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Original Research Article

Epidemiological Determinants of Unmet Need for Family Planning Among Eligible Couples in Ahmedabad

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ABSTRACT

Background
The unmet need for family planning (FP) refers to the disparity between reproductive intentions and contraceptive behavior. According to NFHS-5, the total unmet need for FP is 10.3% among newly married couples in Ahmadabad, with higher rates in rural (10.8%) than urban (9.7%) areas of Gujarat. This study is conducted to identify the epidemiological determinants of unmet need for family planning among eligible couples in Ahmadabad and assess of U-PHC for provision of family planning services.

Methodology
A community-based cross-sectional study was conducted among married women (18-49 years) in 7 AMC zones. Stratified cluster sampling (n=900) was used, with 30 women selected from each of 30 UHCs, representing slum, slum-like, and non-slum areas. One-on-one interviews were conducted using an open-ended questionnaire." Interview of MO with filling up of checklists of 14 U-PHC from 7 zones of AMC (2 centers each).

Results
Among married women, 74% expressed demand for family planning, with 67% seeking spacing and 7% seeking limiting. Non-users exhibited an unmet need 30%, associated with significantly poorer FP knowledge ($p < 0.05$)." All 14 centers had organized an average 137 health and nutrition day in last 3 months; FP and methods of contraception were discussed by ANM. Supervision and counselling of FP found poor.

Conclusions
The study found a 30% unmet need for family planning among participants, with significant knowledge gaps, building and infrastructure is good in all except one U-PHC. Supervision found to be poor in all selected U-PHC's.

Keywords: Family planning, Unmet need, AMC, Contraception, eligible couple, UPHC

INTRODUCTION

'Unmet need' refers to the gap between women's reproductive intentions and their contraceptive behavior. Globally, millions of women desire to delay or prevent pregnancy but don't use contraception, indicating an unmet need for family planning (FP). This concept is crucial for health programs, as it identifies women interested in contraception but not using it.[1] In India, the unmet need for FP decreased from 17% to 10.3% in Gujarat and from 13% to 9.4% nationally between NFHS-4 and NFHS-5 surveys. However, unmet need remains highest among women under 20 and lowest among those over 35.[2] Unintended pregnancies pose health risks for mothers and children, including delayed prenatal care, low birth weight, and developmental problems. Factors like age, education, and household wealth influence unmet need.[3] This study aimed to assess unmet need and its determinants among vulnerable populations in Ahmadabad's urban slums, slum-like, and non-slum areas.[4] The Urban poor have higher fertility, high

unmet need for family planning (FP) services.[5] Quality of FP services is now of a global concern and importance. A diagnostic quality of care assessment is based on structure, process and outcome of FP services.[6] Purpose of this study is to identify weakness and gap areas (shortcomings) in the FP services and to implement improvements.

Aims

- To identify the epidemiological determinants of unmet need for family planning among eligible couples in Ahmadabad
- To assess of U-PHC for provision of family planning services

Objectives

- To evaluate the prevalence and determinants of unmet need for family planning services among eligible couples residing in urban slums, slum-like, and non-slum areas of Ahmadabad, India
- To investigate the multifaceted factors influencing unmet need for family planning services, including knowledge, attitudes, and epidemiological determinants.
- To evaluate the structure, process, availability, and quality of family planning services, and conduct a gap analysis to identify areas for improvement.

MATERIALS AND METHODS

A community-based cross-sectional study was conducted among married women of reproductive age (15-49 years) residing in seven zones of AMC. Ethical approval was obtained from the NHL Institutional Review Board, and informed written consent was secured from each participant prior to enrolment. Confidentiality, privacy, and anonymity were ensured.

A Stratified cluster sampling was employed, with 30 clusters identified, comprising field practice areas of 30 Urban Health Centers (UHCs). A sample size of 900 was achieved by selecting 30 women from each UHC, stratified into slum, slum-like, and non-slum areas (10 women per stratum). Assistance from Accredited Social Health Activists (ASHA) workers facilitated participant identification.

A house-to-house survey was conducted to identify eligible women, with the first house in each cluster selected non-randomly. All eligible women in the first 10 households were interviewed, and in cases where no eligible women were found, the next household was approached. When multiple eligible women were present in a sampled household, one was selected randomly.

Data collection employed open-ended questionnaires administered through one-on-one interviews. Outcome variables included unmet need for family planning (sum of unmet need for spacing and limiting) and demand for family planning (sum of current family planning users and unmet need). Explanatory variables encompassed socio-demographic and economic factors, reproductive health factors, service utilization, contraceptive knowledge and use, informed choice in family planning, and opposition to contraceptive use."

Out of selected 30 U-PHCs, An Interview of MO and supervisor of 14 U-PHC from 7 zones of AMC (2 centers each) selected (Jodhpur, Sankalitnagar, Paldi, Ranip, Shahpur, Madhupura, Nava Naroda, Amraivadi, Meghaninagar, Krishnanagar, Maninagar, Kankaria, Ghatlodiya, New Gota) and filling up of observational checklists- to assess the quality of services, infra- structure, stock, avail methods.

