled predominately by low-income households.

Method

The study methodology involved conducting a household population survey with 5,338 ever-married women. The survey contained questions relating to women's fertility and family planning. The use of family planning services was also identified, including knowledge and use of family planning services, type of services used, cost and location of services and a range of quality of care questions.

Focus group discussions were also conducted in each of the study sites. Separate male and female focus groups were conducted and were stratified by age (15-29 years and 30-45 years). The focus group discussions provide in-depth information on the reasons for non-use of family planning services and examine socio-cultural influences on the use or non-use of contraception. The participants were recruited with the assistance of community leaders at each site. Overall, 40 focus group discussions were held. Interviews were conducted with community leaders in each of the study sites, to identify the attitudes towards family planning of those with influence within the community. Interviews with service providers in the study area were also conducted to identify the services provided.

Information gathered from the household survey, focus group discussions and interviews with community leaders form the basis for an evaluation of the demand for family planning services reported in this study.

Characteristics of the sample

The study sample from the household survey consisted of 5,338 ever-married women aged between 15-45. The mean age at marriage is 18.5 years, although one quarter of women were married below the age of 16 and only 4% of women married over the age of 25 years. Almost all women (99.2%) are Muslim.

The average number of births is 4.4. Approximately one third of women in 5 study areas (with exception of Gujrat) have more that six births, while relatively few are nuliparous. There is variation amongst the study sites with the lowest average number of births in Gujrat (3.8) and the highest in Larkana (4.9).

The level of formal education amongst women is the sample is typically low, 41% of women had received no formal schooling and 37.9% were illiterate. Only 28% of women had received secondary school or further education. The education level of husbands was somewhat higher, with 50% of husbands having secondary school or higher education. Only 25% of husbands had no formal schooling.

More that half (52%) of the sample were categorised as living at a 'basic' or 'low' standard of living. There is strong variation between the study sites, women categorised at a 'basic' or 'low' standard of living range from 23% in Gujurat to 91% in Larkana.

Results

Contraceptive Use

Seventy-eight percent of women approve of contraceptive use. Approval for contraceptive use is lowest in Larkana (68%) and highest in Gujrat (91%). It is often the husband's approval of contraception that may lead to actual method uptake. Women reported that 68% of husbands approved of contraceptive use. In Larkana only 54% of husbands approved the use of contraception.

The *contraceptive prevalence rate* (CPR) refers to the proportion of married women of reproductive age who are currently using (or whose husband is using) a method of contraception. The CPR ranged from 10.8% in Larkana to 28.8% in Hyderabad. Ever use of contraception was higher in each of the study sites (Table 1). The majority of users adopted modern methods of contraception. The use of natural methods (rhythm, withdrawal, abstinence and breastfeeding), although low, was highest in Gujrat (7.8%). The proportion of women currently using contraception increases with the standard of living (SL); 16% of women at a 'basic' SL were users, this increases to 28% at 'low' SL, 32% at 'medium' SL and 35% at 'higher' SL.

The *contraceptive method mix* indicates the distribution of contraceptive use across different methods of contraception. Method mix is variable by study site (see Table 1), however the condom, female sterilisation and the IUD are the most commonly used methods of modern contraception. Periodic abstinence and withdrawal are the most prevalent natural methods of contraception.

Table 1: **Contraceptive Use** (percentage of ever-married women).

