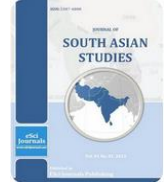




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UNMET CONTRACEPTIVE NEED IN SOUTH ASIA

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ABSTRACT

Over the past two decades, family planning (FP) has received less attention in the South Asian countries. Hence, there is considerable unmet contraceptive need (UCN). The objectives of this paper are to: (i) to discuss the concept of unmet contraceptive need, (ii) to examine the extent and differentials in UCN, (iii) to examine barriers to contraceptive use, and (iv) to identify strategies to address unmet contraceptive need in South Asian countries. The design of this paper is based on data from the Demographic and Health Surveys (DHSs) and other sources of information. The findings of this study are that the extent of UCN ranges from 7% in Sri Lanka to 28% in Maldives, with some decline over the years. There are differentials in UCN regionally within countries, and by socio-economic and demographic characteristics of the women. The major obstacles to contraceptive use, resulting in high UCN, include concerns about health effects of FP methods, limited access to quality FP services, and cultural or familial objections. By improving service delivery systems, FP programmes can reduce those obstacles, and thereby, help reduce the extent of UCN. This paper concludes that over the past two decades, FP did not receive due attention in the South Asian countries, resulting in considerable UCN. The primary obstacles to contraceptive use should be adequately addressed to reduce the extent of UCN in the South Asian countries.

Keywords: Barriers to contraceptive use, South Asia, Unmet contraceptive need.

INTRODUCTION

With an area of only 2.4% of the world's land surface area, South Asia is the home to well over one-fifth of the world's population, making it not only the most populous but also the most densely populated geographical region in the world.

The population of South Asia is around 1.6 billion (Population Reference Bureau, 2010). The population age structure is disproportionately youthful, with those aged 10-24 years accounting for around one-third of the total population. The female age at marriage is relatively low, and hence, there is an increasing need for improving access to quality family planning (FP) services. Also, there is a need to provide appropriate FP methods to those who have completed their family size.

Over the past three decades, well-planned FP policies and programmes in the South Asian countries contributed to considerable increase in the

contraceptive prevalence rate (CPR) and decrease in unmet contraceptive need (UCN), resulting in sizeable reduction in the total fertility rate (TFR). Between 1950 and 2000, the TFR in Asia declined by over 50% to reach an average of 2.8 births per woman. South Asia also witnessed declines in fertility; however, with variations both within countries and regionally. Afghanistan has the highest fertility (TFR of 5.1), while Bangladesh has the lowest fertility (2.3) in the South Asian region.¹

In South Asia, FP programmes started first in India in the early 1950s, followed soon by Bangladesh and Pakistan in 1953, Nepal in 1959, and Maldives in 1984.

In Afghanistan, the overall CPR was 22% in 2011. In Bangladesh, it increased from about 4% in the 1960s to around 8% during the 1970s (Khuda, 1981). The CPR increased to 45% in 1993-94 and further to 61 percent in 2011. In Bhutan, the CPR in 2010 was 66%—almost entirely of modern methods. In India, the CPR increased from 13% in 1971 to 56% in 2005-2006. Maldives had a CPR of only about 10% in 1984, which increased to 42% in 1999; however, it declined to 39% in 2004 and further

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declined to 35% in 2009. Nepal experienced sharp increase in CPR between 1976 and 2011, with its CPR increasing more than 16-fold from 2.9% to 50% , and the use of modern methods increasing 15-fold from 2.9% to 43%. In Pakistan, the CPR remained below 10% throughout most of the 1970s and 1980s, and was only 12% in 1991. It increased to 32% in 2003, and increased only marginally to 35.4% in 2012-2013. In Sri Lanka, the CPR was 68% in 2006—53% modern methods and 15% traditional methods.

There are five major concerns regarding FP programmes in South Asia. First, over the past decade, there has been a slowing down in the annual rate of increase in the CPR. Second, the CPR and the use of modern methods among adolescent women are considerably low. Third, there are pronounced variations in CPR regionally within the countries and by socio-economic and demographic characteristics of the women, indicating limited access to quality FP services among different segments of the eligible population. As a result, sizeable segments of the eligible population remain under-served, resulting in high UCN. Fourth, discontinuation of temporary modern methods is quite high. Most FP users in South Asia drop out because of method failure, side effects, health reasons, or because they want to become pregnant. Dropping out on account of side effects and method failure indicates low quality of FP services, and contributes to the prevalence of UCN. Such high drop-out rate indicates huge system loss for the programme, which could be addressed through improved quality of FP service. Fifth, the contraceptive method mix has changed over time, with the relative share of short-term, temporary methods rising, while that of longer-acting and permanent methods (LAPM) declining in several South Asian countries such as Bangladesh (Khuda & Barkat, 2012a and 2012b; NIPORT, Mitra and Associates & ICF International, 2012; NIPORT, Mitra & Associates and Macro International, 1994, 2005 and 2009; Royal Govt. of Bhutan, UNICEF & UNFPA, 2011; IIPS & Macro International Inc., 2007; Ministry of Health & Family and ICF Macro 2010; Ministry of Health and Population, New ERA and ICF Macro 2011; NIPS and Macro International, 2008; Govt. of Sri Lanka, 2009; UNFPA, 2010).

