

Epidemiological Study Of The Unmet Need For Contraception In Benha City

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Abstract: Background: Although contraceptive use has increased in many developing countries yet unmet need for family planning is an important public health issue because of its negative association with social and health outcomes for both mothers and children. Understanding the underlying reasons and the characteristics of women with unmet need can help to design unmet need strategies. **Aim of the work:** To determine the magnitude and some of the underlying factors of unmet need for contraception for a sample of fecund married women of reproductive age (15 – 49 years) attending medical health center in Benha City. **Subjects and methods:** This cross sectional study was conducted on four hundreds married women. Data were collected through a structured interview questionnaire sheet. It includes socio-demographic data, KAP study, reproductive aspects, and quality of care of family planning services. The size of the unmet need was estimated according to the standard EDHS 2008 definition of women with unmet need. **Results:** This study revealed that the level of unmet need for contraception was 30%. The percentage of illiteracy was higher for the unmet need group 33.3% and the percentage of working women was higher among contraceptive users 23.5%. None of unmet need group 0.0% realize the correct concept of family planning. The attendance of health education sessions about family planning was very low 11%. The majority of women with unmet need (75%) believe that contraceptive methods may be harmful. The main reasons for never use of family planning methods were current lactation and fear of side effects (33% each) and that for discontinuation were the menstrual problems 59.4%. There was no significant difference between women in the unmet and met need group regarding physical accessibility to services. **Conclusion and recommendations:** The rate of unmet need for family planning is still high. Family planning should have a public health focus, concentrating on creating a supportive and active family planning program at multilevels starting from the woman herself to the community as a whole and depend on the health education as the main strategy.

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1. Introduction

Many pregnancies specifically pregnancies characterized as; too early (girls under 18), too many (many births), too late (the age of 35) and too soon (children spaced too closely), un intended, mistimed and unwanted are important public health issues in both developed and developing countries because of their negative association with social and health outcomes for both mothers and children⁽¹⁾.

A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy⁽²⁾.

Although contraceptive use has substantially increased in many developing countries, yet surveys indicate that, in developing countries and countries in transition between 9% and 39% of married women have unmet need for family planning. A recent study estimates that more than 200 million women in the developing world have an unmet need for family planning⁽³⁾.

According to the most recent Egyptian Demographic and Health Survey the level of unmet

need for family planning among Egyptian women was (10%)⁽⁴⁾.

Unmet need is defined as the percentage of fecund married women not using contraception and they either want to postpone their next birth for at least 2 more years (spacers) or do not want to have any more children (limiters), also it included pregnant or amenorrheic women whose current or recent pregnancy was unintended, unwanted, and mistimed⁽⁵⁾.

Family planning programs can not be expected to address all unmet need. Understanding the underlying reasons of unmet need and the characteristics of women with unmet need can help family planning programs to design unmet need strategies, reduce the number of unwanted pregnancies and reduce the birth rate of Egyptian women⁽¹⁾.

Aim of the Work:

This study aims at:

- 1- Determining the magnitude of the unmet need for contraception in terms of spacing or limiting birth for a sample of fecund married women of

reproductive age coming to Maternal and Child Health Center in Benha City.

- 2- Identifying some of the underlying factors for unmet need for contraception.

2. Subjects and Methods

This cross-sectional study was conducted on four hundreds married and fecund women of reproductive age (15-49 years) attending Medical Health Centre in Benha city during the period from the start of October 2009, till the end of March, 2010.

I-Study design:

A) Research setting:-

This study was conducted at two clinics; Family Planning clinic and Antenatal clinic in the MCH center in Benha city.

B) Subjects:

A systematic random sample was taken from all fecund married women of reproductive age (15-49 years) attending MCH centre in Benha city.

C) Tool of data collection

A structured interview questionnaire sheet was designed (in Arabic language) to collect data to measure the unmet need for spacing and limiting births, as well as the underlying factors it included the following items:-

- a- Socio-demographic data.
- b- Knowledge and attitude about family planning.
- c- Pattern of practice of the family planning services and methods.
- d- Items related to the reproductive aspect of the females.
- e- Quality of care of family planning services.

The size of the unmet need was estimated according to the standard (EDHS, 2008) definition of women with an unmet need for family planning. Which include the following:

- (1) Currently married women who are in need for family planning for spacing purposes.
- (2) Currently married women who are in need for family planning for limiting purposes

Menopausal and in fecund women are excluded from the unmet need category as are pregnant or amenorrhic women who became pregnant while using a contraceptive method⁽⁵⁾.