	Gujranwala	Sargodha	Gujrat	Hyderabad	Shikarpur	Larkana
Ever Use of Contraception	30.7	30.6	42.7	48.5	40.7	15.8
Contraceptive Prevalence Rate (CPR)[1]	21.5	24.9	30.9	38.8	34.0	10.8
Current Use:						
Modern Method	14.4	19.5	23.1	33.9	31.0	9.7
Natural Method	7.1	5.4	7.8	4.9	3.0	1.1
Method Mix:						
Condom	29.6	36.9	25.1	43.0	19.0	5.0
Pill	8.4	14.4	9.4	10.5	22.6	11.7
IUD	12.3	12.0	15.2	7.9	11.1	16.7
Injection	1.3	4.4	4.7	6.9	13.0	20.0
Diaphragm, Foam,	1.3	0.8	0.0	0.0	0.3	0.0
Jelly	15.0	9.6	20.5	18.4	25.3	35.0
Female Sterilisation	0.0	0.8	0.0	0.7	0.3	1.7
Male Sterilisation	0.4	0.0	0.0.	0.0	0.3	1.7
Rhythm	7.9	2.8	11.7	6.2	3.3	5.0
Withdrawal	23.0	16.8	12.3	3.8	3.8	0.0
Abstinence	0.0	1.2	1.2	2.6	1.1	1.7
Breastfeeding	0.0	0.0	0.0	0.0	0.0	1.7
Other						
	n = 226	n = 249	n = 171	n = 419	n = 368	n = 60

Notes: [1] current use of any contraceptive method.

During the focus group discussions many younger women stated that they themselves would like to adopt a method of family planning, however they identified the overriding influence of their husband and elders or religion, which led to non-use (see Figure 1). Men were more likely to identify the cost of purchasing contraception as a barrier to use. Older women cited a lack of knowledge about methods of family planning as a reason for not adopting a method, and noted that only natural methods were permitted in Islam. These women stated that they were frightened to use any methods, as they did not have sufficient information to use a method effectively.

Figure1: Comments on Reasons for not Using Contraception.

WANT TO CONCEIVE

My husband is against it because we have not many children (older woman, Larkana).

SIDE EFFECTS

This area is very poor. Here nobody wants to become sick after getting family planning drugs because nobody will take care if they fall sick. Due to such fears they avoid using family planning methods (older man, Hyderabad).

After hearing about the complications caused by practising these methods some are discouraged and apprehensive (young women, Sargodha).

HUSBAND/ELDERS DISAPPROVE

They (non-users) must be pressed by their elders. Her mother in law does not allow her. It's their wish, they think it's against religion (young women, Sargodha).

No, he says don't do any thing, produce children (young woman, Shikarpur).

LACK OF KNOWLEDGE

Here early marriages are common so they don't know about family planning (young man, Shikarpur).

Those people who are not practising family planning do not have knowledge/information about it (older man, Shikarpur).

COST

Only those who are not using can't afford it, but these are only few households. Some are very poor (young man, Gujrat).

It could be that here people consider it too expenses and people can't afford. They are not too cheap. It costs 6 to 7 thousand for an operation it (young man, Larkana).

RELIGION

It is a crime to use these methods in our religion, as it does not allow it. Children are also given to us by God, then why should we avoid this gift (young woman, Gujranwala).

I was told that it is religiously prohibited so I did not opt for operation. Operation is complete birth control. We are told that God may become angry so never think of operation (young woman, Sargodha).

Availability of family planning services

There exist few family planning services within any of the study sites. Often, the nearest family planning service is provided by a Government hospital or clinic. These are located up to 3km from the study areas. Government hospitals usually dispense a range of methods and provide female sterilisation services free of charge.

Demand for family planning

Demand for family planning refers to the desire or motivation of women (or couples) to control their future fertility. Demand for family planning is generally present when the number of children exceeds the desired level of fertility, or when spacing between births is preferred. Indicators of demand for family planning are central to the management and evaluation of family planning programmes. A family planning programme should anticipate to provide sufficient resources to met the existing and expected future level of demand for family planning. It is therefore crucial to identify both the level of demand for family planning and the nature of this demand.

This study examined a number of indicators of demand for family planning. These include the approval of contraception, the wanted status of the last pregnancy and timing of the next pregnancy, the demand for family planning, the satisfaction of demand and the unmet need for family planning. These areas are discussed below.

a) Approval of Contraception

The level of approval of contraception is an indicator of the *potential* willingness of a population to accept the use of family planning methods. Although it is important to note that an individual may indicate approval of contraception in general but not be personally able or willing to adopt a method. With the exception of Larkana, more than three-quarters of women stated that they approved of contraception, women in Gujrat showed the highest level of approval (91.1%). Almost one third of women in Larkana disapproved of contraception.

