

Original Article

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Unmet Need of Family Planning in Urban Slum of Minority Community In Kolkata: is it Any Different?**Dr. Krishna Laskar¹, Dr. Nivedita Das², Fasihul Akbar², Dr. Sujishnu Mukhopadhyay³, Dr. Tarun Kumar Sarkar², Dr. Dipankar Chattopadhyay³**¹Demonstrator, ²Assistant Professor, ³Associate Professor

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Abstract:

Introduction: India may boast of introducing a national programme for fertility control earlier than most countries had conceived it. But in the same breath we are yet to concede the fact that the ultimate objectives of such dreams remained largely unfulfilled. Unmet need for contraception continues to haunt us as being an unresolved riddle. The experts have been concerned about it and the dire necessity to address the problem was vouched in various National Programmes. **Methods:** This cross sectional study was conducted among the parous Muslim women residing in an

urban slum of Kolkata with the objective of estimating the prevalence and finding out the reasons responsible for unmet need in the community. **Results:** The prevalence of unmet need was 20.0%. It varied significantly between age groups below (35%) and above (13.3%) 24 years, between BPL (31.4%) and APL (6.7%) and between Joint (25.5%) and nuclear (5.6%) families. The AOR for joint families was 4.522 (95% C.I. 0.482 - 42.438). There was a statistically insignificant difference in the problem between the groups of women who had less than or equal to two children (19.6%)

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and those who had more than that (21.1%). But the difference that women with adequate spacing had the problem in greater numbers (44.4%) compared to those who did not (10.5%), was statistically significant. The commonest principal reason cited by the respondents was fear of side effects of the methods

Introduction:

India may boast of introducing a national programme for fertility control earlier than most countries had conceived it. But in the same breath we are to concede the fact that the ultimate objectives of such dreams remained largely unfulfilled. The population grew at will and health managers were left flabbergasted pondering what had actually gone wrong. Later it was unanimously found that choosing, accessing and actually using the right contraceptive method at right time was never achieved in our country. The eligible couples were left with no other options than to have too early and too many pregnancies before putting a dead stop in fertility by sterilization. So the need for right contraceptive method remained and was not realized.

Unmet need for contraception is defined by the World Bank as the proportion of currently 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 but are not using any form of family planning (unmet need for contraception for spacing¹). The conception is there in the field of reproductive health

(38.5%). **Conclusion:** More in-depth qualitative enquiries are required to find out the reason of such contraceptive behavior of the minority community living in slums.

Key words: Unmet need of contraception, Family planning, Urban slum, Minority community.

since 1960-s, but continues to haunt us as being an unresolved riddle. The experts have been concerned about it and the dire necessity to address the problem was vouched in the National Population Policy, 2000². But all said and done, according to National Family Health Survey 3, the unmet need in the country remain at astonishingly high rate of 13% and that in the state of West Bengal at albeit lower at 8%³. The same report also indicated that unmet need in Muslims (18.4%) was much more than that in Hindus (11.9%).

It has also been said that unmet need has been more among adolescents, migrant, in women in the postpartum period, refugees and among urban slum dwellers⁴. The reasons have been explored in a few studies in India and abroad and it was found that interference by mother-in-law of the woman in question in choosing the method of family planning, if at all, was almost invariable⁵. They sometimes even decided the number of children the couple would have⁵. The situation grew so grim that some joint families had actually split because of such intrusion into an exclusively intimate and private decision⁵. Alongside such factors, husband's reluctance in taking a worthy resolution to

adopt a suitable method also remained doubtful. The condition was complicated with the general lack or absence of proper information about the advantages and disadvantages of each of the methods⁶; as the system played the role of a passive supplier and not that of an active persuader. Worse still; wherever the couple was decisive, it was never certain that the availability was ensured.