Thus, the weakening of the FP programme efforts in South Asia over the past two decades resulted in stagnation or a very slow rate of increase in the CPR, thereby decelerating the pace of fertility decline. Also, adolescent fertility remains quite high in Bangladesh

(25%), followed by 16 percent each in India, Nepal and Pakistan.ⁱⁱ

OBJECTIVES AND DESIGN

The objectives of this paper are to: (i) discuss the concept of unmet contraceptive need, (ii) examine the extent and differentials in UCN, (iii) examine barriers to contraceptive use, and (iv) identify strategies to address unmet contraceptive need in South Asian countries.

This paper is based on data from several rounds of Demographic and Health Surveys (DHSs) and other relevant surveys and information from various sources.

The paper is organized into different sections, which deals with reviews of the concept of unmet need contraceptive need, examination of unmet contraceptive need in South Asia, and discussion of the major barriers to contraceptive use, resulting in unmet need. Finally this paper puts forward some concluding remarks and makes some recommendations.

UNMET CONTRACEPTIVE NEED

Unmet need for contraception refers to the condition of currently married couples wanting to avoid or postpone childbearing, but not using any FP method.ⁱⁱⁱThe concept of UCN dates back to the 1960s, with the emerging evidence of a gap in the developing countries between women's fertility preferences and their use of contraception. This justified investments in FP programmes (Sonfield, 2006).

Using data from the first set of the World Fertility Surveys (WFSs) from Asia, Westoff (1978) produced a five-country study of UCN, the phrase he substituted for "KAP-gap", in an effort to develop more-refined measures of the gap between fertility preferences and contraceptive use. In his first study on the subject, Westoff, however, excluded pregnant and amenorrheic women, considering that they had no immediate need for contraception. This limitation of the concept soon drew attention of others, including Westoff himself. Westoff and Pebley (1981) developed 12 alternative definitions of UCN, and showed that the different definitions produced substantially different estimates of UCN. Also, they recommended that the concept should be enlarged to cover both the desires for spacing and that of limiting childbearing. Accordingly, the Contraceptive Prevalence Surveys (CPSs) included questions about interest both in spacing and limiting births, thereby making it possible to calculate UCN for both spacing and limiting births. Nortman (1982), Nortman and Lewis (1984) and Khuda and Howlader

(1990) further broadened the definition by arguing that some pregnant, breastfeeding, and amenorrhoeic women should be included in the definition of UCN, because many of those women would be in need for contraception soon after their current non-susceptible status ended. The Demographic and Health Surveys (DHSs) subsequently attached due importance to the concept of UCN. In a comparative analysis of the DHS data, Westoff and Bankole (1995) showed that the low perceived risk of getting pregnant, indeed, accounts for a substantial fraction of UCN in many countries. Not surprisingly, therefore, there is high incidence of unintended pregnancies in developing countries, including South Asia.^{iv} The rationale for UCN is based on its desirability of preventing such unintended pregnancies (Yinger, 1998).

The women's health and rights groups argue that the concept of UCN is too narrow, because: (i) it neglects reproductive health (RH) needs other than preventing births, (ii) it does not take into account potential clients other than married women, and (iii) the standard measure of UCN does not consider the degree to which women are dissatisfied with their present FP method.^v Using such arguments, they used the 1994 International Conference on Population and Development (ICPD) as the forum to shift the focus of population programmes from demographic goals and targets to women's lives, including but not limited to, their RH goals^{vi}, resulting in the elimination of demographic targets, quotas, and goals. However, in the ICPD Programme of Action (POA) UCN received explicit mention as a core rationale for population programmes. The ICPD POA document stated "Governmental goals for family planning should be defined in terms of unmet needs for information and services.... All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services..." (United Nations, 1994 [paragraphs 7.12 and 7.16]). Thus, reducing UCN became a target in itself, rather than a means for achieving demographic goals (Sai, 1997).