In practice contraceptive use is influenced by many factors, most notably the husband. However, the majority of women in all sites stated that if the decision was entirely their own, they would be willing to use a method of contraception. This provides an indicator of the demand for contraceptive use amongst women themselves. The majority of women in all study sites (78%) stated that it was mainly the husbands idea to adopt a method of family planning; only 18% reported that contraceptive use was the woman's own idea.

Women were asked whether their husband approved or disapproved of contraception. Approval of contraception by the husband is paramount for women to use a method. In all sites the proportion of husbands who approve of contraception is lower than the corresponding proportion of women who approve. In some sites there is significant disparity between the proportion of women and the proportion of husbands who approve of contraception, in Shikarpur 81.2% of women and 65.1% of husbands approve of contraception. Husband's disapproval of contraception is highest in Larkana, where 40% of husbands disapprove of contraceptive use. Although some men stated that it is a woman's decision to use contraception, all agreed that a woman is unable to use family planning without the husband's consent. Older women stated that their husband passively approved of family planning, that is they did not object to *women* using a

method but did not actively encourage them to use family planning. There was some exception for educated women as illustrated during the focus group discussions;

> **In our society women can't do anything without men's consent. They are uneducated and men dominate them whereas educated women have equal rights while illiterate women have no rights (young man, Shikarpur).**

> **This is not Islamabad. This is Larkana a rural area where most women are illiterate so the decision lays on the men. Women don't know about basic rights, so whatever the husband say they think is OK (young woman, Larkana).**

> **Near Karachi two to three incidents took place when women got themselves operated without the consent of their husbands and they were killed (young man, Shikarpur).**

Although the majority of women and their husband both approve of contraceptive use, some women approve of contraceptive use while their husband disapproves. In both Larkana and Shikarpur this group accounts for 20% of women. This suggests the existence of *potential* hidden demand for contraceptive use, and the *potential* for concealment of contraceptive use. During the focus group discussions women also reported that a couple may conceal contraceptive use from the elders in the house, particularly a mother-in-law, who may not approve of contraceptive use. Concealment of contraception was identified in all age groups. Particular methods were favoured for concealment, including the pill, injectable methods and the IUD (Figure 4).

Husband's approval of contraceptive use changes by parity of the woman. The broad pattern of change shows that less than 12% of husbands of nulliparous women and those with one child approved of contraceptive use. There is a significant increase in the proportion of husbands who approve of contraceptive use after parity one. The highest approval of contraceptive use is at parity three (where 75% of husband's approve of contraception). Husband's approval declines after parity five, which may be influenced by age, whereby older husbands generally show a lower level of acceptance of contraceptive use regardless of parity.

Women and men aged less than thirty years were more likely than those who are older to identify the benefits of adopting family planning and to approve of its use. Younger couples felt that adopting family planning would assist in reducing family size and the economic burden of large families, as well as improving women's health through child spacing. However, they stated that their elders may not approve of contraception and discourage its use. Some young women felt that those who did not approve of family planning lacked sufficient knowledge of methods. Although many older women and men approve of family planning, they were more likely than younger women to identify that childbearing is the will of *Allah* and advocate for large families. Many older women also stated that they did not practice birth spacing and lacked sufficient knowledge about methods to do this. Women in Larkana and Shikarpur were most likely to identify a lack of knowledge of family planning and the discouragement of their husband or mother-in-law as a barrier to use of family planning (Figure 5).

Figure 4: Comments on Concealment of Contraceptive Use.

Most of the women conceal and take injections because husband does not approve it (young woman, Sargodha).

For instance when I got operated nobody knew at home, even my husband did not know about it. We have four sons but my husband wanted a daughter so I decided myself that it's enough (older woman, Gujrat).

Yes, certainly, in many cases, husbands don't give their consent, so women use methods without telling their husbands. My husband never found that I have been using the Tube (IUD) for the past 4 years (older woman, Shikarpur).

Why do some women hide if they are using family planning? Actually they are scared of their elders, they take pills, injections, husbands have no objections they have allowed it but they are scared of elders (young woman, Shikarpur).

