International Journal of Preventive, Curative & Community Medicine
Volume 11, Issue 1&2 - 2025, Pg. No. 16-27
Peer Reviewed & Open Access Journal

Research Article

Barriers to Satisfy Unmet Needs for Family Planning among Married Women of Reproductive Age in a Rural Community of Nepal: A Qualitative Study

Anjwani Rimal[1], Samyog Uprety[2], Anup Ghimire[3], Nilambar Jha[4], Sailesh Bhattarai,[5] Bipul Bikash Singh[6]

[1,6]Junior Resident, [2,4]Professor, [3]Professor & Chief, [5]Associate Professor, School of Public Health and Community Medicine, BPKIHS, Dharan, Nepal

DOI: https://doi.org/10.24321/2454.325X.202504

I N F O

Corresponding Author:
Anjwani Rimal, School of Public Health and Community Medicine, BPKIHS, Dharan, Nepal
E-mail Id:
rimalanjwani2019@gmail.com
Orcid Id:
https://orcid.org/ 0009-0000-4163-186X

How to cite this article:
Rimal A, Uprety S, Ghimire A, Jha N, Bhattarai S, Singh B B. Barriers to Satisfy Unmet Needs for Family Planning among Married Women of Reproductive Age in a Rural Community of Nepal: A Qualitative Study. Int J Preven Curat Comm Med. 2025;11(1&2):16-27.

Date of Submission: 2025-03-25
Date of Acceptance: 2025-04-30

A B S T R A C T

Introduction: The rising population is a major concern in developing countries like Nepal. Family planning methods are available for controlling the choice of reproduction but their use is limited to certain women. The percentage of women of reproductive age who want to stop or delay childbearing but are not using any method of contraception is known to have an Unmet need for family planning.

Objective: To understand why married women are not using family planning methods in rural Nepal.

Methods: Three focus group discussions were conducted with 24 women in three communities (Muslim, Musahar, and Mixed) of Gadhi rural municipality in Nepal. Notes and audio recordings in the Nepali language were recorded and then transcribed into English to facilitate the analysis. The thematic analysis technique was used for data analysis, focusing on identifying recurring ideas, patterns, and concepts that naturally emerged from participant's discussions with imposing predetermined categories.

Results: The participants in all three communities knew what family planning meant and why it was necessary. They were also aware of the common family planning methods. However, reluctance to discuss condoms due to shyness, and not involving males in field visits was observed.

Conclusion: There was a high unmet need for family planning among married women of the Gadhi rural municipality of Nepal which sheds light on the importance of family planning. The study highlighted the knowledge and attitude regarding family planning methods, the role of female community health volunteers in family planning, and challenges in accessing health services. Additionally, it highlights the in-depth reasons for not using the family planning method, which leads to unmet needs.

Keywords: Focus Group Discussion, Contraception, Unmet Needs, Reproductive Age, Female Community Health Volunteers

Introduction

Millions of women worldwide would prefer to avoid becoming pregnant either right away or never getting pregnant but are not using any contraception. These women are said to have an "unmet need" for family planning (FP). The concept of unmet need points to the gap between some women's reproductive intentions and their contraceptive behavior.[1,2] These women are most likely to be interested in contraception but did not use it. The challenge for FP is to reach and serve these women .[3] Globally, 50 million women resort to induced abortion, which ultimately results in high maternal morbidity and mortality. Thus, family planning and spacing among births are important methods to avoid these deaths .[4] Unmet need is not only limited to whether women/ husbands were not provided with family planning facilities; it also means that provided services have not been introduced as a motivating source to women due to a lack of adequate information and quality services.[5]

Unmet need is often portrayed as a problem of access, leaving the perception that women do not use contraceptives because they cannot find or afford them or they have to travel too far to get them. But while access is an issue, women have many other reasons for not using family planning, including personal, cultural, or religious objections, fear of side effects, health concerns, and lack of knowledge.

In South Central Asia and Southeast Asia, the proportion of women with unmet needs is lower at 18% and 14%, respectively. However, although Asia has lower proportions of women with unmet needs, the size of the population is larger than in other regions. As a result, more than 100 million women in South Central and Southeast Asia have an unmet need.[6]

Twenty-one percent (21%) of currently married women in Nepal have an unmet need for family planning services, including 57% using contraceptives making it 78% of currently married women who have a demand for family planning. Thus, if all married women who said they wanted to space or limit their children were to use family planning methods, the contraceptive prevalence rate would increase from 57% to 78% [7] The analysis revealed that unmet needs in Nepal have not changed much from 24.7% in 2006 to 21% in 2022.[8]

Despite extensive family planning programs, the unmet need for family planning is still high. It shows the gap between women's reproductive intentions and their contraceptive behaviour. A few studies done on this topic so far are mainly focused on urban areas, so this study was planned to provide an understanding of various barriers to unmet needs of family planning in a rural part of Nepal. The study findings could assist concerned authorities at various levels of the governing body in focusing and putting their efforts into factors responsible for the unmet need.

Methods

Gadhi is one of the rural municipalities out of 6 rural municipalities located in the Sunsari district of Koshi Province, Nepal. The duration of this qualitative study was one year (July 2023–July 2024). A purposive sampling technique was used to choose the participants. Among 102 participants with unmet family planning needs identified in the study area, 24 were chosen. Three focus group discussions were carried out in three different communities i.e., the Muslim community, the Musahar community, and the Mixed community of the Gadhi rural municipality. Women whose husbands had died, separated/ divorced, or those who had undergone a hysterectomy were excluded from the study.

