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Contraceptive Morbidity among Current Users of Modern Temporary Methods in India

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Abstract

The past decade has seen an increasing concern on modern contraception methods for preventing unwanted pregnancy and to attain the desirable number of children. While, the use of contraception has certainly helped to achieve the desired family and many others, it has also increased the possibility of contraceptive morbidities. The District Level Household and Facility Survey, 2007-08 data have been utilized for this study. The study finding shows, women's health problems such as weakness/inability to work, body ache/backache, abdominal pain, excessive bleeding, and irregular periods are significantly higher in the rural areas compared to their counterpart in urban areas. Furthermore, the result depicts that, while the use of temporary modern contraception methods is higher in an urban setting, the contraceptive morbidity is found to be higher in the rural setting. Use of temporary modern contraception methods is found to be highly associated with contraceptive morbidities. The results show that the educational level of women, their economic status and place of residence are statistically associated with contraceptive morbidity in India.

Keywords: Women, temporary modern contraception, contraceptive morbidity, religion, India

I. Introduction

Though the past decades have seen an increasing concern on women's health issues in developing countries, the primary focus remains as family planning and reproductive health problems. The family planning methods allow people to attain their desired number of children and determine the spacing of pregnancies. However, use of family planning methods has implications for women's reproductive health problems, contraceptive method failure and contraceptive morbidities. Contraceptive practices widely differ from person to person, and it depends on the women's knowledge, attitude, and socio-economic and demographic characteristics (Decker & Constantine, 2011; Festin, 2020). Hence, advancement of family planning methods and ensuring access to desired contraceptive methods for women and couples are essential to securing the well-being of women and supporting the health and development of communities. However, the morbidities/complications arising out of contraceptive use is an important area of concern.

Contraceptive morbidity is referred to morbidity caused by the use of precise contraceptives. Some of the researchers have also defined contraceptive morbidity as a side effect of contraception. The concept of contraceptive morbidities does include the basic health problems such as weakness, body aches/ backache, weight gain, dizziness, vomiting, irregular periods, excessive bleeding, cramps, infection, allergy and many other health problems (Chin-Quee et al., 2009). These problems are aggravated for women if there is a lack of family support for women to visit Health Care Centre for treatment, social taboos, cultural practices and social norms.

In developing countries, use of modern contraceptive methods prevented 218 million accidental pregnancies, 138 million abortions (among them 40 million are unsafe abortions and 25 million are miscarriages) and 118,000 maternal deaths (WHO, 2014). In the use of modern contraceptive methods such as Intra Uterine Devices (IUDs) and Oral Pills, their effectiveness is

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critically significant in abating the risk of unintended pregnancy, especially among married women for whom an unintended pregnancy would be a pretence of additional health hazards or risks. The effectiveness of modern contraceptive methods depends on both women's inherent capacity (hormonal systems and method acceptability by the woman's body) and efficiency of the methods itself and on how appropriately and consistently used (Farr et. al., 2010; Festin, 2020). However, the prevalence of reproductive morbidities arise due to improper use or failure of contraception among married women in developing countries (AbouZahr & Vaughan, 2000). The use of contraception and contraceptive morbidity vary by the socio-economic, demographic and geographic factors (Palamuleni, 2013, de Vargas et. al., 2019).

In the society, contraceptive behaviour and acceptance have noticeably changed over the last few decades. However, the use of temporary and modern contraception methods may increase the risk of contraceptive morbidities and also women's reproductive health problem (Bhatia et al., 1997; Holt et al., 2005; Tanis et al., 2001). Sometimes the use of modern contraception, such as IUDs and Oral Pills, may create annoying health problems i.e. weakness, abdominal pain, weight gain, irregular period, excessive bleeding and many other health issues among women (Task et al., 1989; Jain, 2017). Furthermore, studies show that these methods may lead to heavy, or prolonged bleeding and sometimes shift menstrual periods duration or make it irregular (Holt et al., 2002; Gilliam et al., 2004; Hube &Toth, 2014; Jones et al., 2002; Baillargeon et al., 2005). Earlier studies have documented that sometimes women may die due to contraceptive side effects. In some of the studies, it is noted that the women suffer for very long time with the contraceptive morbidity (Vessey et al., 2010; Golightly, 2011). However, the women have chosen these methods to have great potential to reduce a substantial number of unwanted pregnancies and plan their interval between births. The choice of contraception method is based on cultural and social factors. The socially and culturally accepted contraception methods are more commonly used in the community (Hatcher et al., 2007; Kabagenyi, et. al. 2016).