Economists criticize the concept of UCN on the ground that if individuals actually wish to space or limit their childbearing, they would find the means to do so.^{vii} From this viewpoint, nonuse of contraception simply demonstrates a lack of sufficient motivation (Demeny 1975; Pritchett, 1994).^{viii} Social scientists, however, argue that strongly held preferences will often not translate themselves into behavioral changes without a

time lag due to obstacles in the implementation of those preferences or because other preferences overrule them (Dawes, 1998; Pittman, 1998). Preferences to avoid pregnancy are often constrained by various obstacles, which predominantly include method failure, fear of side effects of FP methods, health considerations and social opposition; and therefore, not surprisingly, a substantial fraction of pregnancies are reported as unintended (Khuda & Howlader, 1990; RAND, 1998; Ashford, L. 2003). More women today choose not to use contraception either because they are concerned about the health risks and side effects of various FP methods or because they find contraception too inconvenient to use (Maki, 2007). However, Feyisetan and Casterline (2000) concluded that considerable increase in CPR can be achieved by meeting the already-existing UCN.

Unmet need and latent demand for FP have often been used interchangeably.^{ix} However, it needs to be emphasized that satisfaction of all UCN cannot be attained in the short term, because many women with UCN are unlikely to begin using FP any time soon, not necessarily because of their lack of access to FP services but because of their unwillingness to use FP on account of their perception of a low risk of conceiving or because of social, cultural, and health concerns. However, a more balanced view is that some fraction of the estimated UCN in reality represents latent demand for FP, which can be converted into FP use by ensuring quality FP services. This view is supported by the analysis of DHS data by Westoff and Bankole (1996), who considered several scenarios in which only a subset of women with UCN adopts contraception. Thus, the FP programme by satisfying a fraction of the existing UCN would still be able to achieve considerable demographic impact, especially in countries with relatively low CPR, thereby reinforcing the rationale for a focus on UCN.

PREVALENCE OF UNMET CONTRACEPTIVE NEED IN SOUTH ASIA

According to an estimate, there were 137 million women in the developing world with an UCN, and another 64 million with an UCN for a modern FP method (Sonfield, 2006).^x Between 1990 and 2009, UCN declined quite slowly from 13% to 11% globally, from 11% to 9 in Asia and from 18% to about 15% in Southern Asia (UN, 2011). Using data from DHSs, the authors of the Guttmacher report concluded that between 1990/95 and 2000-2005, UCN declined only 2% in sub-Saharan Africa, while it declined between 4% and 7% in other

regions of the developing world, including South and Southeast Asia (Maki, 2007).

Levels of UCN vary considerably among subgroups of women, both at the regional level and within countries.^{xi}

Women who are young, uneducated, poor or living in rural areas or urban slums are generally at high risk of having an unintended pregnancy; and UCN is also high among such women. Among married women, UCN is highest among those aged 15–24 years. Unmet need declines with age, and then, increases among older, high

parity women.

In South Asia, the extent of UCN ranges between 7% in Sri Lanka and 28% in Maldives. It is around 25% in Nepal and Pakistan, 23% in Afghanistan and 12% each in Bangladesh and Bhutan (Table 1). Between 2000 and 2006, UCN declined in Pakistan from 33% to 25%, in Nepal from 28% to 25%, in India from 21% to 13%, and in Sri Lanka from 18% to 7%. Between 2007 and 2011, UCN declined in Bangladesh from 17% to 12%, though slightly higher than that in 2004 (11%).

Table 1. Unmet Need for Family Planning in South Asian Countries

Country	Year	Age	Total	Spacing	Limiting	Data Source
Afghanistan	2006	15-49	23			Govt. of Afghanistan 2006
Bangladesh	1993/94	15-49	17.9	8.8	9.0	DHS
	1996/97	15-49	15.7	7.7	8.0	DHS
	1999/00	15-49	15.0	7.6	7.4	DHS
	2004	15-49	11.1	4.8	6.3	DHS
	2007	15-49	16.8	6.6	10.2	DHS
	2011	15-49	11.7	4.4	7.3	DHS
Bhutan	2010	15-49	12			Govt. of Bhutan 2011
India	1992/93	15-49	16.4	8.8	7.6	DHS
	1998/99	15-49	15.8	8.3	7.5	DHS
	2002/04	15-44	21.1	8.5	12.7	National survey District Level Household Survey on Reproductive and Child Health 2002-2004
	2005/06	15-49	12.8	6.2	6.6	DHS
Nepal	1991	15-49	27.7	12.4	15.3	National survey
	1996	15-49	31.4	14.3	17.1	DHS
	2001	15-49	27.8	11.4	16.4	DHS
	2006	15-49	24.6	9.4	15.2	DHS
	2011	15-49	27	10	17	Govt. of Nepal 2011
Pakistan	1990/91	15-49	31.8	16.3	15.4	DHS
	1996/97	15-49	37.5	13.4	24.1	National survey
	2000/01	15-49	33.0	12.1	20.9	National survey
	2006/07	15-49	24.9	10.9	14.0	DHS
Maldives	2006-07	15-49	28.1	14.9	13.2	DHS
Sir Lanka	2000	15-49	18.2	6.2	12.0	DHS
	2007	15-49	7.3	3.5	3.8	DHS