To ensure the availability of women during the study, coordination was done with the female community health volunteers (FCHVs), and repeated phone calls were made to remind them about the time and venue selected for the data collection.

Focus group discussion was carried out with married women of the reproductive age group of 15–49 years who had an unmet need for family planning. Each FGD lasted for an average of 40 minutes until no new information emerged from the discussions. The discussion was based on the FGD guidelines after which several themes emerged i.e. fundamental knowledge and awareness regarding family planning, perceived appropriate number of children and the ideal gap between two successive children, availability and accessibility of family planning methods, the reason for not using family planning methods, and decision maker of family planning.

Guidelines and open-ended questions were developed and validated. For this, adequate literature was reviewed. The FGD guidelines were checked and verified by experts in community medicine. Subsequently, the guidelines were tested for coherence and flow and necessary modifications were made.

Interviews were initially conducted in the Nepali language. Subsequently, notes and audio recordings were transcribed into English to facilitate the analysis. The thematic analysis technique was used for data analysis, focusing on identifying recurring ideas, patterns, and concepts that naturally emerged from participants' discussions with imposing predetermined categories.

Ethical clearance was obtained from the Institutional Review Committee (IRC), of BPKIHS (Ref. No. 61/080/081-IRC, Code NO: IRC/2565/023). Study permission was taken from the Gadhi municipal office, Sunsari before the start of the study. Informed written consent was taken from the participants before the start of data collection. All the information about the respondents in the study was

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

kept confidential and the data obtained won't be used for any purpose other than research. The participants were assured of confidentiality and they had full authority to accept or refuse to take part in the study. Prior to initiating the interview, the research was clearly explained to the participants and informed consent was obtained for audio recording and notetaking.

The internal validity of the data collection method was rigorously maintained by restricting access to the study environment to any individual not directly going to be a part of the study. The only exceptions were the participants` infants and a Female Community Health Volunteer (FCHV) in the FGD held in the Muslim community, whose role was limited to facilitating the session. To prevent any external influence, if an interruption occurred or onlookers approached the study site, they were courteously asked to leave, ensuring the integrity of the research process remained intact. Additionally, any socially influential individuals who could influence the participants' responses were politely requested to stay away. To revive dying-out discussions, new questions were introduced based on the initial responses, and participants who kept silent were encouraged to share their perspectives openly without feeling pressured or influenced by other members, thus ensuring honest participation from all members.

Each FGD started with a warm greeting and the researcher`s introduction, followed by explaining the purpose of the study and requesting the participants to introduce themselves.

Results

Table 1 represents the sociodemographic characteristics of respondents who participated in the first Focused Group Discussion (FGD) conducted in the Muslim community inside the Masjid premises of Ward No. 2. The participants' ages ranged from 22 to 41 years. The majority of the participants were illiterate and homemakers.

Table 1.Sociodemographic Characteristics of Respondents in Focus Group Discussion 1

Code	Age in Years	Education	Occupation
F1	40	Illiterate	Homemaker
F2	37	Primary	Labour
F3	41	Illiterate	Homemaker
F4	32	Secondary	Homemaker
F5	29	Primary	Labour
F6	22	Secondary	Homemaker
F7	26	Literate	Homemaker

Table 2 represents the sociodemographic characteristics of respondents who participated in the second Focused Group Discussion (FGD) conducted in the Musahar community in Ward No. 1. The participants' ages ranged from 19 to 28, with a majority of the participants educated up to the primary level and homemakers by occupation.

Table 3 represents the sociodemographic characteristics of respondents who participated in the third Focused Group Discussion (FGD) conducted in the Mixed community in Ward No. 5. The participants' ages ranged from 28 to 40 years. The majority of the participants had education up to the primary level, and most of them were homemakers by occupation.

Table 2.Sociodemographic Characteristics of Respondents in Focus Group Discussion 2

Code	Age in Years	Education	Occupation
F8	19	Primary	Homemaker
F9	22	Primary	Homemaker
F10	20	Illiterate	Homemaker
F11	26	Secondary	Labour
F12	20	Can only read and write	farmer
F13	20	Primary	Homemaker
F14	23	Secondary	Homemaker
F15	25	Primary	Homemaker
F16	28	Can only read and write	Labour

Table 3.Sociodemographic Characteristics of Respondents in Focus Group Discussion 3

Code	Age in Years	Education	Occupation
F17	32	Can only read and write	Homemaker
F18	39	Primary	Homemaker
F19	36	Secondary	Homemaker
F20	29	Primary	Homemaker
F21	34	Primary	Homemaker
F22	40	Illiterate	Homemaker
F23	37	Can only read and write	Homemaker
F24	28	Secondary	Labour

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

Table 4.Themes and Sub-Themes of Qualitative Analysis

Themes	Sub-Themes
Fundamental knowledge and awareness regarding family planning	Economic and financial concerns
	Impact of having many children on women's health
	Religious and cultural beliefs
	Historical perspectives
Perceived appropriate number of children and the ideal gap between successive children	Necessity of having sons
	Preference for sons over daughters
	Shift in family dynamics based on the gender of the children
	Risks associated with having only one son
Knowledge and attitudes on different family planning methods	Diverse awareness and attitude
	Negative views toward male sterilisation
	Reluctance to discuss condom
Availability and accessibility of family planning methods	Easy availability
	Adoption of family planning methods secretly by women
	Assumptions of FCHV hoarding or possibly selling oral contraceptive pills
Reasons for not using/ Discontinuing family planning methods	Significant side effects
	Cultural beliefs and practices
	Lack of support from husbands and in-laws
	Cultural norms and beliefs about masculinity
	Low perceived risk of unwanted pregnancies
	The perceived potential harm of contraception to breastfeeding children
Decision-maker of family planning	Mutual understanding between husband and wife
	Predominantly husbands in the Muslim community
Role of FCHVs in family planning	Inconsistent visits
	Lack of comprehensive FP counselling
	Visits mostly to recent postpartum women
	Gender-specific communication

In each FGD, various themes were discussed, following which sub-themes for each theme were generated after the study (Table 4).