Even though we, in generic terms know these causes of unmet need of family planning in our country; we are somewhat

uncertain about the wide regional and religious disparity that exists in this regard. It is still baffling in many scenarios why the eligible couple behaves the way they do when it matters to contraception. Under such circumspection, we wanted to explore the facts in an urban slum predominantly inhabited by Muslims, with the objective of estimating the prevalence and finding out the reasons responsible for unmet need in the community; because we know reproductive health has now been envisaged to go beyond health of the woman to broader development issues.

Materials and Methods:

An observational cross sectional study was conducted among the parous women in DasaburBagan, the urban slum in Kamarhati which is the field practice area of Dept. of Community Medicine, College of Medicine and SagoreDutta Hospital from October 2012 to November 2012. In the said area with a population of 2347; 157 women were in the reproductive age group of 15-49yrs. Among them 139 had history of childbirth and were the study population. Out of them, 130 women agreed to participate in the study, on whom the study was conducted (the non-response rate was calculated to be 6.4%). The nulliparous married women were not included in the study keeping in mind the sensitive nature of the study, being done in a very stubborn and orthodox community. The women were interviewed using a predesigned and pre-tested semi-structured questionnaire about socio-economic and demographic variables, knowledge and practice regarding contraceptives,

willingness to have a child and reason(s) for non-use of contraceptives. The women who are sexually active and did not want a child any more, but were not using any of the recommended method of contraception viz. OCP, IUD, Condoms, male and female sterilization, were considered to have an unmet need for contraception. Those who had no knowledge to knowledge of two methods were considered to have poor knowledge, those who knew three or four methods had average and those who knew all the five methods were considered as having good knowledge. Data were analyzed for generation of suitable hypotheses which were tested using recommended statistical test. The level of significance was fixed at 0.05%. The statistical analyses were computed with the help of SPSS version 20 IBM Corporation LTD. The study had ethical clearance from the institutional ethics committee of College of Medicine and SagoreDutta Hospital.

Results:

This cross-sectional study, conducted among 130 Muslim women who had at least one child; revealed that there were 26 of them in whom the definition of unmet need fits. That constitutes a prevalence of unmet need of 20.0% among the study population. All the participants of the study were home makers. The women having unmet need and not having unmet need of family planning methods were subjected to further analysis (Table 1). It revealed that out of 40 mothers aged less than or equal to 24 years, 12 had unmet need and out of 90 older women, 14 had similar response. This difference of unmet need of 35% in age 24 years or less and 13.1% in older women is statistically significant though the adjusted odds ratio for age remained low at 0.343. 36 (27.7%) mothers in the study were found to be illiterate and only 18 (13.8%) had studied beyond class ten (not shown in table). Though proportion of unmet need among the less educated was more (21.2%) compared to those who studied less than class d (16.2%), such differences were not significant. It was also seen that there was

no unmet need among those who studied beyond class ten (not shown in table). Proportionately, unmet need was worst (31.4%) among the mother who were economically below poverty line (BPL). In comparison, women who were above poverty line (APL) had the problem in significantly less magnitude (6.7%). Considering knowledge about contraceptives, this study did not find anybody to score 'good' according to the operational definitions stated. But there was absolutely no difference in unmet need if the respondents had poor or average knowledge; in either case the figure was 20%. Another independent variable according to which unmet need varied significantly was the type of family the women belonged to. It was 25.5% in those who came from joint families as compared to 5.6% in those who had nuclear families. The adjusted odds ratio also was high for this factor (4.522). But the wide range of 95% confidence intervals and low Nagelkerke R Square score preclude the results of AOR to be taken very appreciably.

Table 1: Distribution of study population with or without unmet need according to different socio-economic and demographic factors.