The structure of the FP services was assessed using related observational checklists, including:
1) Availability of the services, with regard to the opening times signage and IEC of the services inside and outside of the building.
2) Physical environment of the services including the condition of waiting room, the counselling room, the privacy afforded and the examination room in regard to light, ventilation, water supply and seating arrangements.
3) Facilities including educational media, such as adequate storage of contraceptives, availability of contraceptives within the preceding six months, family planning forms or booklets, and the necessary equipment and instruments required for a family planning examination room

Inclusion criteria: All eligible couples belonging to selected clusters from different zones of Ahmadabad Municipal Corporation willing to participate in study.
Exclusion criteria: Not willing to participate in study, infecund women, women who were not legally married and who were critically ill during the survey period were excluded.

Operational definitions

Family planning
As per WHO Family planning is “A way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitude, and responsible decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country.”[6]

Another expert committee of WHO defined and described FP as follows: “Family planning refers to practice that help individuals or couples to attain certain objectives like,
• To avoid unwanted births
• To bring about wanted births
• To regulate the intervals between pregnancies

• To control the time at which births occur in relation to the ages of the parent and
• To determine the number of children in the family."
Eligible Couple (EC): Eligible couple is a newly married couple where in the wife is in the reproductive age group (15-49 years). They are documented in EC register. Each of such couple has to be identified and motivated to accept the family planning services in the interest of the health and welfare of the family and to overcome the hazards of population explosion.[7]

Met need for FP: Currently, married women using contraceptive methods.[7]

Unmet need for FP: Currently, married women of reproductive age who are not using any modern method of family planning but who would like to postpone the pregnancy/next pregnancy (unmet need for spacing), or do not want any more children (unmet need for limiting). The sum of the unmet need for limiting and unmet need for spacing is the total unmet need for family planning.[7]

Spacing between Births: Healthy spacing of 3 years improves the chances of survival of infants and also helps in reducing the impact of population momentum on population growth. SRS 2017 data shows that in India, spacing between two childbirths is less than the recommended period of 3 years.[7]

Total demand for FP: The total demand for family planning is the sum of unmet need and met need.[7]

RESULTS AND DISCUSSION

Out of 900 women 394 (44%) were using contraceptives from that 358 (40%) used for spacing and 36 (4%) for limiting, and 506 (56%) were not using any contraceptives. Among the non-users, 237 (26%) women want pregnancy and 269 (30%) neither wanted to become pregnant /postpone child bearing/didn't use any contraceptives (Unmet need). From these 269 women, 241 (27%) wished to delay (spacing) further pregnancies and 28 (3%) who didn't want to conceive, didn't want any further pregnancies (limiting) (Figure-1). Figures 2 & 3 show comparison with other studies. The total demand for family planning is the sum of unmet need and met need. In present study, out of the 900 eligible women, total demand for family planning among the married women was calculated as 663 (74%) [599 (67%) for spacing and 64 (7%) for limiting]. As per NFHS-5 total demand of FP for spacing (13.7%) and limiting (62.5%) in India and 15% and 5.9% in Gujarat respectively.[12] Girma Garo et al study conducted at Ethiopia in year of 2021 had total demand for family planning was 79% so in comparison to this, total demand for FP in present study is 5% less.[9]
Met need for FP is defined as currently married women using contraceptive method. In this study 394 (44%) couples out of 900 were effectively protected against the child birth by using various contraceptive methods which gives couple protection rate of 44%. This indicates the prevalence of contraceptive practices in the community. The current couple protection rate of India is 46%.[13]