Sources: UN 2011; Govt. of Afghanistan 2006; Govt. of Bhutan 2011; Govt. of Nepal 2011

In Bangladesh, UCN declines with age, from 14% among adolescent women (aged 15-19 years) to 8% among older women (aged 45-49 years). UCN is lower in urban than rural areas. UCN is highest in Chittagong division (19%) and lowest in Khulna and Rangpur divisions (8% each). There is very little differential by education and wealth status (Table 2; and NIPORT, Mitra and Associates and ICF International, 2012). The higher UCN among the younger women, those living in rural areas and those in Chittagong division suggest that those women are less well served by the FP programme. Also,

this may reflect problems with the supply of FP services and/or an increase in demand for FP supplies and services.

In Bhutan, UCN was about 12%, though there are some regional differentials. It is four times higher among adolescents (27%) than among women aged 45-49 years (7%). It is positively associated with education of women, although the relationship with wealth status shows no clear pattern (Royal Govt. of Bhutan, UNICEF and UNFPA 2011).

In India, UCN increased from 16% to 21% between 1992

and 2004, but then, declined to 13% in 2006. Of the 13% currently married women in India having UCN, 7% are limiters and 6% spacers (Table 1). UCN ranges from 5% in Andhra Pradesh to 35% in Meghalaya. More than one-fifth of women have UCN in Nagaland, Jharkhand, Bihar, and Uttar Pradesh. Unmet need for spacing ranges from 3% or less in Himachal Pradesh, Punjab, and Andhra Pradesh to 10% or more in Meghalaya, Mizoram, Jharkhand, Bihar, and Nagaland. Unmet need for limiting ranges from 2% in Andhra Pradesh to 16% in Nagaland. Similar to the national pattern, the unmet need for limiting is higher than that for spacing in most states of India (IIPS and Macro International Inc. 2007).

UCN declines with age, from 27% among adolescents to only 2% among older women (aged 45-49 years). Younger women (15-24 years) have a greater UCN for spacing than for limiting, while the reverse is true of older women. The UCN for spacing decreases very sharply from 15-19 years of age to 35-39 years of age, beyond which it is negligible. The UCN for limiting increases up to 25-29 years of age, and then, declines continuously. Rural women have higher UCN than urban women for both spacing and limiting. The UCN for spacing rises with increasing education through 8-9 years of completed education, but the UCN for limiting is highest for women with no education. UCN is particularly high for Muslim women and particularly low for Sikh and Jain women. UCN for both spacing and limiting declines with an increase in wealth (Table 2; and IIPS and Macro International Inc. 2007).

In Nepal, UCN increased from about 28% to 31% between 1991 and 1996, but then declined to 25% in 2006. The decline in 2006 was much more pronounced among spacers (34%) than limiters (11%). Over the past decade, the decline in UCN was greater in rural areas (21%) than urban areas (9%). However, UCN increased among urban women over the past 5 years (from 16% to 20%). UCN declined in all sub-regions, except in Eastern mountains, Western hill and Eastern terai, where it actually increased between 2001 and 2006 (Pradhan and Pant 2007). In 2011, the UCN was 27%—10% for spacing and 17% for limiting (Ministry of Health and Population, Nepal, New ERA and ICF Macro 2011).

In 1996, 2001 and 2006, UCN in Nepal was higher among younger women, rural women, and women who lived in the mountain zone. However, the relationship between UCN and women's education varied. In general, as women's level of education rises, their level of UCN

increased up to the primary level in 1996 and 2001, and up to the secondary level in 2006, and declined thereafter. There may be several reasons for this pattern. UCN is relatively lower among women with little or no education, primarily because they are less likely to express a need for FP. As the level of education increases, women are more likely to be aware of the benefits of using FP, and thus, are more likely to express greater need for FP. This, coupled with an increasing ability to access FP services, has resulted in a decline in UCN among the more educated women. The interplay between education and UCN is also influenced by exposure to information about FP methods, the availability of the preferred FP methods, and the differential expectations of women across the country, especially across the three ecological zones. UCN was inversely associated with household wealth in 2001 and 2006; however, this relationship was unclear in 1996. Also, there was no clear relationship between UCN and the number of living children and the number of living sons (Aryal, Pathak, Dattel & Pant, 2008).