My mother-in-law does not like it, therefore, I use a method without letting her know. My sister in law got the operation done and did not tell our mother in law (older woman, Sargodha).

Some wives hide the use of family planning from their husbands. Then they feel shy of having a sexual intercourse with their husbands because the husbands say that having copper-T done could be harmful the husband (older woman, Gujranwala).

Less educated people like to have less children but mothers do not approve it, for this reason females conceal their use of family planning methods (young women, Sargodha).

Figure 5: Comments on Approval of Family Planning.

Children already born cannot be undone now, but adopting FP method would be a good thing. So that more children can be prevented (young woman, Gujranwala)

We want to practice some unfailing method. We are poor we can not afford more children (young woman, Larkana).

There is so much unemployment that people are thinking of producing only two to three children. Awareness is there but there is a lack of FP methods (young man, Gujranwala).

It is not sole factor. If there is interval for 3 years then child is healthy and her mother also. And if child comes with in 1 ½ year then both child and mother are affected. If one uses family planning, interval is good for child and mother (older man, Larkana)

Spacing should be for at least 2 to 3 years. Spacing helps a mother in improving her health. If child is older, raising him is easy and it is a lesser problem. I would like to have spacing between the children because it is good for mother's health (young woman, Sargodha).

Our lives are hell. It is good to control giving birth to babies permanently (older woman, Larkana).

Educated women like it (spacing) but elderly or illiterate women don't approve of it (older women, Shikarpur).

They (mother-in-laws) want more children. She has never supported spacing for birth control at all. She would say, if God blesses with a child don't deny it (older woman, Larkana).

Yes, when they (husbands) think of affordability but they disagree when they talk with elders (older woman, Shikarpur)

b) Wanted status of last pregnancy / Timing of next pregnancy

The wanted status of the last pregnancy and the desired timing of the next pregnancy are indicators of demand for fertility and family planning. The proportion of women who wanted their last pregnancy later or did *not* want their last pregnancy provides an indication of mistimed and unwanted fertility. Table 3 shows that more than half (55%) of pregnancies were mistimed or unwanted across all sites. The wanted status of the last pregnancy has a strong relationship with parity (Figure 6). The proportion of women who did not want their last pregnancy (unwanted fertility) increases significantly with increasing parity. The proportion of women who wanted their pregnancy later (mistimed fertility) decreases marginally as parity increases.

Table 3: Timing of Last / Next Pregnancy (percentage of currently-married women)

	Gujranwala	Sargodha	Gujrat	Hyderabad	Shikarpur	Larkana	Total
Wanted Status of Last Pregnancy:							
Wanted Pregnancy	23.6	15.4	69.0	59.8	56.6	52.4	43.5
Wanted Later	32.3	38.5	14.1	19.2	24.3	14.9	25.6
Did not Want	44.0	46.0	16.9	21.0	19.1	32.7	30.9
	n = 949	n = 901	n = 461	n = 966	n = 933	n = 489	n=4699
Timing of Next Pregnancy:							
Currently Pregnant	8.5	7.5	7.2	9.9	11.0	15.8	9.7
As Soon as Possible	9.9	11.8	19.1	12.1	20.4	25.2	15.3
At Least 2 Year Gap	26.0	22.8	21.9	22.7	28.7	29.9	25.2
Don't Want Another	42.3	43.7	39.4	38.2	23.2	21.9	35.5
No Preference	2.3	8.6	4.9	8.3	5.5	1.5	5.5
Unable to Conceive	10.6	5.2	7.5	8.8	11.1	5.7	8.8
	n = 1052	n = 1004	n = 530	n = 1038	n = 1029	n = 543	n= 5196

The desired timing of the next pregnancy indicates future fertility desires (Table 3). There is some variation in the composition of future fertility desires between study sites. In most sites (Gujranwala, Sargodha, Gujrat and Hyderabad) the greatest proportion of women indicated a desire to cease childbearing, while in Shikarpur and Larkana higher proportions of women wanted to have at least a two-year gap between births. Overall, 36% of women did not want another child and 25% wanted to wait at least two years before having another child. The desired timing of the next pregnancy has a strong relationship with parity (Figure 7). Not surprisingly, nulliparous women show a strong desire to conceive or are currently pregnant. This pattern changes significantly at parity one whereby women are more likely to desire birth spacing of at least 2 years. After parity three increasing proportions of women desire to cease childbearing. These patterns have strong implications for demand for family planning methods and the timing in a woman's childbearing cycle whereby different methods of family planning can be promoted.

