Barriers to Effective Family Planning

Evidence from Research Literature

Yuvaa Youth Voices for Agency and Access

PATHFINDER

Busara

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Evidence from Research Literature

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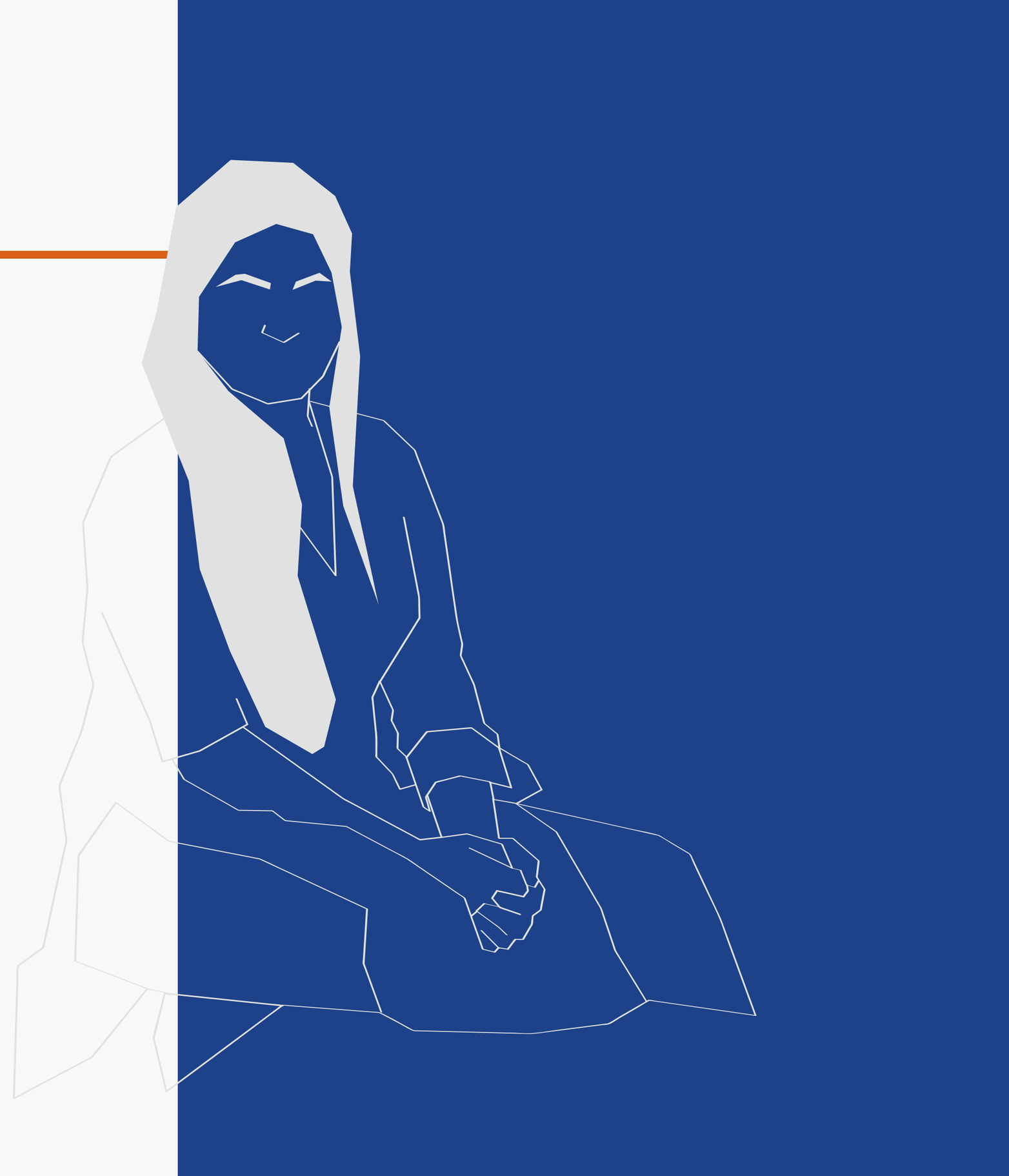
Contents



Abbreviations / Acronyms

ASHA	Accredited Social Health Activist
EPoD	Evidence for Policy Design
FGD	Focus Group Discussion
FP	Family Planning
HCP	Health Care Providers
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancies
IDI	In-Depth Interview
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU CCP	Johns Hopkins University Center for Communication Programs
LARC	Long-Acting Reversible Contraceptives
LMIC	Low and Middle Income Countries
MIL	Mother-in-Law
OCP	Oral Contraceptive Pill
PSI	Population Services International
SARC	Short-Acting Reversible Contraceptives
SPRING	Strengthening Partnerships, Results, and Innovations in Nutrition Globally project
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
YC	YUVAA Corps
YMC	Young Married Couple
YUVAA	Youth Voices for Agency and Access