A women with a met need was defined as a married women using a contraceptive method at the time of the interview either for spacing or limiting⁽¹⁾.

II-Operational design:

Preparatory phase: included.

Writing the protocol.

Review of literature related to the subject.

Choosing the site of the study.

Pilot study:

A pilot study was carried out on September 2009 to test the applicability of the tool. The results of the data obtained from pilot study helped in modification

of the questionnaire that was revised, redesigned, and rewritten.

III-Administrative Design:

An official permission was obtained from the director of the MCH center in Benha city. The selected clinics were visited to clarify the aim of this work for the health team members and for the women. Informed consent was obtained from the participants after explaining the aim of the study. They were reassured about the confidentiality of the data.

IV-Statistical Design:

The collected data were tabulated and analyzed statistically using SPSS v.s16. The accepted level of significance in the present study was 0.05 i.e ($p < 0.05$).

3. Results

Fig. (1) revealed that the level of contraceptive use was 51%, 11.5% of the total sample were using contraception for spacing and 37% for limiting births. On the other hand, the percentage of unmet needs for family planning was 30%, most of them had the desire for limiting the number of births 18.5% (pregnancy unwanted + last child unwanted + not pregnant and want no more) while 11.5% for spacing purpose (pregnancy mistimed + last child mistimed + not pregnant and want later).

Table (1) shows that although there were differences between the two groups in all variable only significant differences were detected in women education ($p < 0.001$).

Table (2) shows that only a minority (2.94%) of the (met need) group and none of (unmet need) group realize the correct concept of family planning. The majority of both groups believe that the ideal number of children and the ideal spacing preferred by the majority of women in the two groups were (3 children and 3-5 years) respectively.

Although there were differences between the two groups in all the studied items of knowledge, yet statistically significant difference were only detected regarding when to start family planning ($p < 0.05$).

Table (3) illustrates that the attendance to health education session about F.P in both groups is very low representing only 11.1%.

Also it shows that nearly two third of women of the two groups agreed with their spouses about the desired number of children by 63.2% and 62.5%, respectively. Also it shows that the majority of women of both groups believe in the religious approval of F.P use by 80.5% and 70% respectively and that 58.6% of the studied group believe that contraceptive methods harm the body with statistically significant results ($p < 0.05$ and $P < 0.001$).

It also illustrated that the majority of the studied group (80.2%) preferred female doctor rather than male one with statistically significant results ($P < 0.05$).