Theme 1: Fundamental Knowledge and Awareness Regarding Family Planning

The responses for this theme showed that family planning knowledge and awareness varied across the groups.

The Muslim community is known to be a bit reserved regarding controlling spontaneous childbirth and considering the child-giving role to be religiously guided. The discussion among the participants revealed that some of the participants in the Muslim community had a lack of awareness of the term 'Family Planning' (*Pariwar Niyojan*). However, when one participant mentioned it is a way to prevent having children, they all seemed to understand its meaning.

A participant (F1) from the Muslim community stated, *"I have not heard about this"*, after which another participant (F2), said, *"It is done to stop children."* Then, (F1) stated, *"Oh! That I know. Female health volunteers come now and then to tell us about it."*

Then, all the other participants nodded, indicating that they knew about it. However, in both the Musahar and the Mixed communities, all participants had heard of the term 'Family Planning'.

Probing into the reasons for the need for family planning, economic and financial concerns were apparent from the discussion of all three communities as a prime reason for the importance of not having too many children. The responses from all three communities emphasized the possible difficulties of providing facilities for many children due to economic constraints.

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

A participant (F7) from the Muslim community said, *"The more children we have, the more difficult it becomes to feed them, send them to school, and buy clothes and shoes for them. How can we do that?"*

A participant (F17) from the Mixed Community stated, *"With fewer children, we can save more money, maybe start a small business to support the family, and maybe even buy some land."*

Another participant from the Mixed community also exclaimed, *"Yes, if there are many children, we have to divide the land between all the children when they grow up. That way, everyone gets only a little share."*

Furthermore, a statement regarding dowry practice leading to financial constraints emerged from the discussion where a participant (F9) of the Musahar community mentioned, *"Not only that, some parents really suffer, because in the hope of getting a son, they have many daughters, and they have to give dowries for those daughters at the time of marriage. It can be very difficult in that situation."*

Additionally, the impact of having many children on women`s health was a common concern in mixed and Muslim communities. A participant (F22) from the Mixed community mentioned, *"Having too many children can make a woman`s body weak. A lot of mothers die while giving birth to children,"* while a participant (F6) from the Muslim community said, *"Yes, even my mother-in-law has 7 children. Look at her. Her womb has come out now" (She now has uterine prolapse).*

However, the Muslim community differed from the other 2 communities in their religious and cultural beliefs regarding family planning.

One participant (F3) from the Muslim community highlighted religious prohibitions against Family Planning, mentioning, *"Yes, but our religion doesn't allow it. It is strictly not allowed for us. I do not consider our women who use these things to be doing something good."*

A majority of other participants agreed with this statement, indicating a cultural resistance to family planning within the community. A participant from the Musahar community reflected on the lack of family planning in previous generations and its impact on poverty. She mentioned, *"Look at our mothers and in-laws. There was no method available at that time, so they had lots of children. Because of that, they were always in poverty."*

A participant in the Mixed community referenced the differences between past and present needs and expectations for children`s upbringing, mentioning, *"It is not like the time of our forefathers when everyone had many children, and there was no need to go to school. They ate little and wore little. My granddad used to tell me that he only got new clothes once in two or three years when he was a child. But children these days are not like that. They need many things, and everything is so expensive".*

Thus, economic constraints, cultural and religious beliefs, health concerns, and the perspectives regarding the requirements of the children of this generation in comparison to the previous generations were the major reasons cited for the need for family planning across these communities.

Theme 2: The Perceived Appropriate Number of Children and the Ideal Gap between Successive Children

Participants across all three communities expressed their opinion that one or two children are optimal for providing the best care, attention, and resources.

However, all three communities emphasised the necessity of having sons. Sons were seen as essential for carrying on the family name and providing long-term support, safety, and security to parents.

(F7) from the Muslim community stated, *"These are all nice things to say, but our lives don't work like that. What to do? Even though we know up to 2 children are good, we must have at least one son so that he can bear all the family responsibilities and continue the generation and name of the family. If we get a daughter, we still keep having children, hoping to get a son."*

A participant (F6) stated, *"Even though we know that bearing too many children is not good for health and might become difficult to take care of them initially, they are our only hope for the future. If we bear enough children, when we get old, one or another child is always available to take care of us, and if all children earn money, it might remove our poverty".*

There also seemed to be a preference for sons over daughters. Both the Musahar and the Mixed communities also highlighted significant family and societal pressures related to having sons, highlighting a conflict between personal wishes and external expectations.