Introduction

Family planning (FP) has been an important policy concern for India in the post-independence era, with the earliest efforts to improve FP outcomes going back to the early 1950s. Identifying with this goal, Pathfinder International conceptualized, designed and implemented the Youth Voices for Agency and Access (YUVAA) program, which blends social entrepreneurship and innovative communication approaches to improve access to FP related information and contraceptive choices. This is accomplished by delivering customized family planning messages to young couples in 10 districts of Bihar and Maharashtra, with the aim of positively shifting gender and social norms around family planning behavior. These messages are supplemented by direct interventions to improve access to FP products through a group of social entrepreneurs (termed as YUVAA Corps (YCs) or YUVAAKAR), along with providing counselling on family planning, use of contraceptives and the benefits of Healthy Timing and Spacing of Pregnancies (HTSP) practices to young, married couples (YMCs). To assess the impact of these interventions from a behavioral perspective, Busara Center for Behavioral Economics was brought on board by Pathfinder.

This document captures the common barriers which influence the decision making process concerning family planning, as well as contraceptive uptake and use as identified from the past literature. The stated objective is to document a comprehensive list of barriers to test during the program implementation of YUVAA. Specifically, Do these barriers exist in the current study population? Does the YUVAA program address these barriers suitably?

Key Findings/Themes

TABLE 1: EMERGENT RESEARCH THEMES

THEME	BARRIER FOCUS	RESEARCH QUESTIONS
Trust and Credibility (Couple)	Refers to barriers related to mistrust of information and information channels.	Covers research questions aimed at disaggregating diversity of opinions amongst couples and community members on trusted sources of FP knowledge (service providers, peers, family members, YC etc).
Agency and Power (Couple)	Refers to barriers that prevent women's (or couple's) agency in decision-making and deciding their family planning use (such as norms, autonomy, self-efficacy).	Research questions aimed to uncover not only the decision-makers, but also factors that influence their authority; further assess how women (or couples) could potentially assert their agency.
Knowledge of FP (Couple)	Refers to barriers around awareness of modern FP methods amongst couples, how to use them, and benefits of contraception on their own (and their family's) life.	Research questions aimed at assessing prevalent use, knowledge and common myths around FP and FP use, disaggregated by gender.
Priority of FP (Couple)	In reference to barriers around priority of FP as compared to other priorities (such as social conformity, income generation, e.t.c) in their daily life; along with priorities between and across different FP methods.	Research questions aimed at assessing reasons for de-prioritization of FP use; further, uncover preference between/ across SARCs, LARCs, traditional methods and modern methods.
Safety and Support (Couple)	Barriers include both experiencing side effects of FP use, and perceived harmful effects of FP use by couples and community members; and its impact on FP use.	Research questions aimed at assessing prevalence of perceived harms of FP; along with both availability and efficacy of current support systems.
Social Norms (Couple)	Barriers associated with descriptive and injunctive social/ gender norms that influence family planning (son preferences, large family size, e.t.c).	Research questions directed at estimating both strength of social norms (that influence FP use decisions), and the channels of influence (e.g. MILs).
Beliefs and Attitude (Couple)	Barriers include those that refer to values that prevent or discourage FP use (self-control being a virtue and FP method).	Research questions aimed at deciphering attitudes and beliefs about FP, and their sources; assess differences by gender.
Convenience (Couple)	Barriers cover issues relevant to ease of access to FP methods, cost of FP, and availability of FP for couples.	Research questions aimed at assessing the effectiveness of providing home access to FP; further, assess and map ideal time and day for delivery of all interventions.

THEME	BARRIER FOCUS	RESEARCH QUESTIONS
Bias and Gatekeeping (Service Providers)	Includes barriers around preferential treatment or discrimination of certain groups (such as migrant women, e.t.c) while providing FP care.	Research questions directed to understanding prevalence of provider bias, reasons for priority of certain groups or FP methods by service providers.
Relation with Users (Service Providers)	Barriers include mistrust and lack of comfort in sharing feelings with service providers.	Research questions explored whether shared community with YC helps create better relationships; further, where there is difference in perception of YCs versus HCPs.
Confidence and Capacity (Service Providers)	Refers to barriers around service providers' limited capacity, resources and belief in their ability to provide FP related services.	Research questions aimed at assessing if training builds adequate capacity of YCs; further, if YCs feel they have the requisite support to deliver all interventions.
Ensuring Supply (Service Providers)	In reference to barriers associated with challenges, such as women's mobility and lack of availability of contraception at health centers.	Research questions aimed at assessing whether providing home access to FP affects use; further, assess and map ideal time and day for delivery of all interventions.

Methodology

LITERATURE SEARCH

The evidence review process utilized the PubMed database, where a structured query was created to define detailed search parameters. Additionally, we searched publications from relevant organizations for grey literature* on family planning.