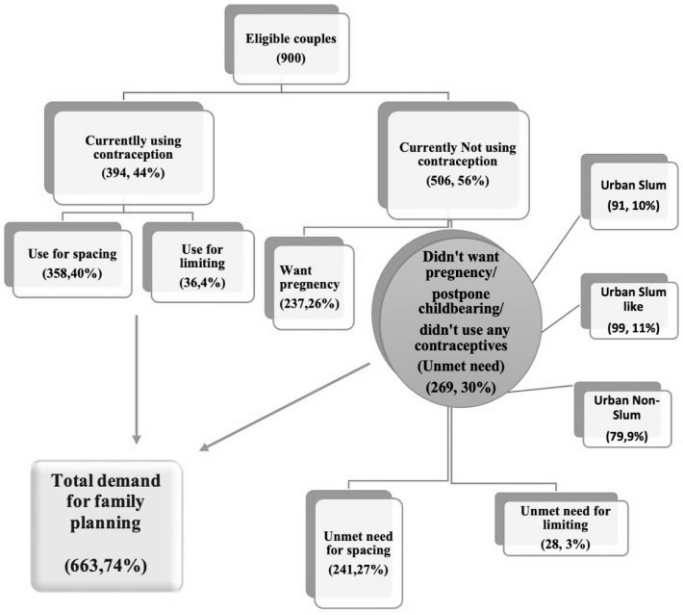

Figure-1: Unmet need and total demand of family planning

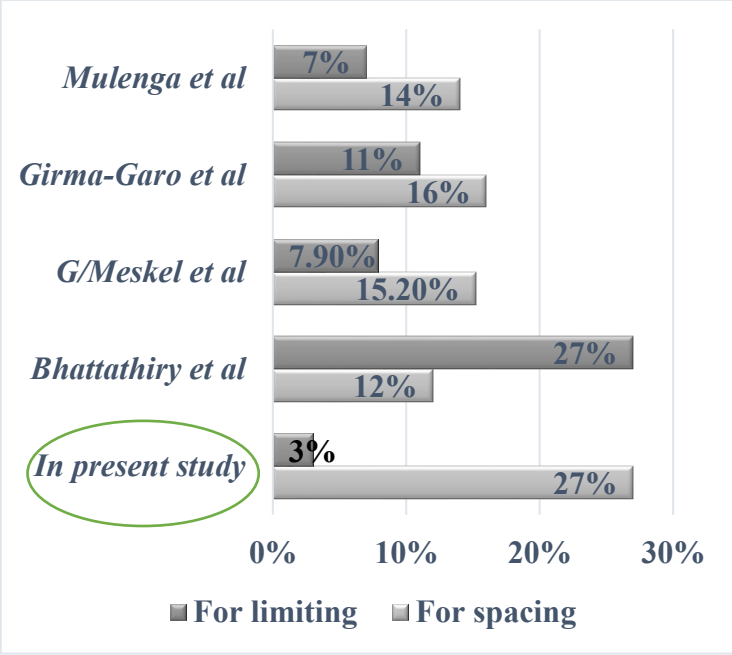

Figure-2. Unmet need found in various studies[8-11]

There are certain socio-demographic characteristics that are known to affect FP practices among eligible couples. They include respondents' residential area, age, cast, type of family, social class, television and mobile facilities at home,

number of children and place of delivery of last child, etc. (Table-1).

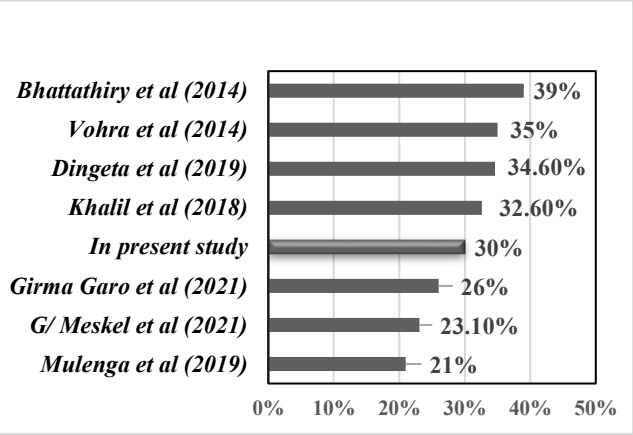

Figure-3: Comparison of unmet need for family planning[11,14,15,3,9,10,8]

Out of total 900 women, 237 wished to have children and therefore they were excluded from the analysis of contraceptive needs. All the following tables, therefore comprise of a total of 663 women. In present study out of 663, highest unmet need is seen in age group 26-32 years followed closely by age group 33-39 years and lowest in age group 19-25 years (Table-2). However, Bhattathiry et al had highest unmet need between 25 -29 years of age group.[11] Khalil et al had high unmet need amongst the women with age above 29 years.[3] Contraceptive non-use showed increasing trends with increase in age of women.

Out of 663, high unmet need seen in women having education of < 12th class compare to women have education of > 12th class and above, showing that unmet need is decreasing with increased level of educational status of women. Education seem to have important role in helping the couples to take decision regarding contraception. (Table-3) However, Bhattathiry et al study had decreases unmet need with > 12th class and above education.[11] Khalil et al higher level of unmet need is observed among women with lower education level.[3] Type of family with unmet need for FP had insignificant association. Out of 663, women belong to joint family (150,56%) had highest unmet need compare to nuclear family (119,44%), which can be due to interference of other family members leading to inability to take decision about FP. Unmet need is higher in women belongs to lower socioeconomic class (172,64%). Socioeconomic class had insignificant association and doesn't seems to have any role in helping the couples to take decision regarding contraception. Yadav et al study shows Unmet need was found to be high among women from lower socio-economic class in comparison to the women belonging to middle and upper middle class.[4] Dejene at al concerning the social class of the respondent, 38.4% of them were found under the upper class followed by the lower class 31.5%.[16] Vohra et al shows couples belonging to an upper class had an unmet need of only 19.44%, while the lower class had an unmet need of 49.31% which is high compare to upper class.[14]

Table-1: Socio-demographic characteristics of the study group (n=900)

Variables	Number	%
Age group (years)		
19-25	172	19
26-32	360	40
33-39	270	30
40-46	98	11
Mean age = 31.48 ± 6.67 SD		
Area		
Slum	300	33
Slum-like	300	33
Non slum	300	33
Cast		
General	227	25
Other Backward Classes (OBC)	353	39
Scheduled Castes (SC)	320	36
Education of Respondent		
< Class 12th	496	55
> Class 12th	404	45
Type of Family		
Joint family	509	57
Nuclear family	391	43
Social Class		
Upper	380	42
Lower	520	58
Television Available		
Yes	786	87
No	114	13
Mobile Available		
Yes	743	83
No	157	17
Total Number of Children		
< 2	770	86
> 2	63	7
Nulliparous Women	67	7
Desired Number of Children (Size of Family)		
0ne child	257	29
Two children	643	71
Place of delivery of Last Child		
Government facility	364	40
Private facility	469	52