In Maldives, UCN among currently married women is 28%: 15% for spacing and 13% for limiting (Table 1). UCN declines with age, from 36% among adolescents to 16% among older women; is slightly higher in rural than urban areas; and varies from a level of 25% in the North and Central regions to 36% in the South (Ministry of Health and Family, Maldives and ICF Macro 2010). However, there is hardly any difference in UCN by educational level and wealth status (Table 2).

In Pakistan, UCN increased from 32% to 38% between 1990 and 1997. The decline started in 2000 at 33% and further in 2006 at 25% (Table 1). Of the 25% with UCN in 2006, 11% were spacers and 14% were limiters (NIPS and Macro International Inc. 2008). UCN declines with age, from 20% among adolescents to 15% among older women (Table 2). As expected, UCN for spacing is higher among younger women, while UCN for limiting is higher among older women. UCN varies by women's education and household wealth status. However, the relationship of UCN with the background characteristics of the women has changed over time. In 1991, women from the poorest households had the lowest UCN; over time, UCN among these women increased substantially, and they now have the highest UCN (Sathar & Zaidi, 2010).

Unmet need, which was initially lower in rural areas in Pakistan, is now higher (26%) than in urban areas (22%). By region, Punjab has the lowest UCN (23%) and

Balochistan and NWFP have the highest UCN (31%) (NIPS and Macro International Inc., 2008). The evidence suggests that the availability and affordability of FP services is an obstacle and limitation to fertility change, a situation which applies more so in rural areas of Pakistan and in Balochistan and NWFP. The high unmet need, the high proportion of unplanned births and the high rate of abortion suggest that a large fraction of

currently married women in Pakistan are at risk of an unwanted pregnancy and potentially an unsafe abortion. In Sri Lanka, UCN is considerably higher in the Eastern province (15-23%) than in all the other provinces (4-9%). UCN declines from younger ages (13% and 10% respectively among women aged 15-19 years and 20-24 years) to older age groups (less than 1% among women aged 40 years and above) (Govt. of Sri Lanka 2009).

Table 2. Unmet Need for Family Planning by selected characteristics of women in selected South Asian Countries

Characteristics	Bangladesh (2011)			India (2006)			Maldives (2009)			Pakistan (2006)		
	Spacing	Limiting	TOTAL	Spacing	Limiting	TOTAL	Spacing	Limiting	TOTAL	Spacing	Limiting	TOTAL
Age												
15-19	12.9	1.2	14.1	25.1	2.0	27.1	36.3	0.0	36.3	18.6	1.4	20.0
20-24	8.8	4.0	12.8	14.9	6.2	21.1	26.3	5.2	31.5	22.1	5.1	27.2
25-29	4.1	8.5	12.6	6.0	9.9	16.0	25.3	8.8	34.2	16.6	9.8	26.5
30-34	1.6	10.1	11.6	2.1	9.0	11.0	13.5	16.6	30.2	9.6	18.8	28.4
35-39	0.5	10.5	11.0	0.5	6.9	7.4	6.1	18.1	24.2	5.3	21.3	26.6
40-44	0.1	9.8	9.9	0.1	4.2	4.3	2.4	20.8	23.2	2.3	20.7	23.0
45-49	0.1	7.7	7.8	0.1	1.8	1.9	0.3	15.7	16.0	0.9	14.6	15.5
Residence												
Urban	3.5	6.4	9.9	4.5	5.2	9.7	14.0	12.2	26.2	9.1	12.8	21.9
Rural	4.8	7.6	12.4	6.9	7.2	14.1	15.3	13.7	29.1	11.8	14.6	26.4
Educational												
No education	2.0	8.7	10.6	5.5	8.1	13.6	3.9	19.8	23.8	10.6	15.8	26.4
Primary	3.3	8.0	11.3	5.2	5.2	10.4						
Primary	4.2	6.8	11.0	7.3	5.2	12.5	12.2	15.3	27.4	11.8	12.8	24.5
Secondary incomplete	6.9	6.4	13.4	7.7	5.7	13.5				13.4	8.5	21.9
Secondary complete (Or higher-for Bangladesh)	5.2	6.1	11.3	7.0	5.2	12.1	23.7	8.4	32.1	10.9	10.9	21.8
Secondary or more/plus				6.0	4.7	10.7	18.4	6.8	25.2	9.5	8.6	18.1
Wealth quintile												
Lowest	4.2	7.4	11.6	7.7	10.5	18.2	14.2	14.6	28.8	13.2	17.9	31.1
Second	4.2	6.2	10.4	7.3	7.5	14.8	15.8	13.6	29.4	13.0	14.5	27.4
Middle	4.2	8.0	12.2	6.5	6.3	12.8	14.4	14.3	28.7	11.7	14.9	26.5
Fourth	5.4	8.3	13.7	5.7	5.0	10.6	15.9	12.8	28.7	7.7	12.2	19.9
Highest	4.1	7.5	11.6	3.9	4.1	8.1	14.3	11.1	25.4	9.1	11.1	20.2
Total	4.4	7.3	11.7	6.2	6.6	12.8	14.9	13.2	28.1	10.9	14.0	24.9