*Grey literature refers to documented information produced outside of traditional publishing and distribution channels, and can include reports, policy literature, working papers, newsletters, government documents, speeches, white papers, urban plans, and so on.

WHITE LITERATURE

We put family planning and YUVAA at the center of the literature search criteria, and searched for papers similar to the project in terms of:

- **Outcomes (family planning),**
- **Interventions (which influence family planning outcomes),**
- **Location (South Asia, LMICs), and,**
- **Target groups (similar to YUVAA, important influencers of family planning).**

To search for studies, the following terms were used:

Outcomes

Contraception, family planning HTSP, second pregnancy, gender norms, social norms, timing of second pregnancy, gender equitable relationships, counselling.

Interventions

Volunteers, contraceptives, counselling, peer counselling, referral clinic, couple counselling, job aids, games, digital platforms, videos, testimonials, targeted visits, Whatsapp audio, messages, SMS, gender transformative counselling, technology, group meetings, video screening, visual aids, mass media, positive deviance, family planning.

Locations

India, South Asia, LMIC, Africa, Bihar, Uttar Pradesh, North India.

Target Groups

Mothers-in-law (MILs), husbands, wives, couples, migrants, young married couples (YMC), newlyweds, first-time parents, males, sisters-in-law, key opinion leaders.

GREY LITERATURE

For grey papers, a general search was conducted on Google Scholar, along with a targeted database search for the following organisations: WHO, USAID, SPRING, EPoD, The World Bank, IDInsight, Ideas42, Engender Health, PATH, UNFPA, PSI, JHPIEGO, JHUCCP, Breakthrough Action & Research, UN Women.

Based on these search criteria, 118 studies from PubMed for white literature and 15 institutional databases for grey literature were reviewed. These studies were further screened on the basis of the inclusion and exclusion criteria defined below:

Inclusion Criteria

- **Qualitative studies that relate to the outcomes of interest to the YUVAA program,**
- **Quantitative studies that discuss barriers to improving outcomes of interest,**
- **Studies that report descriptive statistics on the barriers to improving outcomes of interest,**
- **Studies being conducted in low- and middle-income countries (LMICs), with a focus on India and South Asia, and,**
- **Systematic reviews on barriers to changing outcomes of interest.**

Exclusion Criteria

- **Studies that do not focus on outcomes of interest to the YUVAA program (for instance HIV),**
- **Studies that only report descriptive statistics on the prevalence of outcomes of interest,**
- **Experimental studies that only evaluate outcomes of interest,**
- **Studies that are conducted in countries other than LMICs,**
- **Commentary-based studies on outcomes of interest,**
- **Studies that describe protocols, and,**
- **Studies that report or discuss determinants/factors associated with outcomes of relevance.**

At the end of this process, ***22 white papers*** *and* ***8 papers from grey literature*** *were selected*.*

*The full reading list is provided in the 'List of Papers' section at the end of this report. These studies have been referenced in this report by their reference number given next to the name.