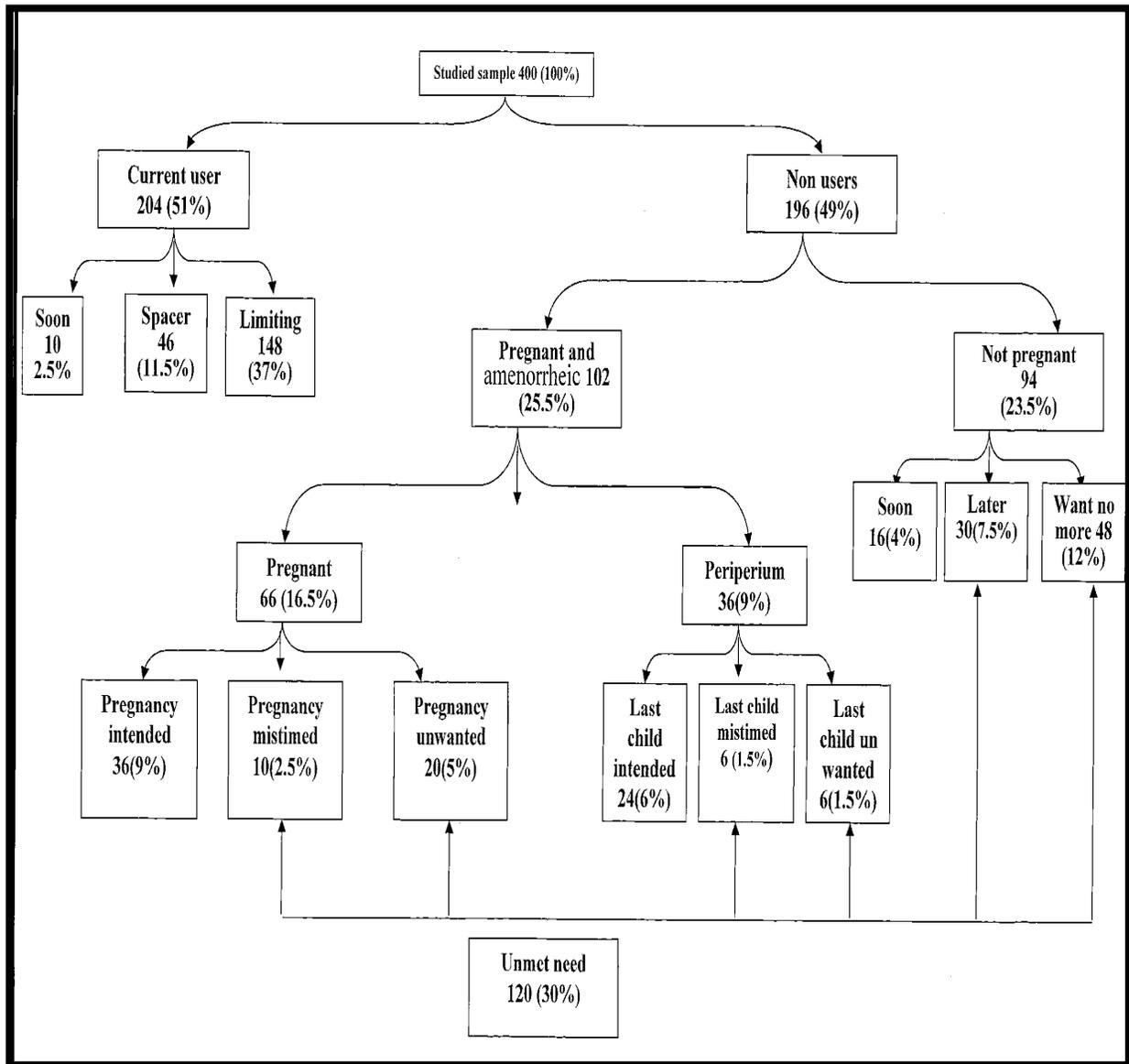
Table (4) reveals that the majority of spacers were young women (72%) with few number of living children (< 3) 68%, while older women were concerned with limiting. The differences were statistically significant ($p < 0.001$)

Table (5) shows that 65.2% of unmet need for spacing perceived risk of pregnancy versus 75.5% of unmet need for limiting. This table also illustrates that 56.5% of unmet need for spacing intend to use contraception. The differences between two groups in intention to use family planning was statistically significant ($p < 0.05$).

Table (6) illustrates that (33.3%) of previous users of F.P say that they will start using contraception method after side effect of last used method subsided and (33.3%) of those who never used F.P method say that they will use it after completing desired number of children.

Table (7) shows that the most common reason for discontinuations of last used method was side effects experienced by a woman, whether menstrual (59.4%) or medical (25.6%) followed by method failure (9.4%).

Table (8) reveals that the main reasons for never use of F.P methods were current Lactation 33.3% and fear of side effects 33.3%.



Fig(1): Percent distribution of the studied sample women according to their current state of contraceptive use

Table (1): Comparison between the studied groups (met need) and (unmet need) according to socio-demographic factors:

Need Factor	met need (N=204)		unmet need (N=120)		X ^{2*}	P Value
	No.	%	No.	%		
Age					7.9	>0.05
15-	2	1.0	0	0.0		
20-	38	18.6	18	15.0		
25-	64	31.4	26	21.6		
30-	40	19.6	30	25.0		
35-	40	19.6	34	28.4		
40-49	20	9.8	12	10.0		
Education					65.8	<0.001
Illiterate	10	5	40	33.3		
Read & write	13	6.4	10	8.4		
Primary	16	7.7	0	0.0		
Preparatory	20	9.8	20	16.6		
Secondary	110	53.9	44	36.7		
Higher	35	17.8	6	5		
Working status					1.7	>0.05
House wife	156	76.5	100	83.3		
Working	48	23.5	20	16.7		
Husband Education					8.4	>0.05
Illiterate	30	14.7	26	21.8		
Read & write	10	4.9	0	0.0		
Primary	4	2.0	2	1.6		
Preparatory	16	7.8	10	8.4		
Secondary	104	51.0	62	51.4		
Higher(university level)	40	19.6	20	16.8		
Husband occupation					3.8	>0.05
Not working	6	2.9	2	1.6		
Laborer	46	22.5	30	25		
Skilled worker	52	25.5	40	33.4		
Employee	82	40.2	38	31.6		
Professional	18	8.8	10	8.4		