Table-2: Association between age groups and unmet need (n=663)

Age (years)	Unmet need		Total	chi ($\chi 2$) square value	P value	Result
	Yes (n=269)	No (n=394)				
19-25	37 (18%)	75 (19%)	112	4.89	0.18	Not significant
26-32	97 (36%)	151 (38%)	248			
33-39	95 (35%)	120 (30%)	215			
40-46	40 (15%)	48 (12%)	88			

Table-3: Association between education and unmet need (n=663)

Education	Unmet need		Total	($\chi 2$) value	P value	Result
	Yes (n=269)	No (n=394)				
< Class 12th	159 (59%)	237 (60%)	396	0.07	0.78	**Not significant**
> Class 12th	110 (41%)	157 (40%)	267			

Table-4: Association between Television and Mobile and unmet need (n=663)

Variables	Unmet need		Total	($\chi 2$) value	P value	Result
	Yes (n=269)	No (n=394)				
Television						
Yes	191 (71%)	365 (93%)	556	55.29	<0.001	**Significant**
No	78(29%)	29 (7%)	107			
Mobile						
Yes	229 (85%)	360 (91%)	589	6.27	0.12	**Not Significant**
No	40 (15%)	34 (9%)	74			

Table-5: Association between message heard/seen on television and unmet need (n=663)

	Unmet need		Total	$\chi 2$ value	P value	Result
	Yes (n=269)	No (n=394)				
Have you heard /seen any message on television in last 6 months?						
Yes	88 (33%)	190 (48%)	278	15.79	0.0071	**Significant**
No	181 (67%)	204 (52%)	385			

According to Table-4, unmet need is significantly more in television and mobile users, it suggests that use of television and mobile can motivate couples to use contraceptive methods provided they view the concerned content. We have not asked in great detail the content that they view on television and mobiles. However, their role in helping couples to use more contraception can't be undermined, which is highlighted in Table-5.

Out of 663 respondents, non-use of contraceptives was found to be increasing with women with < 2 number of children compare to women with had > 2 number of children. In a study by Yadav et al, women who had one or two living children had high (88.0%) unmet need for family planning services.[4] More of the women with < 2 or more number of children were using contraceptives.

Women had high unmet need who delivered in private, compared to delivered in government facility, place of delivery of last child were significantly associated (Table-6). Those women who delivered in private facility were not counselled and aware about FP methods and according to some of the women expenses for utilizing FP methods were high compare to government where it is available free of cost with incentives. In a study by Vohra et al, women 40.76% who took services from the government health facility had an unmet need, in comparison to 75% women who took services from a private health facility.[14]

Table-6: Association between place of delivery of last child and unmet need (n=643)

Variable	Unmet need		Total	($\chi 2$) value	P value	Result
	Yes (n=263)	No (n=380)				
Place of delivery of last child						
Govt. facility	100 (38%)	176 (46%)	276	4.36	0.36	**Not Significant**
Private facility	163 (62%)	204 (54%)	367			

In present study, the age of women at marriage was found to be 18-23 years and 24-30 years. Most of the women were married by the age of 18-23years, followed by 24-30 years, and insignificantly associated. Which depicted that those women who have younger age at marriage have higher unmet need. Almost all women's age at the birth of first child was found to be 18-27 years and some of women was aged is 28-37 years with insignificant association. which means that those who have younger (18-27) age at first child have higher unmet need either of poor knowledge, awareness about contraceptives or dilemma of selecting and usage of FP methods.

Residential area (slum, slum-like, non-slum) of respondents were significantly associated with respondent's age at marriage as well as at first child. Majority of women who were living in slum and slum like area have younger age at marriage and at 1st child birth (Table-7). When a couple has younger age at marriage and as well as at birth of first child,

their active married life is comparatively longer in normal circumstances so, their FP needs may be higher compared to others who have a higher age at marriage as well as at first child. In present study particularly slum and slum like population has significantly higher number of couples who have younger age at marriage and at first child. So, area specific FP needs must be addressed.

Table-7: Respondents age at 1st child (n=833)

Area	18-27 years	28-37 years	Total	χ^2 and p value	Result
Slum	285 (98%)	6 (2%)	291	212.25, < 0.001	**Significant**
Slum-like	271 (94%)	16 (6%)	287		
Non-slum	143 (56%)	112 (44%)	255		
Total	699 (84%)	134 (16%)	833		

Table-9 shows that those couples who belong to unmet need group have significantly poorer knowledge about FP and contraception. This reflects rather the poor understanding of FP and contraception has contributed to their unmet need.