What are the temporary modern contraception methods?

The Oral Pills (whether daily or weekly) and Intrauterine Devices (IUD) are considered as temporary modern contraception methods because it depends upon women/couple choices and how long they wanted to delay pregnancy. The use of contraception pills reduces the risk of getting pregnant when women are sexually active. The contraceptive pills contain hormones that help to prevent pregnancy by stopping eggs being released from a woman's ovaries and thickening the mucus in a woman's cervix (entrance to the uterus), that makes it difficult for sperm to enter women's uterus and fertilize an egg. The copper-bearing IUDs is a small, flexible plastic frame with copper sleeves or wire around it. A specifically trained health care provider inserts it into a woman's uterus through her vagina and cervix. Almost all types of IUDs have one or two strings, tied to them. The strings hang through the cervix into the vagina. The IUD works primarily by causing a chemical change that damages sperm and egg before they can meet.

India was the first country in the world to launch the national family planning programme in 1952. The family planning programme got further attention after the release of 1971 population Census results (Chaurasia & Gulati, 2009). The main concern of family planning programme is to provide family planning services free in the public health care system. The basic objective of the programme was to control fertility and prevent unwanted pregnancy. The contraceptive morbidity is a significant health concern for married women in India (Ram et. al. 1997, Marston & Cleland, 2003). The use of modern contraception methods makes changes in menstrual patterns at various points. Health problems may also arise from improper use of contraception. Sometimes women's body may not accept the method and may lead to hormone changes (Holt et al., 2005; Cleland et al., 2012)

The use of contraception may also be seen as a safeguard against the health hazards related to pregnancy, abortion, childbearing. While, on the other hand, puts one at risk for these potentially health-compromising outcomes of unprotected sexual intercourse and along with increasing

potentials of various health risks (Collumbien et al., 2004) The use of contraception can have serious immediate or long-term health problems or consequences and more general well-being of sexually active women. More serious concerns about the economic implications of temporary method uses need to be understood in the context of contraception behaviours (Cleland et al., 2012). In this backdrop, this study attempts to analyse the contraceptive morbidity caused by Pills and IUD among the currently married women age group 15-49 years with selected background characteristics.

II. Methods and Materials

Data Source

The data from the third round of District Level Household and Facility Survey (DLHS-3) conducted by International Institute for Population Sciences (IIPS) during 2007-08 were used to assess the contraceptive morbidity among currently married women age group 15-49 years in India. The DLHS-3 survey has collected information from a representative national sample of 604804 currently married women aged 15-49 years from 720320 households in India (IIPS, 2009).

Among the all currently married women, 324170 women were reported using any form of contraceptive methods. Out of these, 213661 women were using sterilization, 9871 using IUDs, 23404 using Pills (daily and weekly), and 77234 were using other methods. In the current study, those women who are using IUDs and PILLs were considered for the analysis. The data set provides respondents' self-reported morbidities or health problems related to the use of contraception. DLHS data set also provides basic household information such as socioeconomic condition and demographic characteristics (IIPS, 2009, http://rchiips.org).

Statistical analysis

Descriptive statistics and bivariate and multivariate analyses were performed to assess the contraceptive morbidity among currently married women by selected socio-economic and demographic characteristics in India. For multivariate analysis, Poisson Regression model/technique was used. Furthermore, the results are presented in the form of the odds ratio. The Poisson regression assumes that the response variable Y has a Poisson distribution and also assumes the logarithm of its expected value can be modelled by a linear combination of unknown parameters. The Poisson model takes the form, $\log_e(\mu) = \beta 0 + \Sigma\, \beta i\, Xi$. Where μ is the mean of the distribution. Xi is a vector of explanatory variables and βi is a vector of regression coefficients. The data were analysed in the SPSS 20 and STATA 12 software. Weights were used in the analyses to restore the representativeness of the sample.

Response variable

The various contraceptive morbidities i.e., weakness/inability to work, body ache/ backache, abdominal pain, weight gain, dizziness, nausea/vomiting, fever, tenderness of breasts, Irregular periods, excessive bleeding, spotting, amenorrhea, cramps, decreased libido, rashes/allergy, Infection and others are included in this study. For the bi-variate analysis, contraceptive morbidity were computed as dichotomous variable (yes = 1 and no = 0). For Poisson regression model, all contraceptive morbidities are calculated in a form of the count variable (1, 2, 3 .....). Only the reproductive morbidity due to the use of temporary modern contraception methods such as Pills and IUDs are considered for the analysis.