Sources: Bangladesh Demographic and Health Survey 2011, p. 18; India-NFHS-3- 2005-2006; Trends in Demographic and Reproductive Health Indicators in Nepal, p. 37; Maldives Demographic and Health Survey 2009, p. 78; Pakistan Demographic and Health Survey 2006-07, p. 82.

BARRIERS TO CONTRACEPTIVE USE

Knowledge of FP methods and that of sources of supplies is widespread in South Asian countries, except Afghanistan and Pakistan. What, then, are the reasons that a substantially large number of couples are not practicing contraception in these countries? Is this

because of lack of motivation to space/limit the number of children a woman has or is this due to various programmatic obstacles (such as limited access, poor quality of services resulting in high discontinuation) hindering the use of FP? Up until the late-1970s and early-1980s, couples desired a large number of children

because of high perceived and actual value of children, especially sons, to provide labour input to household farm/business, earn wages to supplement family income, and act as an insurance against old age (Khuda, 1978; Caldwell et al., 1984; Caldwell et al., 1999; Cain, 1977 & 1981). However, over the past three decades, considerable socio-economic changes (both positive and negative) have taken place in these countries to alter the value of children. Positive changes include, for example, increased schooling (especially female schooling), rising female employment opportunities, increasing access to micro credit and greater participation among women in NGO activities, and increasing access to mass media (Caldwell et al., 1999; Khuda et al., 2001). Such changes have contributed to women empowerment, giving them greater say in household decision-making, including the use of contraception. Negative changes include, for example, rising landlessness, shrinking employment opportunities in the agricultural sector, and nuclearization of joint families. Such changes have also contributed to depressing the desire for more children, as is reflected in decline in wanted fertility. Data from the DHSs show that, except in Pakistan where the wanted fertility is 3.1, the wanted fertility in the other South Asian countries is around 2, i.e. one child less than in Pakistan (Bangladesh: 1.9; India: 1.9, Maldives: 2.2; Sri Lanka: 2.1. The ideal family size ranges from 2.3 in Bangladesh and Nepal to 4.1 in Pakistan (Afghanistan: 4; India: 2.4; Maldives: 3.1; and Sri Lanka: 2.7)^{xii}.

Various barriers prevent women from practicing FP. These include: lack of knowledge about contraception, health concerns, fear of side effects of FP methods, limited access to supplies, low (perceived and real) quality of services, high costs, cultural, personal/ family objections, and low motivation to use FP. Such barriers result in moderate to high UCN in South Asia. The evidence from DHSs indicates that there is almost universal knowledge about FP among currently married women in all South Asian countries, except Afghanistan where it is only 28% among ever-married women.

Although there is limited access to FP services among various groups (such as adolescents) and in inaccessible and hard-to-reach areas, it is not a major reason for not using FP. Indeed, less than one percent of currently married women in South Asia reported problems with access as a reason for not intending to use FP in the future.^{xiii} However, quality of FP services continues to be a problem among those not intending to use FP in the

future as well as a reason for discontinuation of use. In Bangladesh, 6% stated health concerns and fear of side effects as the reason for not intending to use FP in the future. In India, 11% of all modern method users discontinued use because of fear of side effects and health concerns; and 9% stated such reasons for not intending to use FP in the future. In Maldives, 18% stated such reasons for not intending to use FP in the future; and 17% stated such reasons for discontinuation of use. In Pakistan, 9% stated such reasons for not intending to use FP in the future. In Sri Lanka, 22% each stated such reasons for discontinuation and for not intending to use FP in the future (NIPORT, Mitra and Associates & Macro International, 2009; IIPS and Macro International Inc., 2007; Ministry of Health and Family & ICF Macro, 2010; Aryal, Pathak, Dattel & Pant, 2008; NIPS and Macro International Inc., 2008; Govt. of Sri Lanka 2009).^{xiv}