Figure 6: Wanted Status of Last Pregnancy by Parity (ever-married women)

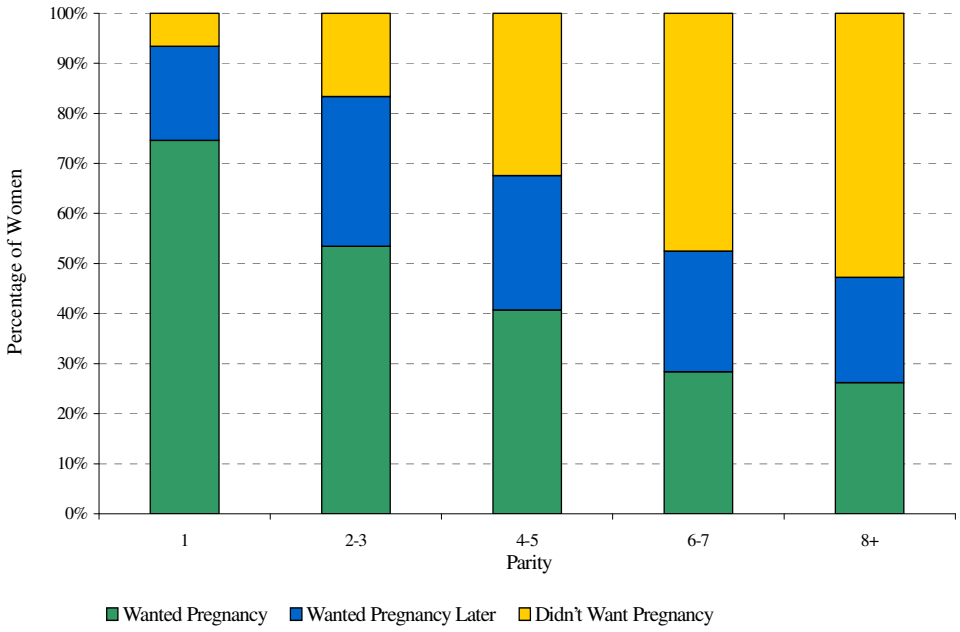
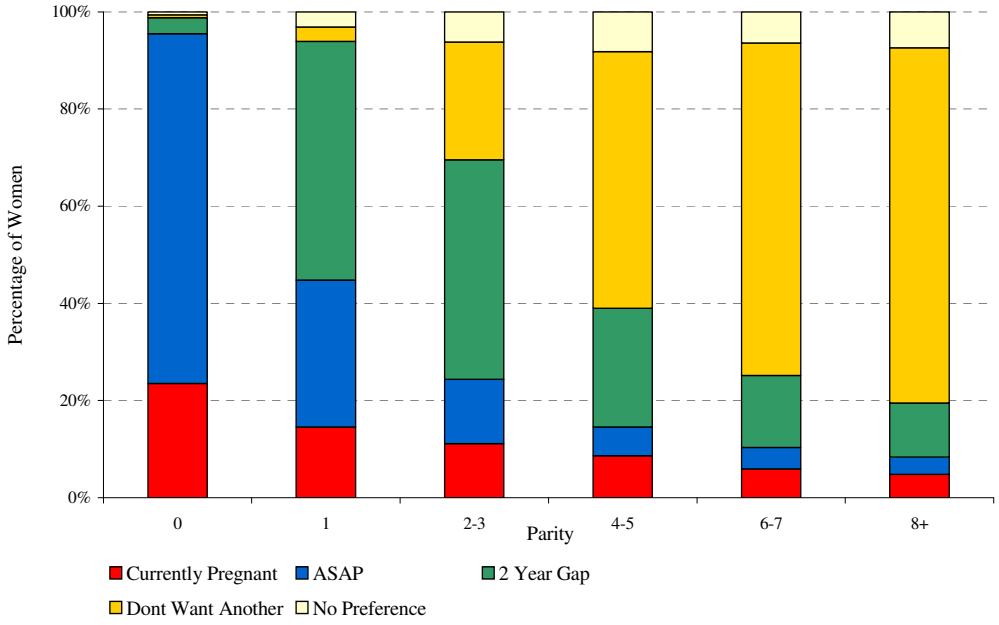