* Adjusted chi square test

Table (2): Comparison between (met need) and (unmet need) groups according to knowledge of some items related to FP:

Need Item	met need(204)		unmet need(120)		X ^{2*}	p
	No.	%	No.	%		
Knowledge about concept of FP:					5.5	>0.05
To have small no. of children	100	49.02	70	58.3		
At least 2 years spacing	98	48.04	50	41.7		
Correct concept	6	2.94	0	0.0		
When to start FP:					25.8	<0.05
If having many children	8	4.0	20	16.6		
If she wants to care for her children	174	85.2	90	75.0		
If working	9	4.50	4	3.4		
If ill	0	0.0	4	3.4		
If she wants to stay in good health	13	6.3	2	1.6		
Ideal spacing:					5.9	>0.05
<3y	80	39.2	46	38.3		
3-5 y	108	53.0	72	60.0		
>5 y	16	7.80	2	1.70		
Ideal no. of children:					4.3	>0.05
One child	2	0.98	0	0.0		
Two child	19	6.3	6	5.0		
Three children	150	78.9	98	81.6		
Four children	27	10.5	12	10.0		
Five children	6	3.2	4	3.40		

* Adjusted chi square test

Table (3): Comparison between (met need) and (unmet need) groups according to items of knowledge, attitude about FP and utilization of health services:

Need items	Met need(204)		Unmet need(120)		Total(324)		X ² *	p
	No	%	No	%	No	%		
Knowledge								
Source of knowledge about FP services:								
Radio/ TV	24	11.7	40	33.3	64	19.7	79.2	<0.001
Medical staff	6	3.0	10	8.3	16	4.9		
Posters	134	65.6	20	16.6	154	47.5		
Newspaper	10	5.0	8	6.7	18	5.5		
Mother/friends/relatives	24	11.7	40	33.3	64	19.7		
others	6	3.0	2	1.5	8	2.7		
Health education about session FP:								
Attended	27	13.3	9	7.5	36	11.1	1.9	>0.05
Didn't attend	177	86.7	111	92.5	288	88.9		
Attitude								
Agreement of both couple about no. of children:								
Yes	129	63.2	75	62.5	204	63.0	0.1	>0.05
No.	75	36.8	45	37.5	120	37.0		
Religious approval of FP use:								
Approve	164	80.5	84	70.0	248	76.5	7.2	<0.05
Doesn't approve	15	7.30	20	16.6	35	10.8		
Don't know	25	12.2	16	13.4	41	12.7		
contraceptive Effects								
harmful	100	49.02	90	75.0	190	58.64	19.9	<0.001
Not harmful	104	50.98	30	25.0	134	41.36		
Utilization of health services								
Physical accessibility to FP services								
Walking	19	9.30	7	5.80	26	8.0	1.2	>0.05
Traffic	185	90.7	113	94.2	298	92.0		
Preferred male or female doctor								
Male	38	18.6	5	4.20	43	13.2	16.6	<0.05
Female	150	73.5	110	91.60	260	80.2		
Doesn't differ	16	7.9	5	4.20	21	6.60		
Satisfaction with services								
Satisfied	195	95.6	120	100.0	315	97.2	5.4	<0.05
Not satisfied	9	4.4	0	0.0	9	2.8		

* Adjusted chi square test

Table (4): Percent distribution of women with unmet need for family planning according to fertility variable by age and number of living children:

Unmet need Fertility variable	Spacer(46)		Limiter(74)		Total(120)		X ²	p
	No	%	No.	%	No	%		
Age								
<30	36	72.0	14	28.0	50	100.0	42.3	<0.001
30-	10	17.2	48	82.8	58	100.0		
40-	0	0.0	12	100.0	12	100.0		
no. of living children								
<3	34	68.0	16	32.0	50	100.0	33.4	<0.001
3-4	12	20.0	48	80.0	60	100.0		
5+	0	0.0	10	100.0	10	100.0		