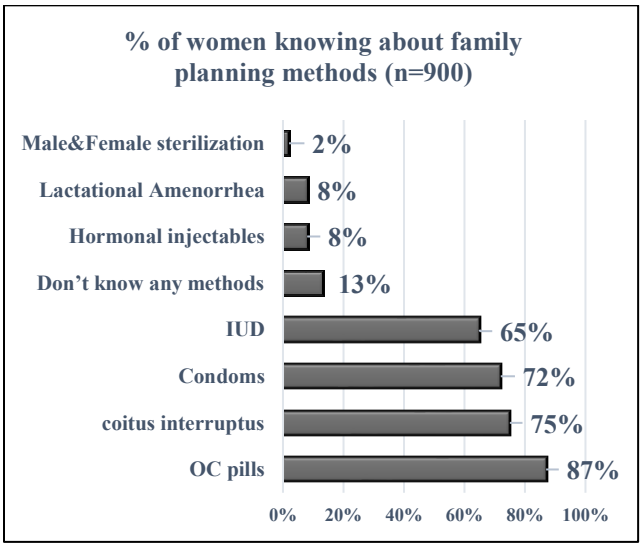

Figure-4: Respondents knowledge about different FP methods

In present study majority of women know about Oral Contraceptive pills, coitus interruptus, condoms, and IUDs. Some of them didn't know any contraceptive methods and some women were unaware about Hormonal injectables, lactational amenorrhea, male & female sterilization (Figure-4). Dingeta et al shows that they knew about Injectable (82.9%), implants (77.8%) and pills (60.5%) most commonly while only 145 (4.9%) knew intrauterine contraceptive device (IUCD).[15] This difference between the two studies may be because of the difference in common contraceptive practices among the countries.

Contraceptive methods were known by sources like, media, health facility, community source significantly associated to unmet need. Vohra et al shows Exposure to mass media and health facilities services provider were found to be statistically significant predictors of the unmet need.[14]

Table-8: Knowledge of respondent about family planning (n=900)

Variables	Number	%
Women's knowledge about JSY		
Yes	13	1.44
No	887	99
Women's knowledge about any government program for family planning		
Yes	171	19
No	729	81
Women's knowledge about any places where FP services are provided free of cost		
Yes	237	26
No	663	73
Did you get any education about Family Planning before you got married?		
Yes	432	48
No	468	52
Advantage of having small family		
Yes	685	76
No	215	24
Disadvantage of having small family		
Yes	183	20
No	717	80
Advantage of having small family		
Child attention	103	11
Education	678	75
Quality of living	666	74
Disadvantage of having small family		
Child pampering	149	17
Over attention seeking	34	4

Out of 663, Planning and discussion about the number of children and spacing with their husband and with anyone else higher unmet need (Table-10). The association of husband's attitude was found to be statistically significant with contraceptive non users. Favorable attitude of husband towards discussion but still they have higher unmet need compare to those women whose husband is disagree and those who didn't discuss with their husband. Reasons behind non users were hesitation, shyness and

embarrassment found in more than half of women. Yadav et al women with husbands having a favorable attitude were found to be less likely to have an unmet need as compared to women whose husband had an unfavorable attitude.[4]

More than half of women have higher unmet need although they were motivated for using contraception which Shows that motivation to use contraceptives had insignificant association. Yadav et al shows 13.9% of the women who were motivated to use contraceptive methods had an unmet need.[4] Motivation and encouragement towards use of contraceptives among non-users doesn't seem to be fulfilled.

Table-9: Association between knowledge of FP and contraceptive needs (n=900)

Score	Unmet need	Met need	No need	Total	$\chi 2$ and P value	Result
Poor	97 (36%)	86 (21.8%)	31 (13%)	214	43.90, <0.001	Significant
Average	165 (61.3%)	294 (74.6%)	204 (86%)	663		
Good	7 (2.6%)	14 (3.5%)	2 (0.7%)	23		
Total	269	394	237	900		
Score: - < 3 = poor, 4-6 = average, > 7 = Good						

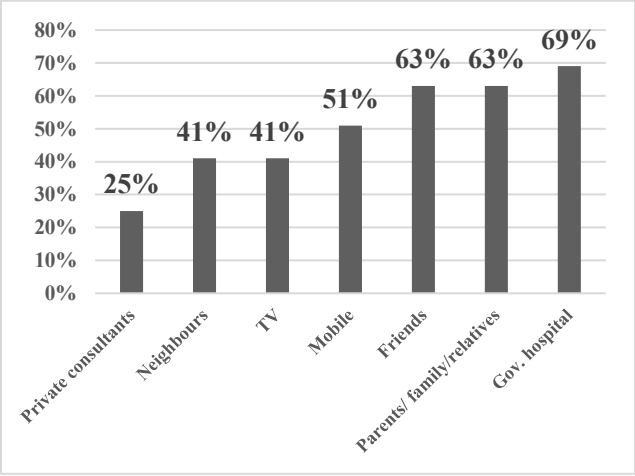

Figure-5: Source of knowledge of FP methods (n=900)

Autonomy of women was present while taking decisions at their home. Major decisions about how earned money will be used, health care facility utilization, and major household purchases taken by both husband and wife jointly. The factors which is associated towards usages of contraceptives like they wish to have children, infrequent sex, and fear of side effects were stood out as major reasons for non-use of FP methods among women with unmet need.