Figure 7: Desired Timing of Next Pregnancy by Parity (ever-married women)



c) Unmet need for family planning

The components of demand for family planning for each study site are shown in Table 4. *Demand for limiting* refers to the proportion of currently married women who are fecund and who desire to have no additional births. *Demand for spacing* refers to the proportion of currently married women who are fecund and who desire to delay their next birth for a period of at least two years. *Total demand for family planning* refers to the proportion of currently married women who are fecund and have a desire to either cease childbearing or postpone childbearing for at least two years. For all sites combined, 62% of currently married women desire to either space or limit future births. Gujranwala has the highest total demand for family planning (71%). The demand for limiting births is greater than the demand for spacing births in Gujranwala, Sargodha, Gujrat, and Hyderabad. While in Shikarpur and Larkana there is a greater demand for spacing births. These components of demand will impact the focus of family planning programme delivery at each site.

Satisfaction of demand for family planning refers to the proportion of total demand for family planning which is being satisfied by current contraceptive use. Overall, 47% of the family planning demand of currently married women is being satisfied. This varies across the study sites, Larkana has a particularly low proportion of demand for family planning satisfied (20%), while 66% of women in Shikarpur are able to satisfy their family planning needs (Table 4).

Unmet need for limiting refers to the proportion of currently married women, who are fecund and have a desire to cease childbearing, but who are not currently using a contraceptive method. *Unmet need for spacing* refers to the proportion of currently married women, who are fecund and have a desire to delay their next birth for a period of at least two years, but who are not currently using a contraceptive method. *Unmet need for family planning* refers to the proportion of currently married women, who are fecund and have a desire to either cease childbearing or postpone childbearing, but who are not currently using a contraceptive method. The level of unmet need is the crucial indicator for the level of need for family planning services in a given area. In general, if satisfaction of demand is low the total unmet need will be high..

The total unmet need for family planning was 39% in the study sites (Table 4). The highest levels of unmet need are seen in Gujranwala (50%) and Larkana (45%). Overall, the unmet need for limiting (23%) was greater than the unmet need for spacing (16%). The unmet need for limiting births is greater than unmet need for spacing births in Gujranwala, Sargodha, Gujrat, and Hyderabad. While in Shikarpur and Larkana there is a greater unmet need for spacing births rather than limiting. Identifying this balance of the components of unmet need is vital for programme planning and evaluation.

The level of unmet need identified in the study sites is considerably higher than that shown in the Pakistan Demographic and Health Survey 1990-91; whereby 28% of currently married women in Pakistan have an unmet need for family planning (PDHS 1990-91). The higher levels of unmet need in the study sites are likely to be attributable to the focus of the evaluation on densely populated urban areas, with a concentration of low-income residents who have limited access to family planning facilities. The higher levels of unmet need in the study areas demonstrates that the need for family planning services in these areas is paramount.