* Adjusted chi square test

Table (5): Percent distribution of women with unmet need for family planning according to perceiving risk of pregnancy and intention to use FP:

Unmet need Item	Spacer=(46)		Limiter=(74)		Total=(120)		X ^{2*}	P
	No	%	No	%	No	%		
perceived risk of pregnancy								
Believe she may become pregnant	30	65.2	56	75.5	86	71.6	3.5	>0.05
Believe she's unlike to become pregnant	10	21.7	15	20.2	25	20.8		
Doesn't know	6	13.1	3	4.30	9	7.6		
Intention to use FP								
Intend	26	56.5	60	81.0	86	71.6	7.3	<0.05
Doesn't Intend	20	43.5	14	19.0	34	28.4		

* Adjusted chi square test

Table (6): Percent distribution of women with unmet need for family planning according to intended timing for starting FP:

Opinion about start using	Using F.P	Previous No=90		Never No=30		Total No=120		X ²	p
		No	%	No	%	No	%		
After birth of next child		8	8.8	6	20.0	14	11.6	22.3	<0.001
After completing of desired no. of children		12	13.2	10	33.3	22	18.4		
After weaning of last child		10	11.1	8	26.7	18	15.0		
When resuming menstruation		30	33.3	6	20.0	36	30.0		
When side effects subside		30	33.3	0	0.0	30	25.0		
Total		90	100.0	30	100.0	120	100.0		

* Adjusted chi square test

Table (7): Percent distribution of previous users for family planning according to reason for discontinuation of last used method:

Method Reason for discontinuation	Pills		IUD		Injectable		SC capsules		Total	
	No	%	No	%	No	%	No	%	No	%
Menstrual Problems	10	50	20	66.6	9	60	5	55.5	44	59.4
Medical Problems	6	30	5	16.6	6	40	2	22.2	19	25.6
Method failure	4	20	3	10	0	0.0	0	0.0	7	9.4
Husband disapproval	0	5.9	2	6.8	0	0.0	0	0.0	2	2.8
Fear of side effects	0	0.0	0	0.0	0	0.0	2	22.2	2	2.8
Total	20	100.0	30	100.0	15	100.0	9	100.0	74	100.0

Table (8): Percent distribution of the group of never users of FP according to reason for refusing FP.

Reason for never use	No.	%
Currently pregnant	2	6.6
Currently lactating	10	33.3
Desire for male child	4	13.5
Desire for big family	2	6.6
Fear of side effects	10	33.3
Heard bad rumors	2	6.6
Total	30	23.4

4. Discussion

Unmet need for family planning has been a core concept in international population for more than three decades. Under the label "KAP-gap" and from this

outset it was recognized as a preeminent rationale for investments in family planning programs because of its causal link to unwanted childbearing⁽⁶⁾.

This cross sectional study aimed at determining the magnitude of the unmet need for contraception in terms of spacing or limiting births for a sample of fecund married women of reproductive age (15- 49) coming to Maternal and Child Health Center in Benha city during the period from the start of October 2009, till the end of March, 2010 and identifying the underlying factors for the unmet need for contraception.

The level of unmet need for contraception within the studied sample was 30%, it was found that nearly one-third of women in this group was space births while two-thirds had the need for limiting births. This is in agreement with the findings of the **Robey et al. (1996)**, **EDHS(2008)**, **El-Zanaty and Way, (2009)**, who mentioned that in most countries outside sub-Saharan Africa, unmet need was either greater for limiting than for spacing or was divided between the two types^(4, 5, 7).

The unmet need in this study is higher than that reported by **EDHS, 1995 (16%)**, **EDHS, 1997 (18%)**, **EDHS, 1998 (15%)** and **EDHS, 2008 (10%)**.

The differences between the detected levels of unmet need might be attributed to that the present work is not a community based survey.

This is confirmed by the findings of **Sultan et al. (2010)** and **Kotb et al. (2011)** who conducted a community based study. They found that the prevalence of the unmet need was (7.4%)^(1,8).

This study illustrated that the percent of illiteracy was higher for the unmet need group than for the met need (33.3% and 5% respectively) and the percent of secondary and higher education was higher among the met need group than among the unmet one, (71.7% and 41.7%, respectively).