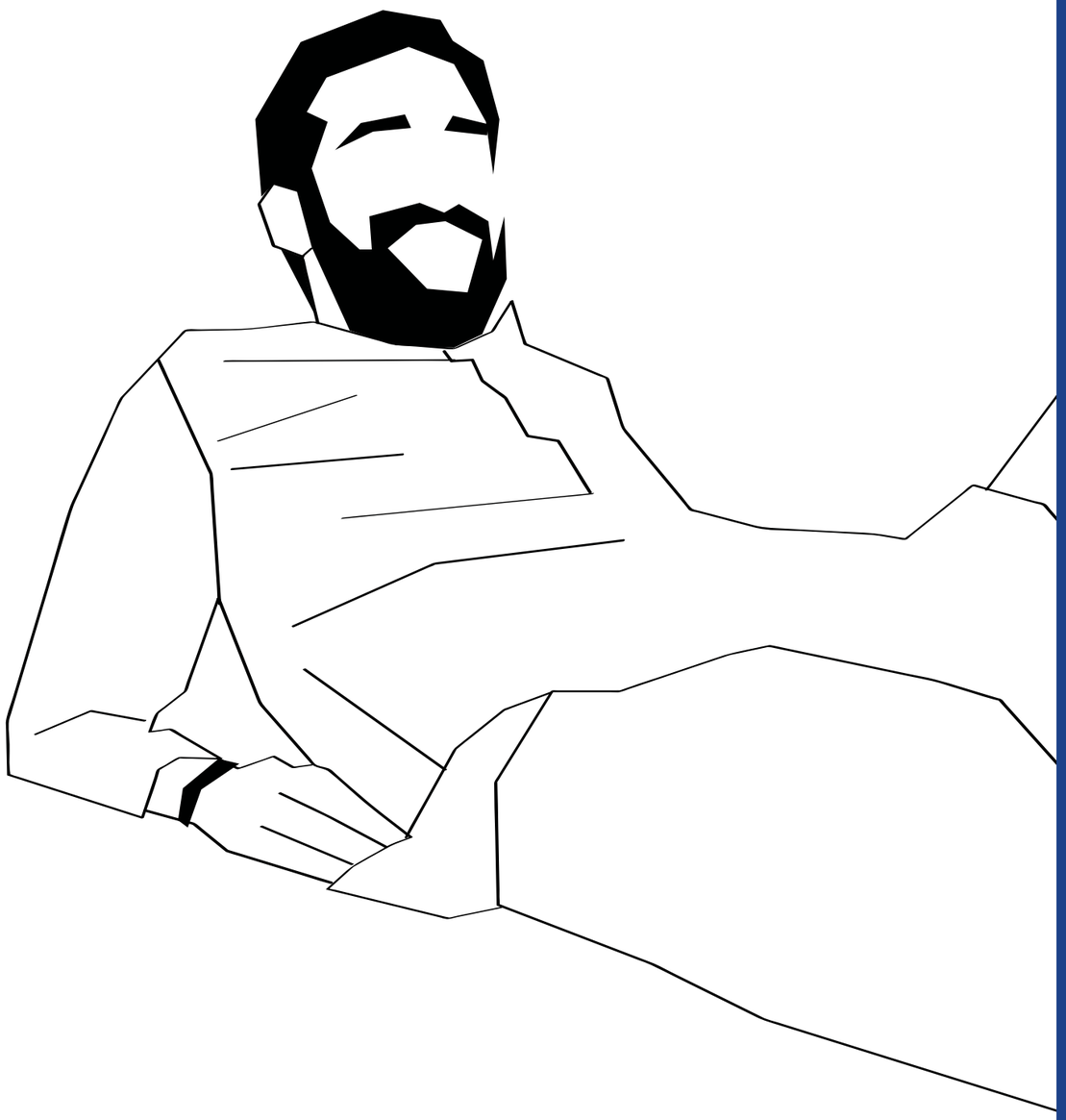
Literature Synthesis and Overview

Shortlisted papers were reviewed and information was collated on type of study, methodology, target groups and, most importantly, barriers. Nineteen studies were qualitative in nature, while others were either quantitative or mixed methods. The qualitative techniques used were Individual In-depth Interviews (IDIs), Focus Group Discussions (FGDs), Participatory Group Discussions, and expert interviews. Seven studies were quantitative in nature, and analysis of surveys was one of the common methods used. Three studies used both qualitative and quantitative methods.

65

Unique Barriers Identified

Overall, 65 unique barriers were identified. The majority of them were individual-level (factual beliefs, aspirations, skills, attitudes, self-efficacy, e.t.c.) and community-level barriers (social support, the configuration of social networks both proximal and distal, exposure to positive deviants in a group, e.t.c.), followed by institutional barriers (formal system of rules and regulations) and material barriers (lack of physical objects and resources - money, land or services, e.t.c.). The majority of the studies used married men/women as their target group and were conducted in rural regions. However, only five studies (ref: study #1,9,10,23,29) used intervention design to address the barriers in-home couple counselling, group discussions, free wellness check-ups for youth, door-to-door visits to mobilize the community, and provide counselling as well as supply of FP methods.



Findings

Existing literature on family planning is relatively dense and offers up many potential barriers which can negatively impact the decision journey of young married couples. Furthermore, how these barriers influence decision-making is diverse, with each appearing at different stages of a typical decision-making process, that is at the intention, decision or action stage. This diversity necessitates a consistent framework to group barriers which are similar to each other, or act in similar ways. We analyzed all barriers identified from the literature and grouped them across emergent themes around married couples and service providers, the two primary human elements of FP-related service delivery and YUVAA.

This exercise yielded relevant research questions for respective barriers/themes, which form the backbone of this assessment exercise, by translating the evidence on barriers from literature into implementable field research.

In total, we identified twelve research themes, eight of which are from the couples' perspective, and the other four from the service providers' perspective. Barriers can be identified with multiple themes depending on how they influence the decision-making process.

Most barriers were reported under themes of knowledge of family planning, support from others (husbands, society, e.t.c.), social norms, and assigning priority to family planning. This section provides details on the themes, along with study references for each.

TRUST AND CREDIBILITY

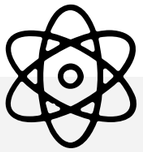
Trust and Credibility reflects the barriers related to mistrust of information and information channels.

Certain factors deter couples from seeking information regarding FP methods, and eventually considering its use. These are centered around the couple's interactions with Community Health Workers (CHWs), and their confidence in them as credible sources of information. For example, Health Care Providers (HCPs) do not maintain privacy (ref: study #2,17), and are driven by their personal and financial needs rather than the needs of the community (ref: study #15). HCPs do not provide complete information about the health risks associated with certain contraceptive methods, leaving couples unaware of the side effects (ref: study #12,15,16,27).