Predictor variables

The study has used the following predictor variables pertaining to women for understanding the contraceptive morbidity: age (15-24, 25-34, and 35-49), residence (rural/urban), religion (Hindu, Muslim, and Others), caste (Scheduled Caste, Scheduled Tribe, Other Backward Class and Others),

level of education (Below 5 years, 6-8 years, 9-10 years and 11 years and above) and Wealth Index (Poorest, Poorer, Middle, Richer and Richest). All these variables discussed above are expected to play a critical role in the contraceptive acceptance and contraceptive morbidity.

IV. Results

The prevalence of temporary modern contraception use and contraceptive morbidity among women in the age group 15-49 years shown in Table 1. The use of temporary modern contraception was significantly higher in the urban area (11.2 per cent) as compared to their counterparts (10.1 per cent). However, the contraceptive morbidity were higher among rural area women (86.6 per cent) than women from urban area (79.0 percent). Women who belonged age group 15-24 years have higher experience of contraceptive morbidity (87.0 percent), whereas use of temporary contraception was higher (13.7 per cent) among women aged 25-34 years. The prevalence of temporary modern contraception user significantly less (8.7 per cent) in Hindu religion as compared to their counterparts.

Table 1: The prevalence of temporary modern contraception method users* and contraceptive morbidity[1] among currently married women age group 15-49 years in India, 2007-08

Background Characteristics	Temporary modern contraception	Any contraceptive morbidity	Number[¥]
Place of residence			
Rural	10.1	86.6	24053
Urban	11.2	79	9222
Age group (in years)			
15-24	21.1	87	6928
25-34	13.7	85.5	18025
35-49	5.5	80.3	8322
Highest years of schooling			
Below 5 years	9.7	85.9	5422
6-8 years	12.2	87.9	6232
9-10 years	15.3	85.9	7116
11 years & above	16.2	78.9	5729
Religion			
Hindu	8.7	83.9	21697
Muslim	17.3	84.2	5321
Others	17.6	85.3	6257
Caste			
Scheduled Caste	7.5	81.6	4130
Scheduled Tribe	15.4	88.6	7119
Other Backward Class	7.5	78.8	8977
Others	13	85.8	11445
Wealth Index			
Poorest	80.2	91	3210
Poorer	8.5	89	4467
Middle	9.6	87.2	6456
Richer	10.4	84	8110
Richest	12.7	76.7	11029
Total	10.5	82.3	33275

Note- * IUD and PILLs.

[1]Any type of contraceptive morbidity included like, weakness/inability to work, Body ache/ backache, Abdominal pain, Weight gain, Dizziness, Nausea/vomiting, Fever, Tenderness of breasts, Irregular periods, Excessive bleeding, Spotting, Amenorrhea, Cramps, Decreased libido, Rashes/Allergy, Infection and Others.

¥ Un-weighted cases, while in some variable total some of cases may not equal to total due to missing cases.

Likewise, the use of temporary modern contraceptions were higher (15.4 & 13.0 per cent) among the scheduled tribe and others caste women followed by contraceptive morbidity (88.6 &

85.8 per cent) as compared to their counterpart. The analysis also shows that the use of temporary contraception was statistically associated with women's economic status (wealth index). Furthermore, women from poor households (91.0 per cent) reported more contraceptive morbidity than the corresponding women from affluent households (76.7 per cent).

Table 2 shows the prevalence of contraceptive morbidities among currently married women age group 15-49 years who had used temporary modern contraception methods by place of residence in India. The major problems like, body ache/backache, abdominal pain, excessive bleeding and weakness/inability to work are found significantly higher (32.0, 32.7, 31.4 & 24.5 per cent) among IUD user. Likewise, weight gain, weakness/inability to work, body ache/backache, nausea/vomiting and abdominal pain (59.7, 40.5, 15.5, 14.7 & 10.9 per cent) are common among Pills user. Majority of the contraception morbidities are significantly higher among rural areas women as compared to their counterpart. These pattern was observed for both IUD and pills users. About one third of women from rural areas using IUD reported body ache/backache. The corresponding figure for urban area was 30 percent. Further, more than 38 percent of IUD users from rural area as compared to 26 percent of women from urban area reported abdominal pain. Similarly, about 64 percent of pills users from rural area and 48 percent of urban area dizziness in the study.