Socio-Economic & Demographic Factors		With Unmet Need	Without Unmet need	Significance	A O R (95% C I)
Age(years)	≤ 24 (n=40)	14 (35)	26 (65)	X ² = 0.0080 d.f. = 1 p < 0.001	0.343 (0.091 – 1.301)
	≥ 25 (n=90)	12 (13.3)	78 (86.7)		
Education	Up to Class IV (n=66)	14(21.2)	52 (78.8)	X ² = 0.8275 d.f. = 1 p > 0.05	0.64 (0.172 – 2.963)
	Class V & Above (n=64)	12 (18.7)	52 (81.3)		
Economic status	BPL (n=70)	22(31.4)	48(68.6)	X ² = 0.004 d.f. = 1 p < 0.001	0.71(0.172 -2.936)
	APL (n=60)	4(6.7)	56(93.3)		
Knowledge regarding contraceptives	Poor (n=80)	16(20)	64(80)	X ² = 1.0 d.f. = 1 p > 0.05	1.102(0.276 – 4.406)
	Average (n=50)	10(20)	40(80)		
Type of family	Nuclear (n=36)	2(5.6)	34(94.5)	X ² = 0.0129 d.f. = 1 p < 0.01	4.522(0.482 – 42.438)
	Joint (n=94)	24(25.5)	70(74.5)		

(Figures in parentheses indicate percentages)

Table 2 revealed that unmet need was only marginally more (21.1%) among those who had more than two children compared

to their counterparts (19.6%) and the difference was not statistically significant.

Table 2: Distribution of study population with or without unmet need according to number of living children

Number of living children	With Unmet need	Without unmet need	Significance
≤ 2 (n=92)	18 (19.6)	74 (80.4)	P>0.05 f=0.373, d.f.= 1
>2 (n=38)	8 (21.1)	30 (78.9)	

(Figures in parentheses indicate percentages)

There was thirty-six women in this study who have single child in whom ten was detected to have unmet need (not shown in table) and there were 94 (72.3%) women who had at least two children and the

prevalence of unmet need was calculated in groups having adequate spacing or not (Table 3). It was revealed that unmet need was more (44.4%) among the women who had adequate spacing of more than three

years compared to those who had it found to be statistically significant. inadequate (10.5%). This difference was

Table 3: Distribution of study population with or without unmet need according to duration of spacing

Duration of spacing	With Unmet need	Without unmet need	Significance
≤3 years(n=76)	8 (10.5)	68 (89.5)	X ² = 7.08 d.f. = 1 p < 0.05
>3 years (n=18)	8 (44.4)	10 (55.6)	

(Figures in parentheses indicate percentages)

**36 women had single child and 10 of them had unmet need.

The principal reasons of non-use of contraceptives cited by the respondents (table 4) were fear of side effects of the methods (38.5%), continuing lactation and infrequent conjugal stay (23.1% each) and forced imposition by other family

members (15.3%). The commonest reason, fear of side effects, was seen to be more common from those who came from joint families and those belonged to BPL class (not shown in table).

Table 4: Principal reason of unmet need cited by the respondents (n=26)

Reasons for unmet need	Frequency
Irregular conjugal stay	6 (23.1)
Fear of side effects	10 (38.5)
Imposed inhibition by family members	4 (15.3)
Lactation	6 (23.1)

(Figures in parentheses indicate percentages)

Discussion:

This study was conducted among the minority community residing in an urban slum of the city of Kolkata with an objective to find out the prevalence and the contributory factors of unmet need in that area. The proportion of urban population in West Bengal is 31.89% and that of minority community of Muslims is 25.25%⁷. Though the exact estimate of population residing in slums is not available, be it Muslims or Hindus or mixed; this study aimed to find out any

discernible differences if existed with regard to prevalence and contributory factors of unmet need when it was related to Muslims residing in urban slums.

Among the study population, 26 mothers i.e. 20.0% had unmet need for family planning, which is more than national average 13.2% (according to NFHS 3 survey) and 11.6% for West Bengal. Though the national figure for Muslims in this regard is quite similar (18.4%)³

almost an identical figure of 20.5% was obtained in a study in western Indian slums⁸. The finding in the present study somewhat resembled the findings obtained in East Delhi⁹ where the figure was 25.4%. Similar studies in urban Kerala¹⁰ revealed the proportion to be 17% and that in Karnataka¹¹ to be 16%.

But in a study on determinants of unmet need among married women in urban slum area of Guntur by Pravin N. Yerpude et al¹², the unmet need for family planning was higher at 38.57% and in urban Tamil Nadu it was 39%¹.