This agrees with the result of many studies. They found that respondents with higher education had a lower level of unmet need and that less educated women face more obstacles to use contraception^(9,10)

On the contrary **EDHS (2008)** and **Elzanaty and way (2009)** revealed that generally the rate of unmet need remains relatively constant regardless of educational level. This may be due to comprehensive family planning services provided to the general public by the Ministry of health in Egypt, which is able to deliver these services to a large segment of the population, irrespective of their socioeconomic status^(4,5). This is confirmed by the findings of **Khadr (2009)** who have reported that socioeconomic differentials in contraceptive use become smaller in countries where contraceptives are widely available and accessible⁽¹¹⁾.

This study revealed that the percentage of working women was higher among contraceptive users than women with an unmet need for contraception (23.5% and 16.7% respectively). This is in agreement with **Degraff and de Silva, (1996)** who found a slightly higher incidence of unmet need for limiting

and spacing purpose among nonworking women than among working ones⁽¹²⁾.

Counseling and education help women to sustain contraceptive use. It is not sufficient to supply contraceptives without providing adequate counseling services⁽⁶⁾.

In this study none of the unmet need group (0.0%) realize the correct concept of family planning. Also it revealed that the attendance of health education sessions about F.P was very low 11% with higher percentage of attendance among the met need.

These findings agree with **Adhikari et al. (2009)** and **Kotb et al. (2010)**. They reported that women who knew about contraceptive methods and had a higher level of knowledge about family planning methods were less likely to have unmet need^(1, 13). On the contrary **Casterline et al. (1997)** found that whether or not a woman knows of just one contraceptive method makes little difference to unmet need⁽¹⁴⁾.

This study revealed that medical staff as a source of knowledge for family planning for the met need group constitute low percentage 3% this is in contrary with **Kotb et al. (2010)** who shows that unmet need cases were less likely than meet need to report that their main source of knowledge of family planning was from physicians⁽¹⁾. Other investigators have reported that non users were less likely to have heard of family planning from a health care provider⁽¹⁵⁾.

This study revealed that the majority of women of met need and unmet need groups believe in the religious approval of F.P use by (80.5% and 70%) respectively.

This is confirmed by **Westoff and Bankole, (1995)** and **Casterline, et al. (1997)**^(14, 15) who mentioned that in most countries religious opposition was not an important reason for unmet need and that religious objections were equivalent in magnitude among users and nonusers.

On the contrary other studies found that belief that contraception is religiously prohibited is a predictor of un met need, which indicates the need for close cooperation between family planning programmes, religious authorities and the media to emphasize the religious acceptance of contraceptive use to the public^(1, 9, 15, 17- 19).

Deficient intersposal communication about contraceptive use and the desired number of children was an important risk factor for unmet need and better intersposal communication is correlated with increased contraceptive use^(2, 15, 20).

In this study as regard attitude of women toward family planning it was found that nearly two third of women of met need and unmet need groups agreed with their spouses about the desired number of children represented by (63.2% and 62.5%) respectively with statistically un significant results ($P > 0.05$).

This study illustrated that women who had unmet need for contraception were likely to believe that contraceptive methods may be harmful to their bodies than did women who use contraception (75% versus 49% respectively) with statistically significant results ($P < 0.05$).

This is confirmed by others who mentioned that health concerns are more frequently reported reasons for nonuse of contraception and that a large portion of women who had heard of modern methods feared harmful effects from using them^(22, 23).

So the best way to address obstacles related to side effects, health concerns and incorrect knowledge about contraceptives is better counseling. Counseling about side effects can improve continuation rates, thus lowering the portion of women who may fall into the unmet need category.

There was no significant difference between women in the unmet need group and in the met need one who utilized family planning services concerning the physical accessibility to family planning services but there was statistically significant differences regarding social accessibility (Preference of female physicians). This indicates that physical access to services does not affect the level of unmet need.

This is in agreement with **Casterline et al. (1997)** and **Islamabad Population Council, (1998)** who concluded that lack of access to family planning services does not contribute to the country's high level of unmet need and that the social costs of contraception (e.g., fear of side effects and spousal, cultural and social acceptance) were the decisive obstacles to its use, rather than the monetary and related direct costs of obtaining supplies^(14, 23).

Furthermore, literature exists demonstrating that unmet need is driven mainly by health concerns and societal opposition, rather than quality of services⁽²⁴⁾.

On the contrary this finding does not agree with the major review of unmet need performed by **Robey et al., (1996)** who proposed that access to high-quality services is the first approach to take to address this issue⁽⁷⁾.