Family planning programmes in South Asian countries face continuing challenges in their efforts to address various barriers to non-use of FP, raise contraceptive prevalence, reduce discontinuation, and reduce unmet need. All these are interrelated. Therefore, to be able to identify challenges/barriers to reducing UCN, one has to identify the major programmatic challenges, which if addressed adequately, will help reduce UCN and also raise the CPR. There is evidence that addressing UCN help raise the CPR and also help women achieve their own goals (Sedgh et al., 2007)

The key challenges faced by the South Asian FP programmes include: (i) lack of political will and commitment, (ii) low contraceptive use among adolescents, (iii) regional variations in contraceptive use, (iv) high discontinuation rate, (v) change in method mix, and (vi) various systemic problems such as problems relating to human resources, contraceptive security and logistics management, behavior change communication (BCC) efforts, and limited funding.^{xv}

CONCLUSION

The family planning programmes in the South Asian countries achieved considerable success until the mid-1990s, but, due to erosion in political will and certain organizational problems, the programmes have since then been lagging behind.

The CPR in the South Asian countries ranges from 22% in Afghanistan to around 60% in Bangladesh, Bhutan, India and Sri Lanka. There are a number of programmatic concerns, including but not limited to, the

slowing down in the rate of increase in the CPR since the mid-1990s, lower CPR among adolescents, and lower CPR in rural areas, regional variations in contraceptive use, high discontinuation, and change in method mix. Also, there are various systemic problems affecting programme performance.

The governments in the South Asian countries have recently renewed their commitment to containing the rate of population growth. Also, they have initiated various measures to address the existing constraints and challenges faced by the programmes. The process has started; however, it would take some time before their impact becomes discernible.

Among the South Asian countries, Afghanistan has the highest fertility level, while Bangladesh has the lowest. A point of concern relates to the slowing down in the rate of fertility decline. However, an encouraging point is that the percentage of women wanting to either space or limit their childbearing has increased in all South Asian countries.

Adolescent fertility is high in several South Asian countries, especially Bangladesh (25%), followed by India, Nepal and Pakistan (16%).

- Since adolescents represent quite a sizeable group in several South Asian countries, they deserve priority programmatic attention. They should be provided with adequate information on FP in general, and more specifically about different FP methods and their side effects to educate and motivate them for not giving birth at early ages and maintain proper birth spacing. In addition, there should be regular follow-up and proper management of side-effects to help them prevent high risk pregnancy. Also, and quite importantly, efforts should be strengthened to delay both ages at marriage and first birth by vigorously promoting girls' education up to secondary school, and by creating more employment opportunities for females.
- In South Asia, the extent of UCN ranges between 7 percent in Sri Lanka and 28% in Maldives. In each country, understanding the size of UCN and the characteristics of women with UCN can help programme managers design and strengthen programmes to overcome the obstacles and weaknesses in services.
- By strengthening and expanding BCC efforts, FP programmes can help people get the information

and services they need to make informed choice by addressing women's fears about contraceptives, countering incorrect beliefs, and by showing women how to manage the side-effects. Also, the programmes should take steps to reduce the barriers which women face in their efforts to obtain FP methods and services, give greater emphasis on males, and encourage greater use of male methods. In addition, the programmes should improve couples' communication about fertility goals and contraceptive practices and work to make FP use more acceptable in their communities, thereby preventing unintended pregnancies, unplanned births and unsafe abortions. Furthermore, contraceptive security needs to be enhanced.

Most South Asian women, except those in Afghanistan and Pakistan, ideally prefer around two children on an average. This segment of women requires LAPM to limit their childbearing; however, in some countries like Bangladesh, access to LAPM is quite limited, and therefore, such women have UCN for LAPM.

- The FP programmes should give due emphasis on the provision of LAPM among couples in need of such methods.

The high discontinuation rate mostly due to fear of side-effects and health concerns points to the need for improving the quality of FP services.

- The problem of high discontinuation can be addressed through better counseling, better management of side-effects, and improvement in quality of services.
- The reasons for non use should be understood and addressed effectively. Both counseling and quality of services are important for motivating never users to begin practicing FP. Since the never user group has higher unmet needs for both spacing and limiting and are not practicing FP because of fear of side-effects and health reasons, they should be educated about their problems and motivated to accept FP method, according to their need.
- There is need for the governments in the South Asian countries to re-evaluate their existing FP programmes; and adopt and effectively implement appropriate strategies to make their programmes more efficient and sustainable. Adequate investments in FP will not only benefit the various target groups such as the adolescents and the older

women themselves by avoiding unintended pregnancies resulting in unsafe abortions, but also contribute to broader development goals by enhancing the overall status of women in the society. This will help accelerate the rate of increase in the CPR, reduce discontinuation and UCN, and ultimately achieve population stabilization within the shortest possible time. Finally, the governments should strengthen efforts towards repositioning of the FP and RH programmes as part of their overall development agenda; otherwise, their development objectives will not be fully achieved.