Table-10: Attitude of the respondents about family planning (n=900)

Variables	Number	%
Discussion about the number of children and spacing with your husband		
Yes	574	**64**
No	326	**36**
During discussion your husband's attitude towards number of children and spacing		
Strongly Agree	215	**24**
Agree	304	**34**
Strongly disagree	55	**6**
Did you discuss about these matters (the number of children and spacing) with anyone else?		
Yes	531	**59**
No	369	**41**
Discuss about the number of children and spacing with anyone else		
mother/mother-in-law	460	**51**
sister/ sister-in-law	420	**47**
friends	214	**24**
neighbors	40	**4**
health professionals	46	**5**
Did anyone motivate to use contraceptives		
Yes	549	**61**
No	351	**39**
Motivation of using contraception given by		
family members	639	**71**
friends	344	**38**
neighbors	3	**0.33**
health professionals	40	**4**

Modern contraceptive methods utilized by respondents were condoms followed by COC pills, and IUDs are available at U-PHCs of their respective zones. All most all of respondents were thought that they would use/ continued to use any contraceptive method to delay or avoid getting pregnant at any time in the future, but some of respondents expressed no intention to use any contraceptive methods in the future because of fear of side effects of method and self

not willing. Some of women were done requesting abortion. Reasons for requesting abortion shown in (Figure-8).

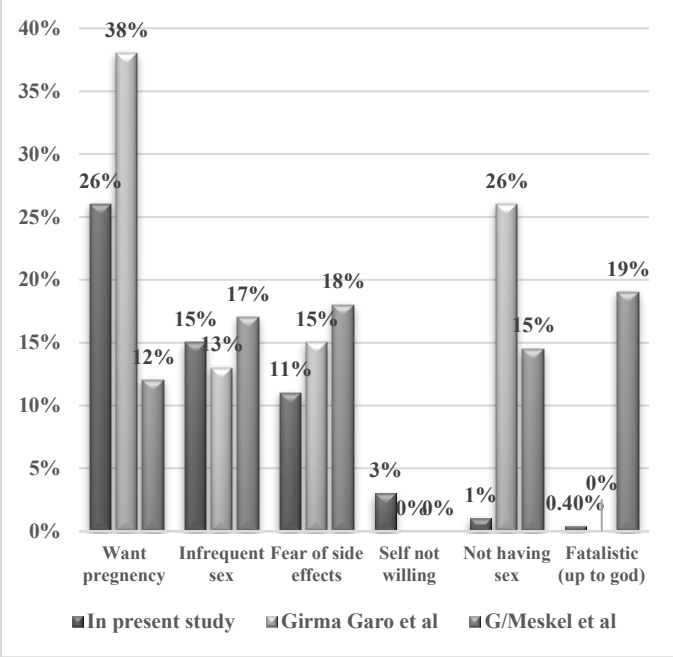

Figure-6: Reasons for not using any modern contraceptives currently (n=506)[9,10]

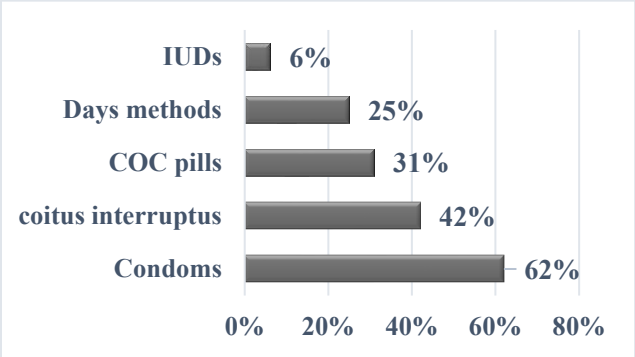

Figure-7: Percentage of women utilizing family planning methods (n=394)

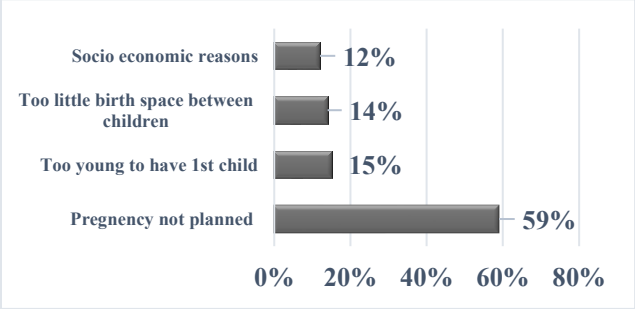

Figure-8: Reasons for women requesting abortion (n=109)

Utilization of health services

Among all 900, half of respondent's nearest health facility was government hospitals, almost all women know about UPHC in their locality. Health services were aware and that utilized by respondents. In present study, during field visits of ANM in last three months, ANM was providing information/services about FP and different matters discussed according to respondents. There was minimum discussion about incentives of FP, importance of ideal age at marriage and at first child as can be seen in Figure-9. Most appropriate person for imparting education regarding FP were ANM and ASHA according to respondent.