It is important to differentiate between limiting and spacing purposes in the unmet need group because women who want to space their next birth are usually interested in temporary methods while those who want to limit their births are likely to be interested in permanent ones.

Differences in unmet need group according to women's characteristics provide additional insights into which subsets of the population should be targeted to reduce levels of unmet need for contraception.

Regarding the age difference between the two types of unmet need group. It was found that unmet need for limiting appeared to increase with age, while unmet need for spacing declined sharply. This is consistent with the findings of others. Also this could

be explained by that older women are likely had completed their desired number of children while younger women had not^(4, 12).

This study revealed that the number of living children a woman had was directly related to her limiting preference. The majority of women (68%) who had less than three children were spacers while the majority of those who had three or more children were limiters. This agrees with the findings of others who reported that unmet need for limiting generally increased with the number of children ever born while, in contrast, after the first birth, unmet need for spacing declined with increasing number of children ever born^(4, 8, 12).

Many women with unmet need for contraception believe that they are unlikely to become pregnant which is considered one of the main reasons for unmet need^(8, 14). They represented, in this study by 21.7% of spacers and 20.2% of limiters, but the difference between them was not significant ($p > 0.05$).

Women who had an unmet need for contraception and intended to use contraception in the future represented the majority of the unmet need group 71.6%. This finding is consistent with that of **El-Zanaty and Way, (2009)**. This may indicate that providing high-quality services to couples who are already motivated to use will help to solve the problem of unmet need⁽⁴⁾.

The differentiation between previous users of contraception and never users is important because family planning services needed by each group may differ.

In this study previous users constituted a higher percentage of the unmet need category than the never users; (75% and 25%, respectively).

These findings disagree with results reported by others. They mentioned that most women with unmet need have never used contraception^(7, 12).

The present study illustrated that the reasons for discontinuation of contraceptive methods were mainly due to menstrual problems 59.4% and medical problems 25.6%.

These findings are consistent with the findings of **Tolley et al. (2005)**, **EDHS (2008)**, **El-Zanaty and Way (2009)** and **Koth (2011)**. Their study showed that the side effects were the main reasons mentioned for discontinuation. This gives health care providers the opportunity to identify women with a possible future unmet need, and with effective appropriate counseling they can provide a suitable alternative method^(4, 15, 25).

This study revealed that the main reasons for never use of F.P methods were current lactation and fear of side effects 33% each.

These findings are consistent with that of **Ross and Winfrey, 2002**. They found that the slow return of menses in Sub-Saharan Africa reflecting the extended practice of breastfeeding there explained the relatively

small number of postpartum women there who use contraceptives⁽²⁶⁾.

Also this is consistent with other studies which ensures that the strongest independent risk factor for unmet need was the respondent's actual previous experience of an adverse effect from contraceptive use^(4, 8, 9, 14, 25, 27).

Conclusion and Recommendations:

We can conclude from this study that in spite of the benefits of family planning for the mothers, sibling and community, the rate of unmet need for family planning is still high. The following recommendations are suggested as approaches to decrease the rate of unmet need:

- (1) Upgrading a health education program to educate women in the child bearing period about family planning and its value which is the best approach to decrease the rate of unmet need.
- (2) Considering the central role that men play in decision-making in families. Men's involvement and participation in family planning (F.P) are crucial and should be involved in family planning counseling.
- (3) Access to affordable, high-quality family planning services which must be repositioned within reproductive health programmes.
- (4) Empowering the communication skills of F.P physicians and workers under proper continuous guidance and refreshing courses of quality of care in F.P.
- (5) Linking family planning program with other maternity facilities in order not to miss a lot of opportunities.
- (6) Assure availability of family planning counselling and supplies for post abortive case and women who experience contraceptive complications and or previous unwanted pregnancy in addition of strengthening referral system in order to address more women with unmet need.
- (7) The success of the program will depend on the participation of the community and fighting country's traditional believes and norms e.g. early age of female marriage, the habit of big families etc.
- (8) Use a broader concept of unmet need than one the used in the present work in order to include more women with needs for family planning which are still unmet.
- (9) More in depth studies which will improve our knowledge about the reasons of unmet need with special concern about Husband's attitude and decision making process to enhance the ability of the family planning program.
- (10) Community based distribution and collaboration of service providers with other medical and social service.

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