Table 4: Demand for Family Planning (percentage of married women)

INDICATORS	Gujranwala	Sargodha	Gujrat	Hyderabad	Shikarpur	Larkana	Total
Demand for Limiting[1]	43.7	45.3	39.6	39.0	23.6	24.2	36.6
Demand for Spacing[2]	28.0	23.5	22.2	23.4	29.8	31.2	25.6
Total Demand for Family Planning	71.1	68.8	61.8	62.4	53.4	55.4	62.2
Satisfaction of Demand[3]	29.9	36.4	52.2	64.4	66.7	20.0	46.7
Unmet Need for Limiting[4]	31.7	31.4	20.1	18.6	12.5	19.3	22.7
Unmet Need for Spacing[5]	19.0	15.6	14.9	10.4	15.4	25.8	16.2
Total Unmet Need	50.7	47.0	35.0	29.0	27.8	45.1	38.9

Notes: [1] Proportion of fecund women who desire no additional children (includes mistimed births and contraceptive failure). [2] Proportion of fecund women who desire to delay their next birth by at least 2 years (includes mistimed births and contraceptive failure). [3] Proportion of total demand satisfied by contraceptive use. [4] Proportion of fecund women who desire no additional children and are not currently using a contraceptive method. [5] Proportion of fecund women who desire to delay their next birth by at least 2 years and are not currently using a contraceptive method.

Demand for family planning varies by age, education level and number of children. The demand for limiting births increases with age in all study sites and is highest amongst women aged over 35 years. The demand for spacing births is highest amongst younger women, particularly those aged under 25 years. Overall, the total demand for family planning is greater amongst women aged over 35 years. Satisfaction of demand, through contraceptive use, in each age group is variable across study sites. The total unmet need for family planning is significantly higher amongst women aged over 35 than in the younger ages. In general, unmet need for limiting is greater amongst older women (35+) and unmet need for spacing is greatest amongst women under 25 years.

The pattern of demand for family planning by the level of education of women shows that the demand for limiting births is highest amongst women with no formal education. While demand for spacing is greatest amongst women with secondary or higher education. The total demand for family planning by education is variable by study site. The satisfaction of demand is highest amongst women with either primary or higher education. The total unmet need for family planning is significantly higher amongst those with no formal education. Unmet need for limiting births is greatest amongst women with no formal education, while the unmet need for spacing births is greatest amongst women with secondary or higher education. These patterns are consistent across all study sites.

Demand for family planning also varies by parity. The demand for limiting births is greatest amongst women at parity four or higher, while women at lower parities have the greatest demand for spacing. The total demand for family planning is highest amongst women at parity four, however a higher proportion of these women have also satisfied their demand for family planning through contraceptive use. Unmet need for family planning is generally highest amongst women of higher parity (4+). Unmet need for limiting is highest amongst women of parity four or above, while unmet need for spacing births is greatest among lower parity women.

Conclusions

The key findings from this study, regarding the demand for family planning services, are detailed below. However, wide variations exist between the study sites for a number of the indicators.

- Women reported a high approval of contraceptive use (78%) but a low uptake of modern methods of family planning (21%).
- Husbands play an important role in deciding whether to adopt a family planning method. Husband's approval increases with parity, particularly after the second child.
- Some women conceal their use of contraception from their husband.
- Younger men and women are more likely to approve of contraception.
- More than half (55%) of last pregnancies were mistimed or unwanted.
- 62% of currently married women desire to either space or limit future births. 47% of this demand is currently being satisfied.
- The total unmet need for family planning is 39%; 23% of these have an unmet need for limiting births and 16% have unmet need for spacing births.
- Unmet need for limiting is greater amongst older women (35+), those with no formal education and women of parity four and above.
- Unmet need for spacing births is greatest amongst women under 25 years, women with secondary or higher education and those with lower parity.

Policy Implications

The following policy implications arise from the reported levels of demand for family planning in the six study areas:

- Approval of family planning is high, although the low levels of use and the high numbers of unwanted pregnancies point to high levels of unmet need for family planning. The main policy implication of this study is the need to provide accessible quality family planning services in the six study sites.
- Family planning services must recognise the differing needs of women of different ages and levels of education, and must focus service provision to meet these individual needs.
- Despite high levels of demand for family planning, the opposition of the husband poses a significant barrier to service use. There exists the need to inform men in low-income areas of the potential benefits of family planning.
- There exists both an unmet need for spacing and limiting of births. Family planning services need to provide a range of methods that can provide for both these needs.
- Unmet need for family planning is greatest among illiterate women. Family planning services need to target services towards this group, and provide services that are accessible to agroup characterised by low-incomes and personal autonomy.

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