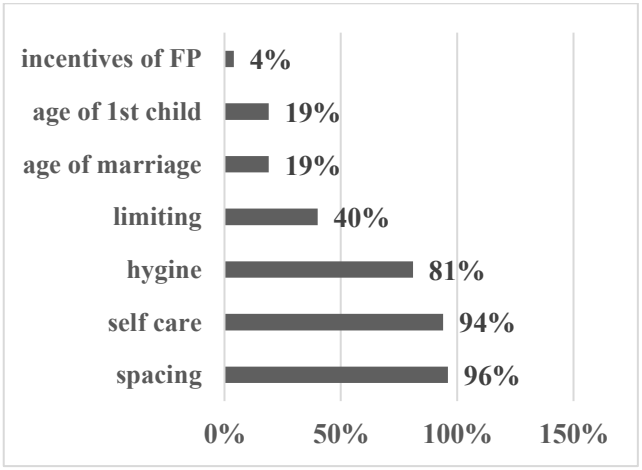

Figure-9: Services provided by ANM visit (n=900)

All the above-described facilities were provided through U-PHCs of respective zone. For that the quality of services, infra- structure, stock, available methods for FP at UPHC were assessed.

Good practices among U-PHC were following:

• FP services are being offered in selected 30 U-PHCs since (6-40) years for 8 hours daily.

• The catchment population is mapped and surveyed on regular basis at all selected UPHC's.

• Infrastructure, staff and maintenance of records are adequate.

• All 30 centers had organized on an average 83 health and nutrition day every month, FP and methods of contraception were discussed by ANM.

• Medical officers were aware about the referral system and referred cases when needed.

• All the methods are in stock and stock is replenished on monthly basis

Almost all selected U-PHCs had available services regarding FP, PNC, growth monitoring, immunization, referral to higher centers. Services like ANC, and PAC were found poor at some of the selected centers. ANC were referred to UHC affiliated MoU (memorandum of understanding) hospitals because of lack of Obstetrics &

Gynecology consultant, however antenatal examination facility was in place at all UHCs. So, if medical officers are trained adequately, these services can be provided at UHCs themselves.

Of all, 97% UHCs had good conditions of building and compound, adequate light, total space & work space were adequate, waiting area had adequate space and shelter, FP booklets & leaflets, 93% UHCs had adequate ventilation and provision of self service for condom distribution & had display board with timing of UHC, 90% UHCs had separate room for IUCD insertion, 77% UHCs had separate room for FP counselling/ services (Figure-11).

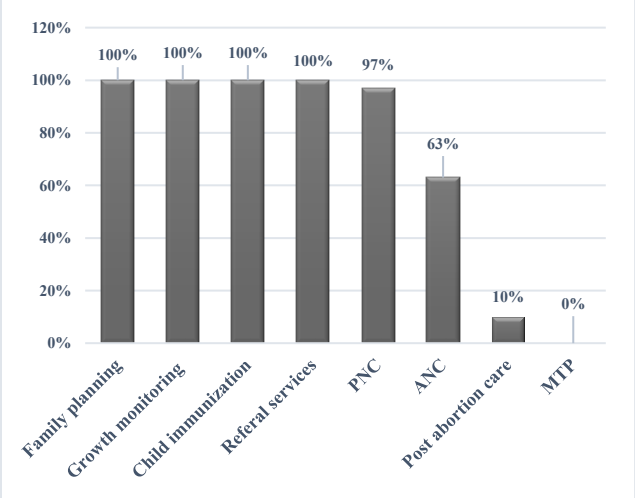

Figure-10: Services available at U-PHCs (n=30)

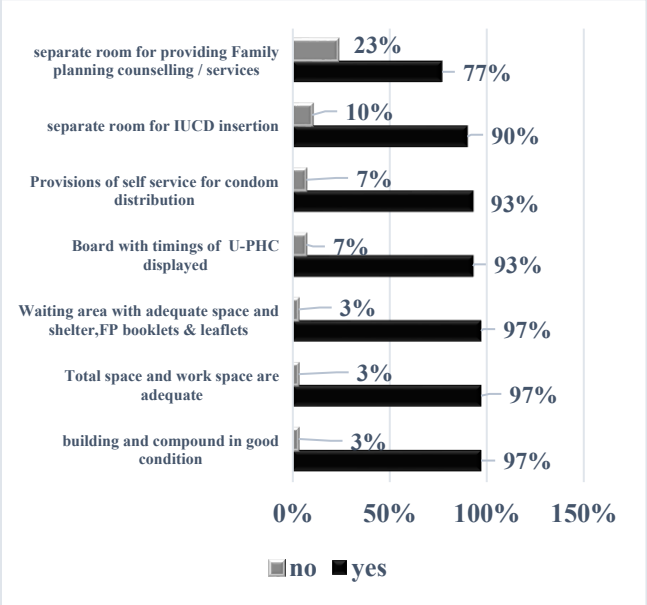

Figure-11: Infrastructure availability at U-PHCs (n=30)

All Selected UHCs had adequate stocks and equipment. Most of UHCs had and Functioning antibiotics, antiseptics, cotton swabs, clean gloves, > 10 Copper-T sets, scissors, and some UHCs did not have (Figure-12) Male condoms and OC pills were distributed at center, in filed by 97% and 100% of UHCs respectively, and IUDs, Injectables, Emergency contraceptives were distributed only at 26%, 13%, 30% of UHCs respectively. Figure-11 depicts that there were separate room for IUD insertion in 90% of UHCs but only 26% IUCDs were inserted at center. There were only 13% of UHCs, where outside supervisors visited the facility in last 6 months and counselling about male sterilization were discussed at 90% of UHCs.