(F10) from the Musahar community stated, *"I already have 2 daughters, and I don't want more, but my family members and my husband want more children from me. They told me that one son must be there."* (F23) from a mixed community stated, *"A son stays with you lifelong, but a daughter, you have to give away and send to another family. A family is always weak without a son."*

(F2) from the Muslim community stated, *"Not only about our family but if we don't have a son, then our society will not look at us in a good way. Everyone, including our relatives, will ask now and then, when are you planning to have another child? So, for the sake of society also we need to have a son".* Two participants from the Musahar community also highlighted that the birth of a son could lead to better treatment from in-laws, indicating a shift in family dynamics based on the gender of the children.

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

Furthermore, in the Muslim community, there was a strong concern about the risks associated with having only one son, such as accidents or illness leading to the loss of the son.

A participant (F2) said, *"Yes, the only son of [mentions the name of a woman] in Brahmin tole died because of an accident, lost a lot of blood, and died on the spot. I feel very sad for the couple. Now, they have no child. Who will look after them when they become old?"* [with a serious expression on her face].

In the Mixed community, there was a strong cultural emphasis on the necessity of sons for performing rituals after their parent's deaths and providing lifelong support.

(F14) said, *"It's not about one or two children; it's about whether you have a son or not. If we are unable to give birth to a son, we need to conceive. There will be no one to do our rituals after death if we do not bear the son. It is a son who gives fire to your body at your funeral"*.

Thus, sons were seen as a vital part of family stability, ensuring lifelong security, both for economic reasons and long-term support, and were considered more capable than daughters for these purposes. Additionally, they were seen as vital for performing death rituals.

In the above discussion, the participants articulated an ideal scenario where having fewer children was seen as beneficial for economic reasons, health, and quality of life. This perspective reflected a rational and pragmatic approach to family planning. However, the responses that came out of the third theme revealed a more complex reality where personal preferences are often overridden by societal and family pressures. The strong cultural emphasis on having sons and the fear of social stigma played a dominant role in the actual decision-making process regarding family size. Thus, this highlights the challenge of changing deep-seated beliefs and practices even when there is awareness of the benefits of smaller family sizes.

This necessitates more targeted interventions and education to address and balance these conflicting influences, promoting family planning practices that align with personal well-being and societal change.

Regarding the spacing between pregnancies, participants in all communities acknowledged the importance of spacing pregnancies for the health and well-being of the mother and child. Suggested gaps ranged from 1 to 4 years, with a consensus of around 3–4 years being ideal. Statements from the Muslim community:

(F2) said, *"They say it should be 3–4 years but I think 1 year will be good. Both the children can grow together and be like friends"*

(F9) from the Musahar community: *"…. But it is good to have a lot of time between the two pregnancies, maybe 3 or 4 years".*

Thus, there was adequate knowledge about the appropriate birth spacing duration between subsequent pregnancies in all three communities.

Theme 3: Knowledge and Attitudes on Different Family Planning Methods

All communities were aware of the common family planning methods such as oral contraceptive pills, Depo-Provera, and, to some extent, condoms.

Responses from the Muslim community:

(F7) mentioned, *"Yes, I used to use pills and, after that, the three-month injection."*

(F5) from the Musahar community [pointing at her left arm with her right index finger] said, *"I put a pill (Goti) in my arm 3 years back."*

Only 1 participant (F18) belonging to the Mixed community stated about condoms, *"for males, dhaal is used".*

It was surprising that most of the participants did not mention "condoms" as a way of family planning method on their own unless prompted. There was shyness and hesitation while talking about it. Thus, it was unknown to the full scale whether the couples relied upon condoms as a method of family planning.

In the Musahar community, when asked if they knew about condoms, some were giggling, some bending their heads, some had shy expressions on their faces, and one participant covered her face with her saari in shyness.

After asking each specific participant also, they were reluctant to talk about condoms.

Only 1 participant nodded her head, indicating she knew.

In the Muslim community, (F4) said, *"Yes, there is, but my husband never uses it, nor do I tell him to. Once, I suggested him. He scolded me, never again to talk of such things. Please don't tell my husband I am saying these things."*

In the Muslim community, there were strongly religious and cultural beliefs that discouraged both male and female sterilisation, with severe consequences like going to hell. There was a lack of knowledge regarding male sterilisation in some participants, and for some, male sterilisation was particularly unimaginable due to cultural norms and gender roles.

A participant (F4) said, *"Even after we had enough children, we cannot go for sterilisation (Nasbandhi) because our family and religion tell us that those who do an operation to stop children will go to hell and be stuck there."*

Another participant (F2) said, *"Talking about the male operation is a too far thing. We cannot even imagine our male doing an operation to stop children." "We want them to be strong and look after the family"*

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

There was a recognition of female sterilisation as an option, but significant reluctance and cultural barriers prevented its widespread acceptance.

The responses reflected diverse awareness and attitudes toward family planning methods across the three communities. While there is a common understanding of basic methods like pills and injections, cultural and religious beliefs heavily influenced the acceptance and use of sterilisation, particularly in the Muslim community. A reluctance to discuss condoms directly reflected that shyness prevailed among the women in all three communities.

Theme 4: Availability and Accessibility of Family Planning Methods

All three communities mentioned that family planning methods are readily available at the health post and provided without cost. However, religious beliefs, particularly in the Muslim community, prohibit the use of family planning methods.

A participant (F2) from the Muslim community mentioned, *"It is provided at the health post without cost. Some even go to the medical shop. But our religion doesn't allow it. It is strictly prohibited for us. I do not consider our women who use it to be doing something good."*

However, an astounding remark from one of the participants in the Muslim community reflected that despite being aware of the religious prohibitions, there was an extreme urge to adopt family planning methods secretly.