This theme covers research questions aiming to disaggregate diversity of opinions amongst couples and community members on trusted sources of FP knowledge. For example, what is the level of trust couples have on the YUVAA field team that delivers interventions? Do couples feel their privacy is valued by the YUVAA team (ref: study #2,17)? How do couples deal with the dissonance between information received through YUVAA during counselling, and information from their social networks on perceived side effects? Which opinion prevails and when (ref: study #2,3,7,8,14)? Apart from YUVAA, what are the main sources of information on FP for couples? Are they trusted over YCs (ref: study #12,27)?

Barriers

- **Women do not think ASHAs will maintain privacy since they are from the same village, and decide not to seek them for FP information or contraception.** [2][[17]
- **Women receive inaccurate information about side effects from their peers, family or partner, and are directly counselled by others not to engage with or use family planning methods, consequently deterring their use.** [2][3][7][8][14]
- **Women want to appease their husbands/MILs by having more children to prove their fertility, meaning there is no intention to consider FP use.** [15][9][7][5]
- **Individuals perceive HCPs as being driven by their own personal and financial needs, rather than the needs of the community, and avoid procuring FP from them.** [15]
- **HCPs do not provide couples with complete information about the health risks associated with certain contraceptive methods.** [12][15] [16][27]



AGENCY AND POWER

Barriers identified under Agency and Power include factors that prevent women's (or couple's) agency in decision-making, and determining their family planning use.

In some cases, there is intention but no follow-through to use FP methods as the final decision around FP and contraception does not rest with the end-users, that is, the women or married couples. For example, women do not discuss FP use for fear of conflict with their husbands (who control usage decision) (ref: study #2,5,9,11); women do not have adequate autonomy to decide on FP use (ref: study #15); FP is made available to women and not men; and men do not take any action to procure it (ref: study #24).

This theme covers research questions aiming to uncover factors that influence authority and how women (or couples) could potentially assert their agency. For example, do women have the interpersonal skills to negotiate the use of FP/HTSP with their husbands and/or family members (ref: study 2,5,9.11)? How do couples start talking about FP? What are the triggers (ref: study #15,22)? Whose responsibility is it to procure the contraceptive method? Why? How does the choice architecture of the primary healthcare system influence this responsibility (ref: study #24)?

Barriers

- **Communities believe that God is responsible for providing children and family planning interferes with God's plan. Non-conformity to such beliefs could lead to a woman's death when practicing FP, thus deterring them from using it.** [15][19][24][27]
- **Women do not bring up family planning discussions for fear of conflict with their husbands (who control usage decision) thus there is little intention to use FP.** [2][5][9][11]
- **Women decide not to speak against their husbands, or use FP without their input/support for fear of domestic violence, being abandoned, or being perceived as selfish and uncaring.** [15][25][22]
- **Women do not have adequate autonomy to decide on FP use.** [15]
- **FP is made available to women and not men, and men do not take any action to procure it.**
- **Couples do not have adequate information on how to use FP methods, thus do not take any action to procure or use contraceptives.** [22][20][18][15][8][7]
- **Women taking FP despite opposition from their husbands are seen as violating gender norms, and do not feel supported.** [1][[22][28]

KNOWLEDGE OF FAMILY PLANNING

Knowledge of FP identifies barriers around awareness of modern FP methods amongst couples, how to use them, and benefits of contraception on their own (and their family's) life.

These barriers reflect the incomplete or misleading information that married couples have of FP and contraception. These can be manifested from a variety of issues, for example, HCPs focus their attention on counseling women, thus men remain unaware of FP methods (ref: study #15). Since information on FP methods is not translated properly, couples remain unaware of key information regarding such methods (ref: study #7,8,12,15), and women fear that FP methods can reduce sexual desire in females, thus forcing men into infidelity (ref: study #15,17,25). Men, on the other hand, fear loss of energy - and consequently their ability to work in farms - due to using FP methods, which deters contraception use (ref: study #24).

This theme covers research questions aiming to assess prevalent use, knowledge and common myths around FP and FP use, disaggregated by gender. For example, how have men's awareness, knowledge, attitudes and involvement toward FP issues changed through YUVAA (ref: study #15)? What are the myths around sexual desire and contraceptive use? How do these differ between men and women? How do these differ by contraceptive type (ref: study #17,25)? What are the myths around infertility and contraceptive use? How salient is the association in people's minds? Is this more (or less) for certain types of contraceptives (ref: study #3,28)? Do women/ couples know the benefits of HTSP (ref: study #22,24,25)?