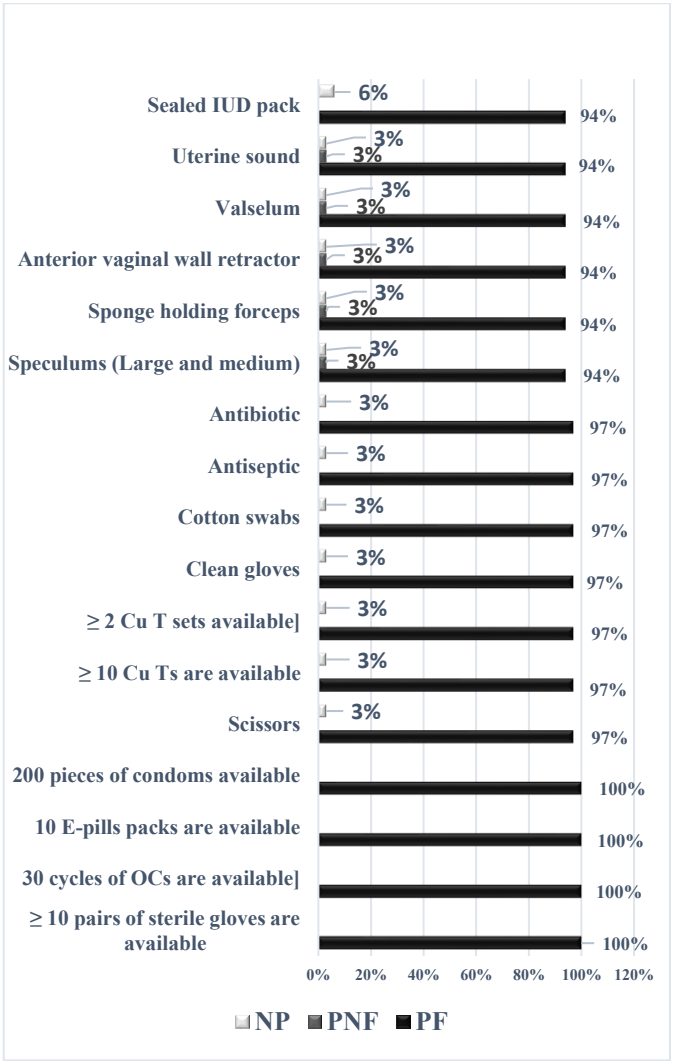

Figure-12: Stocks and equipment available at U-PHCs

CONCLUSION

This cross-sectional study, conducted among 900 married women of reproductive age in urban Ahmedabad, assessed the prevalence and determinants of unmet need for family

planning (FP). The study revealed a 30% prevalence of unmet need for FP, with 27% for spacing and 3% for limiting. Socio-demographic factors associated with unmet need included age (26-32 years), education (< 12 years), and joint family structure. Knowledge and awareness about FP methods and services were poor, with 81% of women unaware of government FP programs.

Health facility assessments revealed inadequate infrastructure and services, including lack of waiting rooms, condom distribution facilities, and male sterilization services. Supervision and counselling services were also found to be poor. The study highlights the need for targeted interventions to address the unmet need for FP, improve knowledge and access to FP services, and strengthen the quality of care provided by Urban Primary Health Centers (U-PHCs). Some of the services like waiting room, provision of self service for condom distribution were not available in few centers. Supervision found to be poor in all selected U-PHC's. Non scalpel vasectomy and its counselling were not performed actively.

Key findings

• Poor knowledge about FP methods and services
• Ineffective use of television and mobile facilities for FP promotion
• Beneficiaries were having limited awareness about government FP programs and incentives
• Inadequate FP counselling and services at some of Urban Primary Health Centers (U-PHCs)

Recommendations

- Regular visits by family planning (FP) service providers and counselling on method usage are essential, particularly in slum and slum-like areas.
- Targeted counselling and motivation to use contraceptives should focus on younger age groups.
- Mass media campaigns should promote FP programs, schemes, and methods.
- Efforts should be made to address issues related to intrauterine device (IUD) and injectable contraceptive use.
- Male and female sterilization should be encouraged for limiting family size.
- Healthcare providers should encourage men's involvement in FP decision-making and provide joint counselling to couples.
- The health sector should promote integrated healthcare services to improve FP utilization and reduce unmet need.
- Education and awareness programs should focus on promoting women's empowerment, FP education, and awareness about government incentives and free contraceptive services.
- Training programs for healthcare workers should emphasize interpersonal communication skills to address myths and misconceptions about contraceptive use.
- Regular supervision, monitoring, and follow-up services are essential to improve the quality of FP services and organize community awareness programs.

Limitations: A limitation of the present study was the inability to incorporate the male partners of eligible couples due to the survey's timing, which precluded their participation on the designated day. Consequently, their perspectives, attitudes, and related factors could not be assessed or analyzed, representing a notable gap in the study's scope.

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