In the mixed community, the distance between their locality and the health post, around 40 minutes away, could have been a geographical barrier. Constant surveillance about the whereabouts of the women by family members further limited the access of these women to family planning methods.

One participant (F21) said, *"Yes, they are available at the health post, but my family always has an eye on me and my activities. I feel too shy even to talk about this with my husband and cannot go alone to get it because I am always under their observation or busy with housework."*

Theme 5: Reasons for Not Using/Discontinuing Family Planning Methods

In all three communities, women reported significant side effects from family planning methods such as oral contraceptive pills and Depo-Provera as a reason for not using/ discontinuing the use of family planning methods. These side effects included excessive bleeding, irregular periods, weight gain, and vomiting.

They also reported having fear of potential health risks related to pre-existing conditions (e.g. hypertension) or breastfeeding that discouraged their use.

A participant (F4) from the Muslim community said, *"I have already taken medicine for blood pressure for the last 3 years, and I am afraid that if I take these pills, my blood pressure might worsen. I do not know if it is true, but I think that even if I go for an injection also, my blood pressure will somehow worsen. When I was a child, my elders used to tell me that one should not depend on things like tablets for even a fever because taking too much of these can harm the body. So, I try not to take any pills or injections as much as possible. Already, the pressure pill is too much for me. If I take these pills or injections to prevent children, what might happen to my body?"*

Furthermore, many husbands refused to use contraception, placing the burden of contraception on women.

Cultural norms and beliefs about masculinity further emboldened the husband's refusal to undergo male sterilisation due to fear of losing their manliness.

A participant (F18) from the Mixed community said, *"I have used pills and injections, too. Both had bad effects on me; look at my weight now [holding her abdominal fat with her fingers of the right hand and shaking it]. I am not doing anything now, and I am waiting for permission from my family to let me get the operation. I once asked my husband if he could do the operation for family planning, but he told me that I am a man, I couldn't do this, my manliness would go if I did, and it was not my job to do this."*

There were also challenges related to consistently adhering to family planning methods such as OCPs and Depo-Provera injections. Forgetting to take pills regularly or issues with scheduling subsequent Depo-Provera injections led to inconsistent use of these family planning methods. This may have further resulted because of the underlying fear and confusion about the effectiveness of methods due to irregular menstruation and the above-mentioned side effects.

The women also reported a lack of support from husbands and in-laws for using family planning methods, leading to feelings of isolation and frustration regarding this matter.

Cultural beliefs about masculinity and fears of social stigma prevented men from undergoing sterilisation, with women preferring to bear the burden themselves. Women also feared that undergoing sterilisation might lead their husbands to seek other wives in case they desired more children in the future.

One participant (F19) said, *"I also want to do the operation by now, but I have the fear that after doing the operation, my man will think that I won't be able to reproduce just in case in the future he wants to have children again and then he might bring another wife. [With a sad face] Where shall I go in this late age if he does so? It's good fortune if a woman gets a good and supportive husband. Only a few*

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

women are lucky. Their husbands go through the operation by themselves."

Looking at the overall picture across all three communities, women faced barriers to using family planning methods due to side effects, health concerns, and cultural dynamics. Husbands refused to use condoms due to a lack of pleasure. They also refused to undergo male sterilisation due to fears of losing masculinity, while societal and familial pressures further complicated women's choices. Misconceptions about breastfeeding as a contraceptive method, even after the start of menses following childbirth, and religious practices during the month of Ramadan also played a role. Women desired permanent solutions but feared social stigma and abandonment.

Theme 6: Decision-Maker of Family Planning

In the Musahar and mixed communities, family planning decisions were generally made through mutual understanding between the husband and the wife.

In these two communities, the role of family members was also evident. The influence of family members, particularly mothers-in-law, was significant in family planning decisions.

However, in the Muslim community, decision-making regarding family planning was predominantly in the hands of husbands, with women having little or no say.

One participant (F2) from the Muslim community stated [with an indifferent expression and tone], *"Males only make all decisions. Who asks women about such things? What males say, that is what happens."* [Others nodded their heads in agreement].

Theme 7: Role of Female Community Health Volunteers in Family Planning

The responses to this theme varied in each community. Both the Muslim and the Musahar communities reported inconsistent visits by the FCHVs.

One participant (F1) from the Muslim community said, *"Yes, they visit sometimes but talk less frequently about family planning. They only visit to know whether there is someone pregnant at home or if there is a small child for vaccination."*

Another (F9) from the Musahar community said, *"I am not sure how often health volunteers visit our area. I haven't seen them recently."*

In the Musahar community, there was also a lack of comprehensive family planning counselling, as evidenced by the FCHVs providing limited family planning information. Women desired clearer, more detailed, and more understandable explanations of family planning methods and demonstrations if possible.

However, the women from the mixed community reported gender-specific communication by the FCHVs. The FCHVs primarily communicated with women, leaving men less informed about family planning. Women expressed a desire for FCHVs to also communicate with men about family planning. However, cultural norms and comfort levels restricted this interaction, making it challenging to involve men in family planning discussions and decisions.

One participant (F22) said, *"But you cannot blame FCHV. She is a woman, so she is comfortable talking about those things with women"* [laughs]. *Imagine them talking about these things with men. Then, our men would run away.* [Everyone laughed louder].