Barriers

- **HCPs focus their attention on counseling women, leaving men unaware of FP methods.** [15]
- **As information on FP methods is not translated properly, couples remain unaware of key information regarding such methods.** [7][8][12][15][19]
- **Women fear that FP methods can reduce their sexual desire and force men into infidelity. Such attitudes disincentivize FP use.** [15][17][25]
- **Fear of infertility due to FP methods deter both men and women from its use. For men, having children reflects higher status, while for women its important to prove their fertility.** [3][15][28]
- **Condoms can reduce sexual pleasure for men, so they avoid using them.** [12][15][17]
- **Women need to prove fertility by having children quickly, thus do not consider family planning.** [25][24][22][17]
- **Men fear loss of energy- and ability to work in farms - from using FPs, deterring contraceptive use.** [24]
- **Due to lack of information about existing FP options, couples are unable to choose a method that is best suited to their needs.** [27][20]18[12][7]
- **In the event of falling sick due to side effects from contraception, women are more worried about childcare (considered their responsibility), therefore may opt not to use family planning.** [2]
- **There is significant fear of side effects from contraception by both men and women [Pills: menstruation, weight gain/loss, nausea; IUD: stomach pain, and bleeding; Condoms: cause HIV, can reduce pleasure] thus deterring use of family planning.** [14][15][19][20]
- **While couples want to use [traditional] FP methods, they don't have accurate information - such as understanding safe days in rhythm method - therefore family planning becomes ineffective.** [7]
- **Couples do not have adequate information on how to use FP methods, thus do not take any action to procure or use contraceptives.** [22][20][18][15][8][7]
- **FP can affect breast milk (postpartum family planning), and is not considered for use between pregnancies.** [11]
- **HCPs can develop myths that LARCs can cause long-term harm such as infertility.** [2][26]

PRIORITY OF FP

The theme covers barriers around the priority of FP relative to other priorities (such as social conformity, income generation, e.t.c.) in their daily life; along with priorities between and across different FP methods.

These barriers reflect the often conflicting priorities that users face while making FP or contraception decisions. For example, couples (particularly men) do not seek information on FP on their own, as they do not see it as a priority requiring their attention (unlike the priority of income generation). Therefore, they remain unaware of the need for, and methods of, family planning FP (ref: study #3,22,24,25,27). Family planning, FP is not a priority for couples because of a high cognitive load imposed by poverty and labor (ref: study #13), therefore sterilization is the preferred method, and there is no action to use any other method (ref: study #3,7,15).

This theme covers research questions aiming to assess reasons for de-prioritization of FP use, and uncover preference between methods. For example, how do men manage and prioritize family planning issues with other competing priorities such as income generation (ref: study #3,22,27)? What cost-benefit analysis do men/ women do when building an intention to use family planning (ref: study #17,24)? Are condoms prioritized by certain groups over others? If so, why (ref: study #15)? Is there any default preferred option for contraceptive use (ref: study #15)?

Barriers

- **Couples (particularly men) do not seek information on FP on their own as they do not see it as a priority compared to income generation, thus remain unaware of both need and methods of FP.** [3][22][24][25][27]
- **Women need to prove fertility by having children quickly, so do not consider the use FP.** [25][24][22][17]
- **FP is deemed unnecessary by women when their husbands are away (migrants), thus no intention towards using FP.** [2]
- **FP is not a priority for couples because of a high cognitive load imposed by poverty and labor issues affecting any desire to consider its use.** [13]
- **Men believe that condoms are not required for older married men, and are only for young unmarried men, thus they decide to not use them.** [15]
- **Negative side effects from contraception use can affect income generation capacity, so men decide against using FP.** [24]
- **Sterilization is the preferred method of family planning, therefore there is no action to use any other method.** [3][7][15]
- **While couples want to use [traditional] FP methods, they don't have accurate information - such as understanding safe days in rhythm method - therefore family planning becomes ineffective.** [7]
- **HCPs do not provide adequate counselling on LARCs, thus use is limited.** [16]

SAFETY AND SUPPORT

Barriers under this theme include experiencing side effects of FP use and perceived harmful effects of FP use by couples, and the lack of a support to mitigate these effects.

There is limited or non-existent support for couples and women dealing with side effects of contraceptives. As a result, there is no perceived safety net for use of family planning, especially for new users. For example, community members such as HCPs are unable to provide the requisite material, knowledge or emotional support to those seeking/desiring FP (ref: study #1,8). Consequently, a woman from their community falls sick due to contraceptive use side effects (ref: study #2), and men are indirectly affected by the women's side effects - such as reduced sexual desire/ infertility/ illness/ irregular periods (ref: study #15).

This theme covers research questions aiming to assess prevalence of perceived harms of FP, along with availability and efficacy of current support systems. For example, what type of males support FP decisions? What are strategies they employ to fight notions of toxic masculinity (ref: study #3)? What are the couple's attitudes towards these side effects? What are the common side effects reported about different contraceptive methods (ref: study #2)? How do perceived or experienced side effects influence decision-making (ref: study #14,15,19)? Do couples receive support from their social networks to adopt HTSP and FP methods (ref: study #18,21)?