Table 2: Prevalence of contraceptive morbidities among currently married women age group 15-49 years who are currently using temporary modern contraception methods by place of residence in India, 2007-08

Type of health problems/ side effects	Intra-Uterine Device (IUD)			PILLs[#]		
	Rural	Urban	Total	Rural	Urban	Total
Weakness/inability to work	26.7	21.9	24.5	42.5	35.0	40.5
Body ache/ backache	33.5	30.0	32.0	14.9	17.2	15.5
Abdominal pain	38.2	26.2	32.7	11.5	09.4	10.9
Weight gain	06.1	05.2	05.7	06.7	13.0	08.4
Dizziness	15.5	07.5	11.8	63.8	48.3	59.7
Nausea/vomiting	04.9	03.4	04.2	14.0	16.5	14.7
Fever	04.3	01.9	03.2	02.5	01.9	02.3
Tenderness of breasts	01.9	00.6	01.3	01.6	01.3	01.5
Irregular periods	19.8	16.9	18.5	11.9	15.0	12.7
Excessive bleeding	26.0	37.8	31.4	04.3	05.7	04.7
Spotting	05.2	04.9	05.1	01.7	01.6	01.7
Amenorrhea	00.8	00.9	00.9	00.9	01.1	01.0
Cramps	03.6	03.0	03.4	03.3	03.9	03.5
Decreased libido	03.6	02.1	02.9	02.3	02.5	02.4
Rashes/Allergy	02.1	01.0	01.6	01.6	02.0	01.7
Infection	01.1	00.2	00.7	00.4	00.6	00.5
Others	07.1	13.2	09.9	10.3	12.2	10.8
Any morbidity	10.1 (6222)	09.1 (3649)	09.6 (9871)	13.1 (17831)	09.6 (5573)	11.9 (23404)

Note: [#]Oral Pills are included daily and weekly

Table 3 depicts that the prevalence of contraceptive morbidity among currently married women aged 15-49 years using IUD in India. The findings suggest that, contraceptive morbidity significantly higher among women age group 15-24 years' (9.2 percent) as compared to their counterparts. Women with 11 years and above schooling reported contraceptive morbidity (15.6 per cent) more than the women with 9-10 years (6.5 percent), 6-8 years (2.6 percent) and below five years schooling (1.8 percent). Women from 'Others' religion category reported more contraceptive morbidities than the Hindu and Muslim. Furthermore, Scheduled Caste women had less contraceptive morbidity as compared to scheduled tribe, other backward class and others. Women's economic status and contraceptive morbidities are positively correlated in the study. This association was statistically associated at $P<0.000$ with a considerable high value of the chi square test. Only

one percent of women from the poorest households as compared to more than seven percent of women from the richest households reported contraceptive morbidity in the study.

Table 3: Prevalence of contraceptive morbidity among IUD users currently married women age group 15-49 years in India, 2007-08

Background Characteristics	Contraceptive morbidity	χ^2- *test*	*p-value*
Place of residence			
Rural	2.4	341.391	$p < 0.000$
Urban	5.5		
Age group			
15-24	9.2		
25-34	4.4	72.282	$p < 0.000$
35-49	1.5		
Highest years of schooling			
Below 5 years	1.8		
6-8 years	4	94.561	$p < 0.000$
9-10 years	6.5		
11 years & above	15.6		
Religion			
Hindu	2.6		
Muslim	5.4	43.382	$p < 0.000$
Others	7.3		
Caste			
Scheduled Caste	1.4		
Scheduled Tribe	3.4	274.781	$p < 0.000$
Other Backward Class	3.1		
Others	5		
Wealth Index			
Poorest	1.1		
Poorer	1.3		
Middle	2	42.029	$p < 0.000$
Richer	3.7		
Richest	7.4		
Total	4.6		

It is evident in the Table 4 that, women aged 15-24 and 25-34 years had significantly higher contraceptive morbidity (27.4 & 11.4 per cent) as compared to women aged 35-49 years (3.8 per cent). Education of women and the prevalence of contraceptive morbidity was showing a positive relationship. As the education level of women increased from below 5 years to 11 years and above, contraceptive morbidity also increased from 9.5 to 14.2 percentage among women who using Oral pills. Muslim women (22 percent) had more contraceptive morbidities than the Hindu (7 percent) and women from 'Others' religion (10 percent). Furthermore, women from upper caste (Others) reported more contraceptive morbidities than the women from the lower caste. The result was statistically at *P<0.000* among all categories.