This may have created a barrier to joint decision-making and understanding between spouses about family planning options and their importance.

Looking at the women's responses from all three communities, while FCHVs played a crucial role in providing family planning information and support, there were notable gaps in their reach and effectiveness, particularly in the Muslim and the Musahar communities.

Discussion

The majority of the participants in the FGDs conducted in all three communities (Muslim, Musahar, and Mixed) knew what family planning meant and why it was necessary. All three communities were also aware of the common family planning methods such as oral contraceptive pills and Depo-Provera. However, there was a general reluctance to discuss condoms directly across all three communities due to shyness, as observed during FGDs. Pradhan et al. and the National Report of Nepal observed that in 2006, sterilisation accounted for 38% of all methods used but declined to 28% in 2016. Similarly, male sterilisation during the same time declined from 13% to 10%. Other methods increased in popularity over time, including implants, oral contraceptive pills, and traditional methods.[9,10] A study done by Acharya in 2020 stated that contraceptive use has increased 16-fold in the past 30 years[11].

Even during the FGDs, participants from all three communities mentioned oral contraceptive pills, Depo-Provera, and female sterilisation as methods of family planning. The participants did not mention or were reluctant to mention "condoms" as a way of family planning method on their own unless prompted. There was shyness and hesitation while talking about it. Thus, it was unknown to the full scale whether the couples relied upon condoms as a method of family planning.

The FCHVs mainly communicated only with women and not with men regarding family planning, leaving the men out of family planning discussions and decisions. This may have

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

been a hindrance in strengthening joint decision-making and understanding of family planning options in some of the participants.

Spousal agreement for family planning is a good observation because the practice of discussion with the spouse decreases unwanted pregnancies, but this needs to be further strengthened by empowering women through education and not losing the opportunities to discuss family planning when married women are visiting the FCHVs. It has been observed that agreement with a spouse decreases unmet needs and increases the use of contraceptive methods [12].

Further, as found in the study, it would be better if the FCHVs also talked to the male counterparts regarding family planning to strengthen family planning decisions since a majority of married couples make family planning decisions via spousal agreement followed by the husband making family planning decisions. Among the findings of the 3 communities, in 2 communities (Musahar and Mixed), family planning decisions were generally made through mutual understanding between the husband and the wife.

When asked about the appropriate birth spacing between pregnancies during the FGDs, participants in all 3 communities acknowledged the importance of spacing pregnancies for the health and well-being of the mother and child. Suggested gaps ranged from 1 to 4 years, with a general consensus of around 3 to 4 years being ideal. Hence, the knowledge regarding the appropriate birth spacing was good in all three communities.

The reasons for low male sterilisation were apparent as it was found that there was a lack of knowledge regarding male sterilisation in some of the participants, and also the patriarchal nature of the society prevented males from undergoing sterilisation. Also prevalent were fears of social stigma that could arise if others knew that they had gone through sterilisation and a misconception that if males went through sterilisation, they would lose their masculinity.

A majority of women in all three communities primarily reported fear of side effects and past experiences of side effects (such as excessive bleeding, irregular periods, weight gain, and vomiting) as reasons for not using or discontinuing contraceptives. Besides these, religious and cultural factors also deter women from using contraceptives, particularly in the Muslim community. The women also reported a lack of support from husbands and in-laws for using family planning methods. Most of the women who participated in FGD in the Muslim community reported a low perceived risk of pregnancy to be the reason for not using the family planning method.

Our findings are supported by the study conducted by Genet et al., which also found that the main reason for not using family planning methods among those with unmet needs was a less perceived risk of pregnancy (33.0%) followed by fear of side effects (32.0%)[13].

The findings also align with the study done by Rattan et al. in Punjab, which showed that the main reasons for not using family planning methods in those with unmet needs are fear of side effects and lack of knowledge [14] Also, the study done by Thobani et al. in Karachi in 2019 showed the single most common reason for discontinuing contraception within 12 months was health concerns/ fear of side effects [15].

However, in contrast, the study done by Fakeye and Babani-yi in Nigeria showed that the major cited reason for the non-use of contraceptives was the husband's rejection of the contraceptive method [16].

A higher unmet need for family planning was observed in Muslim women as they explained the religious prohibitions that barred them from opting for family planning services. This finding is also consistent with the study done by Bhandari et al. which showed that respondents belonging to other religions had a much higher prevalence of unmet needs compared to those of Hindu religion[17].

The likely reason for this could be that Muslim communities emphasise larger families as desirable, leading to cultural norms that discourage the use of contraceptive devices. This can create social pressure against using contraceptives, also in the majority of Muslim communities, there may be lower levels of education, particularly for women. This lack of education can contribute to a lack of contraceptive methods and family planning options.

There were fewer unmet needs for family planning in the respondents who lived far distance from the nearest health facility. These are controversial findings but they could be explained as people living closer to health facilities might fear being seen by neighbours or acquaintances leading to reluctance in accessing the services. It was found in the Mixed community where women were closely monitored by other family members regarding their whereabouts, limiting their ability to seek family planning services. Also, people from far places travel with their vehicles and come to the health facilities in a few minutes and avail the services, whereas others from nearby places could be lazy in availing of services.