Barriers

- **Males are socially ridiculed for supporting or using FP, leading to negative repercussions for FP use.** [3]
- **In the event of falling sick due to side effects from contraception, women are more worried about childcare (considered their responsibility), therefore may opt not to use family planning.** [2]
- **There is significant fear of side effects from contraception by both men and women [Pills: menstruation, weight gain/loss, nausea; IUD: stomach pain, and bleeding; Condoms: cause HIV, can reduce pleasure] thus deterring use of family planning.** [14][15][19][20]
- **Couples may have the intention to use contraception, but worry about being judged or stigmatized by elders because discussions around sex are considered taboo.** [18][21]
- **MILs make decisions regarding timing and spacing of children, leaving couples no autonomy on use of FP.** [7][8][9]
- **Men are indirectly impacted by side effects such as reduced sexual desire, infertility, illness, and irregular periods, therefore discourage women from using FP methods.** [15]
- **HCPs are unable to provide the requisite material, knowledge or emotional support to those seeking/desiring FP.** [1][8]
- **Men do not support women's decision to use FP for fear of side effects or health risks that affect reproductive health and fertility.** [14][16][24]
- **Experiencing negative health consequences of the contraceptive without adequate support can prevent usage(for instance IUDs cause longer or infrequent periods, or other methods cause discomfort during sex).** [11]
- **HCPs are rude to users and dismissive of their concerns/fears, thus couples do not feel supported by the system.** [2][17]

SOCIAL NORMS

This theme includes barriers associated with descriptive and injunctive social/ gender norms that influence FP use.

Certain social norms act as barriers and deter intention to use FP among young couples. For example, women are afraid to be perceived as promiscuous by neighbours or family members for using FP methods (ref: study #2,15,20,23), or communities believe that God is responsible for providing children and FP use interferes with God's plan. Non-conformity to such beliefs could lead to a woman's death when practicing FP (ref: study #15,19,24,27). Further, couples are shy of buying FP methods like condoms (ref: study #5,15).

This theme covers research questions directed at estimating strength of social norms and its channels of influence. For example, how do people view women/couples who use contraceptives? What is the perception of the type of women who use contraceptives (ref: study #24)? What are the costs of non-conformity to norms around FP use, particularly from religious institutions (ref: study #15,19,24,27)? What gender roles and norms force women/couples to complete their family early? What social pressures do couples face just after marriage (ref: study #5,7)?

Barriers

- **FP methods were most often used in contexts of female commercial sex exchange, thus considered unacceptable for married women. Such stigmatizing beliefs around contraception deter intention to use.** [24]
- **Women are afraid to be perceived as promiscuous by neighbours or family members for using family planning methods.** [2][15][20][23][26][27]
- **Communities believe that God is responsible for providing children and FP interferes with God's plan. Non-conformity to such beliefs could lead to a woman's death when practicing FP, thus deterring them from using it.** [15][19][24][27]
- **Women want to appease their husbands/MILs by having more children, and proving their fertility.** [15][9][7][5]
- **Menstruation is a taboo and OCPs are used to delay it. Although there is intention to use FP, women do not follow through as they are not comfortable talking about it.** [2]
- **Using FP methods postpartum indicates sexual activity - a transgression of social norms that promote celibacy at that point.** [11][15]
- **MILs make decisions regarding timing and spacing of children, leaving couples no autonomy on use of FP.** [7][8][9]
- **Couples are embarrassed of buying FP methods like condoms.** [5][15]
- **Women cannot leave the house unaccompanied or without the consent of their husbands or MILs, therefore cannot procure FP methods.** [9]
- **Family members (MILs, males) want more children, particularly sons, to increase their status and carry on the family name.** [15][2][3]

BELIEFS AND ATTITUDES

Barriers under Beliefs and Attitudes refer to values that prevent or discourage FP use.

These barriers cover stigmatizing beliefs around contraception which can deter intention to use FP among young couples. For example, FP methods were most often used in contexts of female commercial sex exchange, therefore not considered acceptable for faithful married women (ref: study #24). Communities consider use of FP methods as synonymous with abortion and killing, which goes against religion (ref: study #2,8,12,19.25). Condoms are perceived as a strategy to harm people through promotion and distribution of old/inferior or HIV infected products. Furthermore, contraception is seen as a government conspiracy to weaken women (ref: study#9,19,22), while vasectomy is considered loss of masculinity leading men to decide against it (ref : study #24). Couples choose self-control over modern FP methods as it is considered a personal virtue (ref: study #7), whereas having more children earns couples respect in the society (ref: study# 2,3,15,25).

This theme covers research questions aimed at deciphering attitudes and beliefs about FP and its sources, and to assess differences by gender. For example, what are existing attitudes around contraceptive use and female infidelity (ref: study #24)? How do religious beliefs influence family planning decisions (ref: study #2,8,12,19)? What conspiracy theories exist against the use of contraceptives? How do these differ between men and women? How do these differ by contraceptive type (ref: study #9,19,22)? What are couples' attitudes towards these side effects (ref: study #14,15,20)?