Women's aged 25-34 and 35-49 years were more likely (1.73 & 1.10 times) to have contraceptive morbidity than women from the referencing group i.e. 15-24 years. Women with 11 and above years of schooling were 1.5 times more likely to have the contraceptive morbidities than the women with below 5 years of education. Women from Others religion were nearly two times more likely to report contraceptive morbidity than Hindu and Muslim women. Further, Other Backward Class women are 1.5 times more likely to report contraceptive morbidity as compared to the Scheduled Caste women (Table 5).

Table 4: Prevalence of contraceptive morbidity among Oral Pill users currently married women age group 15-49 years in India, 2007-08

Background Characteristics	Contraceptive morbidity	χ^2- test	p-value
Place of residence			
Rural	8.6	99.269	$p < 0.000$
Urban	8.8		
Age group			
15-24	27.4		
25-34	11.5	96.909	$p < 0.000$
35-49	3.8		
Highest years of schooling			
Below 5 years	9.5		
6-8 years	11.8	120.645	$p < 0.000$
9-10 years	14.5		
11 years & above	14.2		
Religion			
Hindu	6.8		
Muslim	21.8	49.676	$p < 0.000$
Others	9.6		
Caste			
Scheduled Caste	6.7		
Scheduled Tribe	9.4	61.036	$p < 0.000$
Other Backward Class	5.4		
Others	12.2		
Wealth Index			
Poorest	8.3		
Poorer	9.2		
Middle	9.2	75.263	$p < 0.001$
Richer	8.6		
Richest	8.1		
Total	10.9		

Table 5: Results from Poisson regression model for currently married women who are currently using IUD and who had contraceptive morbidity in India, 2007-08

Background Characteristics	Exp (β)	Lower limit	Upper limit
Place of residence			
Rural®	1		
Urban	1.819	0.624	1.075
Age group			
15-24®	1		
25-34	1.704***	1.597	2.902
35-49	1.103**	1.001	1.403
Highest years of schooling			
Below 5 years®	1		
6-8 years	1.088*	1.001	1.399
9-10 years	1.137	0.872	1.482
11 years & above	1.507**	1.040	2.184
Religion			
Hindu®	1		
Muslim	0.921	0.706	1.202
Others	1.824**	1.211	2.749
Caste			

Scheduled Caste®	1		
Scheduled Tribe	0.893	0.551	1.446
Other Backward Class	1.461*	1.066	2.001
Others	1.063	0.765	1.477
Wealth Index			
Poorest®	1		
Poorer	1.406	0.895	2.208
Middle	1.348	0.865	2.100
Richer	1.603*	1.024	2.511
Richest	1.940**	1.186	3.174

Note-®; reference category, Level of significance: * p < 0.05; ** p < 0.01; *** p < 0.001

The result of the Poisson regression model for contraceptive morbidity caused by Pills use among currently women age group 15-49 years is presented in Table 6. Women aged 25-35 years using pills are 1.03 times more likely to have contraceptive morbidities than women aged 15-24 years. Furthermore, women with 11 years and above education are 1.5 times more likely to develop contraceptive morbidity than the women from Schedule Caste. However, women from richer households are 1.13 times more likely to have contraceptive morbidities than the women from the poorest households.

Table 6: Results from Poisson regression model for currently married women who are currently using Oral Pills and who had contraceptive morbidity in India, 2007-08

Background Characteristics	*Exp. (β)*	Lower limit	Upper limit
Place of residence			
Rural®	1		
Urban	0.874	0.607	1.26
Age group			
15-24®	1		
25-34	1.025*	1.002	1.258
35-49	0.924	0.852	1.965
Highest years of schooling			
Below 5 years®	1		
6-8 years	0.906	0.81	1.354
9-10 years	1.09	0.739	1.983
11 years & above	1.543**	1.016	2.961
Religion			
Hindu®	1		
Muslim	1.051**	1	1.583
Others	0.92	0.589	1.438
Caste			
Scheduled Caste®	1		
Scheduled Tribe	0.875	0.626	1.466
Other Backward Caste	0.875	0.639	1.198
Others	1.511***	1.013	2.718
Wealth Index			
Poorest®	1		
Poorer	0.951	0.383	1.37
Middle	0.862*	0.601	0.937
Richer	1.128*	1.012	1.32
Richest	0.636	0.383	1.056