Other reasons were highlighted by Acharya et al. and others that integrated health services are not readily available in peripheral health facilities even when provided free due to several limitations related to human resource, financial, and logistic issues[18]

It is observed that pressure from in-laws to have a son or more sons led to large families. Another possible reason could be that the couples may have ignored their need

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

for contraception or may have had a desire to opt for permanent methods but did not act upon them, Whereas the use of contraception increased when children were fewer or none. It could be explained as more use of contraceptives leads to fewer children. It has been observed in other studies that strong patriarchal traditions, higher value for male over female children, and mainly rural practices ensuring economic or social security based on large family sizes expect women to bear many children[19]

Postpartum women often face delays in resuming contraceptive use after childbirth due to cultural practices, misconceptions about fertility, or lack of awareness regarding the quick return of fertility in postpartum. Additionally, the demand for caring for young children might limit their access to family planning services. In the Musahar community, most of the women had smaller children and they believed that contraceptives were not required for them as their babies were small and also mentioned the potential side effects that can be caused to their babies if they use the contraceptives.

Respondents from Muslim and Musahar communities reported inconsistent visits by FCHVs, a lack of comprehensive family planning counselling, visits predominantly to recent post-partum women as well as a lack of family planning counselling to men. Only in the mixed community FCHVs were appreciated for their active work. This study is concurrent with the study done in Ethiopia by Tadesse et al. which found that a well-implemented health education programme with trained personnel visiting homes contributed to a decrease in the unmet need for family planning, leading to higher demand for family planning.[20] Garo et al. and Mouse and Gadeyne also found that being visited by the health care provider in the last 12 months and the desired number of children less than two were significantly associated with unmet needs for family planning.[21,22] Another study conducted by Solomon et al. in Tiro Afeta District, South West Ethiopia also showed that the higher unmet need for family planning was associated with a lack of counselling from health workers[23]

Women from the Musahar community believed that there is a low risk of becoming pregnant when they have small children irrespective of the resumption of menstruation or the infrequent and non-exclusive breastfeeding. This finding was supported by the study done by Pasha et al. which reported that postpartum unmet need for family planning is high as women had no knowledge of appropriate family planning methods and the likely time, they could become pregnant again [24] Mehata et al. also found that more than one-quarter of women who gave birth in the last five years became pregnant within 24 months of giving birth and many had an unmet need for family planning within 24 months postpartum.[25]

Talking openly allows both partners to understand each other's desires for family size and preferred methods of contraception, which can lead to a more informed decision about what works best for them as a couple so that they feel more comfortable which helps to overcome any hesitation about seeking out the services thus can significantly reduce the unmet needs for family planning. This was also supported by the study findings where most of the women with unmet needs reported that they usually don't discuss the family planning methods with their husbands.

When family members, including the husband, are involved in the decision-making of family planning, support in obtaining and using contraception is more probable. This support leads to better access to resources, including information on family planning, contraception, and healthcare services thereby reducing unmet needs for the family.

The study has a few limitations also as it was conducted in a rural municipality therefore, the generalisability of findings may be limited to the rural part of the country and may not reflect the true picture of the urban areas.

As the husband has an equal role in the family planning their non-inclusion could have affected the information gathered on unmet needs.

The results would have been more reliable if key informants' interviews and in-depth interviews of health providers had also been carried out to find their perspectives regarding why family planning needs are not being met in that region.

The present study recommends regular health education to fill the gap between women's awareness, attitudes, and practices. Educating women about the importance, potential side effects, and use of appropriate methods would be beneficial. Further, health education for husbands may be necessary because often, it is the husband`s influence on the wife's reproductive attitude that decides family planning decisions and methods.

Ensuring methods like male condoms, OCPs, and Depo-Provera injections are readily and regularly available at local health facilities can have a significant impact on reducing unmet needs. So, any logistics or financial barriers hindering access to these methods should be identified. Healthcare providers especially FCHVs need to provide information about family planning methods during their regular visits to women and their husbands.

Conclusion

The present study highlighted many barriers, such as lack of awareness, misconception about fertility, non-involvement of family members and husbands in decision-making, irregular visits by the female community health volunteers,

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

and non-availability of all possible contraceptive methods at health facilities in satisfying the unmet needs of family planning among married women. Addressing these factors may decrease the unmet needs in rural communities of Nepal.

Conflict of Interest: None

Source of Funding: None

Authors' Contribution: All authors conceived the study idea and contributed to the development of the review protocol, including the search strategy, and methodology, conducted the initial literature search, and managed the data in Nepal. All authors contributed to the interpretation of findings and the critical appraisal of the draft manuscript. All authors provided critical revisions and approved the final version for submission.

Declaration of Generative AI and AI-Assisted Technologies in the Writing Process: None