Socio-demographic factors that might have been related to the proportion of unmet need were analyzed further (Table 1). The unmet need was maximum in the age group of less than 24 yrs (35.0%); the finding being similar to what had been obtained in Guntur, where 37.96% had unmet need in the age group of 20 – 24 years¹². A similar study in East Delhi revealed that 24.1% had unmet need in the corresponding age group⁹. In the Western Indian study maximum problem was found in the age group of 25-34yr (28.18%) though in the age group of 18 to 25 years, it was 12.96%¹¹. Country-wide, according to NHFS 3, the corresponding figures in 20 – 24 years were 21.1% and in 15 – 19 years were 27.1%¹⁴. However, a study conducted in Lucknow city revealed that 53.1% of women had unmet need which was extremely high and worst among the age group of 15 to 19 years (86.4%)¹⁵. The subtle differences apart, it may be concluded that the unmet need seems to be at its worst among the more fecund age groups of the population.

Expectedly; unmet need was found to be inversely related with higher education; as

seen in Kerala¹⁰ and Urban Delhi⁹. Such relationship was marginally supported in the current study where it was more among the illiterates and those who studied less than class four. In contrast, higher educated women had more unmet need in the studies in urban Guntur¹². However it has to be mentioned here that the standard of education was poor among the whole of the study population, where no respondent studied beyond class X who had unmet need.

The relation that less is the family income more will be the unmet need was found in the current study. In Kerala¹⁰ they did find out that poor working class of the husbands, which may be taken as proxy to the family income, had higher unmet needs. The study in East Delhi revealed that unmet need was more among women with low per capita monthly income (32%)⁹ as well.

The women from joint family had more unmet need (25.5%) whereas contrasting finding can be calculated from a study in western India where majority women came from nuclear family⁸. This socio-demographic factor was probably most conspicuous in the present study; that not only the difference in the proportion of unmet need in joint and nuclear families has been statistically significant; the adjusted odds ratio also was very high on this factor. Women from joint families are 4.522 times more at risk of having unmet need compared to those who came from nuclear families. It was beyond the scope of the study that why this factor stands out as being the most important; but lack of privacy in decision making in such conservative community could be the reason behind.

Knowledge regarding contraceptives is a documented determinant for unmet need of family planning and has been most definitively found in the study conducted in urban slum of Kerala¹⁰, where the figure was 85.9% among those who had poor knowledge. In the present study though; unmet need was same(20%) among those with poor or average knowledge regarding contraceptives. However, it must be mentioned that we did not find anyone to possess knowledge about all the recommended methods.

Majority of the study population in the slum concerned had less than or equal to two children. So, though the unmet need was more (21.1%) among the women having more than 2 children; parity itself was not seen to be a statistically significant factor associated with unmet need. Similar trend in unmet need was evidenced in studies in Guntur¹² and East Delhi⁹.

It is logical to relate unmet need and spacing in the way that; women with greater unmet need would have inadequate spacing between children. But in contrast, in our study women who had spacing more than three years had more unmet need (44.4%) than those having spacing three years or less, and the difference is

statistically significant. So it might be said that the measure of unmet need reflects the perception and practice of family planning methods and not the outcome of conjugal relationship. Another point which should also be counted; is that in our study we concentrated only on the recommended methods of family planning and the issue of spacing might even be ensured by other methods, which we did not consider.

The commonest reason for non- use was fear of side effects (38.4%). On further analysis it was found to be more in lower income group and in those from joint family but paradoxically more among better educated group (not shown in table). Imposed inhibition by family members & lactation were the other important reasons of unmet need in our study. It seems post-partum lactation is accepted as an effective method of contraception in the community. As the slum was situated just beside College of Medicine and Sagore Dutta hospital there was supposedly no problem of geographical or economic access for contraceptives for this slum. However, it needs further in-depth qualitative research to find out if socio-cultural accessibility was a deterrent in meeting the needs of family planning.

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