Note- ®; reference category, Level of significance: * p < 0.05; ** p < 0.01; *** p < 0.001

V. Discussion

Contraceptive adoption is a key aspect of women's reproductive health, influencing both

family planning and overall well-being. While some women's bodies readily accept contraceptive methods without complications, others may experience difficulties in adaptation. The body's response to contraception can vary due to physiological and hormonal differences among individuals (Cleland et al., 2012). Moreover, health issues that arise in women using contraception may not always be directly linked to the contraceptive method itself. Several confounding factors, such as pre-existing medical conditions, nutritional status etc. may contribute to health complications (Singh, & Hussain, 2014). Women with previous health issues experience adverse effects regardless of contraceptive use (Hubacher & Cheng, 2020). Lack of proper knowledge, limited access to healthcare, and misconceptions about contraception contribute to misuse (World Health Organization, 2019). Therefore, it is crucial to provide comprehensive education and counselling on correct contraceptive use to minimize health risks and improve reproductive health outcomes (Foster et al., 2015). It is important to conduct comprehensive health assessments before prescribing contraception. Identifying and addressing confounding factors through proper medical evaluation and counselling can help mitigate potential risks and ensure safer contraceptive adoption (Foster et al., 2015; World Health Organization, 2019). The use of modern contraception is one of the key strategies that help women in limiting and delaying pregnancy, thereby contributing to improve maternal and child health. Despite their benefits, modern contraceptives can also lead to several health issues (Hubacher & Cheng, 2020).

VI. Conclusion

The each and every woman has passed through their reproductive life through different stages and uses various contraception methods according to their needs or choice, which is offering a somewhat different combination of health risks and benefits along with their wellbeing. The study found a high percentage of contraceptive morbidity among the rural areas women, whereas health facilities are very less, or women do not have access to the health centres due to poverty and illiteracy. After having contraceptive morbidity women did not go to the hospital due to lack of family support or busy with their livelihood activities. High prevalence of contraceptive morbidity among rural area women may be because of lack knowledge of the use of modern contraception, as well as the regular or inappropriate use of contraception. The contraceptive morbidity among Pills users is higher in comparison to IUD users in both rural and urban areas. The contraceptive morbidity among Pills users is higher in comparison to IUD users in both rural and urban areas. In the one hand, the use of temporary methods of contraception allows the spacing of pregnancies or can delay pregnancy among women who wish to limit their family size. On the other hand, it may increase contraceptive morbidity among women, while it makes an adverse impact on women's overall health and their wellbeing. However, these problems may be due to lack of counselling and proper knowledge about the use of these methods. If women use any contraceptive, according to their body resistance power with the appropriate medical advice, then it will be useful for women to space the pregnancies.

Generally, In Indian society women tend to consider many symptoms as a normal and do not seek treatment until the severity is high or it is a long time health problem. These situations are common in rural areas where women usually belong to poor social and economic status. Moreover, the high percentage of contraceptive morbidity among rural areas is associated with income, women’s autonomy and use of health care services. Even currently Government does the various family planning programs and promotion at the massive level. Still, there is a need to recheck program and improve according to the current requirement of the people. However, there is a need for improving the provision of contraceptives and regular follow-up of women, especially the temporary contraception methods user. The emphasis on screening before IUD insertion and suitable training for health workers to identify and handle the cases is essential. Moreover, the strengthening of the family planning is required in remote areas of the country as they are more vulnerable due to less medical facilities. The Government needs to give timely training to the health professionals or health workers and to increase awareness among women to appropriately use any method of contraception.

There is an urgent need to find out the leading causes of contraceptive morbidity among temporary contraception method users. Further studies at the community level will help the knowledge on this issue

VII. Limitation of the study

In this study only currently married women who are currently using (at the time of survey) temporary modern contraception such as the IUD or Pills are considered. Therefore, it is not based on contraceptive morbidity related to other methods. In the DLHS data, counselling information about the side effect of any method at the time of use is not available. Hence, it is not possible to relate the role of family planning programme in the management of contraceptive morbidity. The survey collected information about contraceptive morbidities; these are self-reported, and it is not based on any test that has been performed to check any contraceptive morbidities.

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