References

1. Sinai I, Omoluabi E, Jimoh A, Jurczynska K. Unmet need for family planning and barriers to contraceptive use in Kaduna, Nigeria: culture, myths and perceptions. Cult Health Sex. 2020 Nov;22(11):1253-68. [PubMed] [Google Scholar]
2. Casterline JB, Sinding SW. Unmet need for family planning in developing countries and implications for population policy. Popul Dev Rev. 2004;26(4):691-723. [Google Scholar]
3. Westoff CF. The potential demand for family planning: a new measure of unmet need and estimates for five Latin American countries. Int Fam Plan Perspect. 1998;14(2):45-53. [Google Scholar]
4. World Health Organization. Reducing risk, promoting healthy life. Geneva: WHO Report; 2002.
5. DHS Program [Internet]. Women's lives and experiences: a decade of research findings from the Demographic and Health Surveys Program; [cited 2025 Sep 29]. Available from:
6. Population Reference Bureau [Internet]. The faces of unmet need for family planning; 2012 Jul 10 [cited 2024 Jul 26]. Available from: https://www.prb.org/resources/the-faces-of-unmet-need-for-family-planning/
7. Ministry of Health and Population, Nepal, New ERA, ICF. Nepal Demographic and Health Survey 2022: Key Indicators Report. Kathmandu, Nepal: Ministry of Health and Population; 2022.
8. Planning and fertility in Nepal: levels, trends, and determinants. DHS Further Analysis Reports No. 119. Rockville, Maryland, USA: ICF; 2019.
9. Pradhan A, Aryal RH, Regmi G, Ban B, Govindasamy P. Nepal Family Health Survey 1996. Kathmandu, Nepal: Ministry of Health/Nepal, New ERA/Nepal, and Macro International; 1997. [Google Scholar]
10. Ministry of Health and Population (MOHP), Nepal. Nepal Health Sector Programme–III 2015–2020, Results Framework. Kathmandu, Nepal: Ministry of Health and Population; 2015.
11. Acharya C. Family planning in Nepal: trends and pattern. Int J Arts Humanit Soc Sci Stud. 2020;5(5):1-8. [Google Scholar]
12. Hall MA, Stephenson RB, Juvekar S. Social and logistical barriers to the use of reversible contraception among women in a rural Indian village. J Health Popul Nutr. 2008;26(2):241-50. [PubMed] [Google Scholar]
13. Genet E, Abeje G, Ejigu T. Determinants of unmet need for family planning among currently married women in Dangila town administration, Awi Zone, Amhara regional state; a cross sectional study. Reprod Health. 2015;12:42. [PubMed] [Google Scholar]
14. Rattan S, Kalia M, Rohilla R, Grover PK, Dandona S, Sharma MK, Bhandari P, Dalal M, Goel NK. Contraceptive awareness and practices in reproductive age couples: a study from urban slums of Punjab. J Family Med Prim Care. 2022 Jul;11(7):3654-9. [PubMed] [Google Scholar]
15. Thobani R, Jessani S, Azam I, Reza S, Sami N, Rozi S, Abrejo F, Saleem S. Factors associated with the discontinuation of modern methods of contraception in the low income areas of Sukh Initiative Karachi: a community-based case control study. PLoS One. 2019 Jul 3;14(7):e0218952. [PubMed] [Google Scholar]
16. Fakeye O, Babaniyi O. Reasons for non-use of family planning methods at Ilorin, Nigeria: male opposition and fear of methods. Trop Doct. 1989 Jul;19(3):114-7. [PubMed] [Google Scholar]
17. Bhandari GP, Premarajan KC, Jha N, Yadav BK, Paudel IS, Nagesh S. Prevalence and determinants of unmet need for family planning in a district of the eastern region of Nepal. Kathmandu Univ Med J (KUMJ). 2006 Apr-Jun;4(2):203-10. [PubMed] [Google Scholar]
18. Acharya K, Subedi D, Acharya P. Health facility readiness to provide integrated Family Planning, Maternal and Child Health (FPMCH) services in Nepal: evidence from the comprehensive health facility survey. PLoS One. 2022 Feb 25;17(2):e0264417. [PubMed] [Google Scholar]
19. Mosha I, Ruben R, Kakoko D. Family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania: a qualitative study. BMC Public Health. 2013;13:523. [PubMed] [Google Scholar]
20. Tadesse D, Medhin G, Kassie GM, Dadi TL, Tigabu S, Demissie M, Alemayehu M, Gerbaba MJ, Denberu BF, Teklu AM. Unmet need for family planning among rural married women in Ethiopia: what is the role of the health extension program in reducing unmet need? Reprod Health. 2022;19(1):15. [PubMed] [Google Scholar]

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504

21. Garo MG, Abe SG, Girsha WD, Daka DW. Unmet need for family planning and associated factors among currently married women of reproductive age in Bishoftu town, Eastern Ethiopia. PLoS One. 2021 Dec 6;16(12):e0260972. [PubMed] [Google Scholar]
22. Mosuse MA, Gadeyne S. Prevalence and factors associated with unmet need for family planning among women of reproductive age (15-49) in the Democratic Republic of Congo: a multilevel mixed-effects analysis. PLoS One. 2022 Oct 7;17(10):e0275869. [PubMed] [Google Scholar]
23. Solomon T, Nigatu M, Gebrehiwot TT, Getachew B. Unmet need for family planning and associated factors among currently married reproductive age women in Tiro Afeta District, South West Ethiopia, 2017: cross-sectional study. BMC Womens Health. 2019 Dec 30;19(1):170. [PubMed] [Google Scholar]
24. Pasha O, Goudar SS, Patel A, Garces A, Esamai F, Chomba E, Moore JL, Kodkany BS, Saleem S, Derman RJ, Liechty EA, Hibberd PL, Hambidge K, Krebs NF, Carlo WA, McClure EM, Koso-Thomas M, Goldenberg RL. Postpartum contraceptive use and unmet need for family planning in five low-income countries. Reprod Health. 2015;12(Suppl 2):S11. [PubMed] [Google Scholar]
25. Mehata S, Paudel YR, Mehta R, Dariang M, Poudel P, Barnett S. Unmet need for family planning in Nepal during the first two years postpartum. Biomed Res Int. 2014;2014:649567. [PubMed] [Google Scholar]

ISSN: 2454-325X
DOI: https://doi.org/10.24321/2454.325X.202504