To achieve the desired decline in UCN, and thereby, achieve the desired increase in the CPR, the governments should develop country-specific action plans to meet the diversified unmet needs in the South Asian countries. More specifically, they should undertake a number of measures. First and foremost, there should be a renewed commitment on the part of the political leadership to further contain the population growth rate. Second, the organizational problems affecting the programme (including the need to fill out the vacant posts, increase field worker visitations, train programme personnel, enhance worker morale and job satisfaction, and improve the commodity security and logistics systems) should be addressed on an urgent basis. This will help improve access to quality FP services. Third, there is a need for a multi-sectoral approach, focused on collaboration and linkages between policy commitments and their implementation and sustained funding, thereby ensuring effective delivery of quality FP services. Fourth, service delivery and programme efficiency should be further strengthened and expanded by making better use of existing infrastructures, resources and personnel and through effective public-private partnerships. Fifth, the role of the community leaders and the media should be taken into consideration in the design and delivery of FP programmes. Sixth, efforts should be made for greater mobilization of domestic resources for the FP programmes, especially in the context of reduced donor funding as well as priority shifting of donor agencies away from FP to RH and other related issues. Finally, issues relating to better governance and accountability should receive high priority.

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ⁱ Khuda & Barkat, 2012a and 2012b; Khuda et al., 2001.

ⁱⁱ For more elaborate discussion, see Govt. of the Islamic Republic of Afghanistan 2006; Royal Govt. of Bhutan, UNICEF and UNFPA 2011; Khuda & Barkat, 2012a and 2012b; NIPORT, Mitra and Associates, ICF International, 2012; Jain & Jain, 2010; International Institute for Population Sciences (IIPS) and Macro International, 2007; Niraula, 2010; Ministry of Health and Population, Nepal & ICF Macro, 2011; Ministry of Health and Population, Nepal, 2005; Pradhan & Pant, 2007; Tang, Subedi & Packer 2010; National Institute of Population Studies (NIPS) & Macro International Inc., 2008 and 2013; Sathar & Zaidi, 2010; Sathar. 2013; Govt. of Sri Lanka 2009).

ⁱⁱⁱ This section draws heavily from a comprehensive discussion on the concept of unmet need and related issues by Casterline & Sinding, 2000.

^{iv} Between one-fifth and one-quarter of births in the developing world are unwanted (Bongaarts, 1997). However, this figure could be an under-estimate, given that a substantial fraction of pregnancies are terminated through induced abortion, the fraction of unwanted pregnancies must be even higher than the fraction of unwanted births, and a further fraction of recent births are reported as mistimed (Alan Guttmacher Institute 1999). The DHSs report that large number of recent births were aborted, unwanted, or mistimed, indicating the prevalence of UCN.

^v For more detailed discussion, see Dixon-Mueller & Germain, 1992; Dixon-Mueller, 1993.

^{vi} See, for example, Sen, Germain, & Chen, 1994; McIntosh & Finkle, 1995.

^{vii} Under the conventional economic theory, unmet need (which economists consider synonymously with unmet demand) can be viewed as a temporary disequilibrium which market forces would correct in the short run.

^{viii} This criticism originates from misunderstandings of the concept of UCN, and the absence of a sound behavioral model in much of the mainstream research on UCN. The key concept which has not been routinely articulated in the literature is competing preferences (Casterline & Sinding, 2000).

^{ix} See, e.g., Westoff & Bankole, 1995; Sinding, Ross & Rosenfield, 1994.

^x Unmarried women also add to UCN, accounting for 4% in Asia (Ross & Winfrey, 2002). See also Westoff, 2006.

^{xi} For more detailed discussion on UCN among specific population groups, see, for example, International Planned Parenthood Federation (IPPF) 2010a and 2010b.

^{xii} No information on wanted fertility is available for Afghanistan, Bhutan and Nepal.

^{xiii} Access to FP services is extremely limited in Afghanistan, while no information is available for Bhutan.

^{xiv} No such information is available for Afghanistan, Bhutan and Nepal.

^{xv} See Khuda and Barkat 2012a and 2012b.