Barriers

- **FP methods were most often used in contexts of female commercial sex exchange, thus considered unacceptable for married women. Such stigmatizing beliefs around contraception deter intention to use.** [24]
- **Communities consider use of FP methods synonymous with abortion and killing, which goes against religion [use of FP goes against the will of God/ God's plan of procreation].** [2][8][12][19][25]
- **FP is considered a method of domination which needs to be avoided. Condoms are a strategy to harm people through promotion and distribution of old/inferior or HIV infected products. Further, contraception is seen as a government conspiracy to weaken women.** [9][22][19]
- **There is significant fear of side effects from contraception by both men and women [Pills: menstruation, weight gain/loss, nausea; IUD: stomach pain, and bleeding; Condoms: cause HIV, can reduce pleasure] thus deterring use of family planning.** [14][15][19][20]
- **Vasectomy is considered a loss of masculinity, so men decide against it.** [24]
- **Couples choose self-control over modern FP methods as it is considered personal virtue.** [7]
- **Family planning is perceived as a means to limit family size, not delaying or spacing birth.** [12]
- **More children are desired for the family's labor and income. More children also means more respect in the society.** [25][15][2][3]
- **Religion does not approve the use of FP because having children is seen as a gift from God, or, it may interfere with menstruation which is considered a taboo.** [2][15]

CONVENIENCE

Convenience barriers cover issues relevant to ease of access to FP methods, cost of FP, and availability of FP for couples.

For many couples, the choice of FP is determined by convenience and ease of access. For example, natural methods are viewed as simpler, healthier, cheaper and without side-effects compared to modern methods, thus are preferred (ref: study #3,15). HCPs are either unknown, unavailable, or treat service seekers unfairly, causing individuals to avoid seeking support (ref: study #8,17,19,26). Where couples want to use contraceptives, HCPs are either too far away or don't have FP methods readily available (ref: study #15,16,18,25,26).

This theme covers research questions aimed at assessing the effectiveness of providing home access to FP and mapping the ideal time for such an intervention. For example, what reasons do couples use to justify the use of natural methods? How prevalent is its use? Do couples know the benefits of modern contraceptive methods in comparison to natural methods (ref: study #3,14,15)? Are there some unavoidable circumstances where the couple cannot use contraceptives (ref: study #14)? How do users feel about the frequency, timing and environment of the counselling touchpoints (ref: study #8,17,19)?

Barriers

- **Women and men are not available at the same time for counselling, therefore deterring overall impact of the session, and follow up action or use.** [1]
- **Natural methods are viewed as simpler, healthier, cheaper and without side effects compared to modern methods.** [3][14][15]
- **Couples decide to use FP but slip back into natural methods because of ease, convenience and social acceptability.** [14]
- **Negative side effects from contraception use can affect income generation capacity, thus men decide against it.** [24]
- **While individuals may desire or want to use contraceptives, procurement is a challenge due to unavailability in health centers or distance.** [26][25][19][16][15]
- **HCPs are either unknown, unavailable or treat service seekers unfairly, deterring couples from seeking support.** [8][17][19][26]

BIAS AND GATEKEEPING

Bias and Gatekeeping identified barriers around preferential treatment or discrimination of certain groups while providing FP care.

In a few studies, it was observed that HCPs act with strong bias and assumptions in how they provide information, and who they provide it to. For example, HCPs do not provide FP counselling to YMCs as they believe it is not required (ref: study #1,2,5), or FP is made available to women and not men (ref: study #24). Such factors deter individuals from seeking information regarding FP methods, and eventually considering its use.

This theme covers research questions directed towards understanding prevalence of provider bias, reasons for priority of certain groups or FP methods by service provider. For example, do HCPs prioritise certain FP methods (LARCs, short term methods, or sterilization) while counselling and offering FP advice (ref: study #16)? Is the healthcare ecosystem still not focusing on men and YMCs (ref: study #1,2,5,26)?

Barriers

- **HCPs do not provide FP counselling to YMCs as they believe it is not required, therefore couples are not aware of FP methods.** [1][2][5]
- **FP is made available to women and not men, and men do not take any action to procure it.** [24]
- **HCPs do not provide adequate counselling on LARCs, thus their use is limited.** [16]
- **Men do not feel welcome at FP centers, or feel uncomfortable speaking to a female provider regarding FP.** [26]

RELATION WITH USER

This theme reflects the barrier of mistrust and discomfort in sharing feelings with service providers.

These barriers act on the relationship between HCPs and married couples, and deter effective flow of knowledge and advice. These can be rooted in either of the two actors leading to a detrimental effect on FP use for couples. For example, women do not think ASHAs will maintain privacy since they are from the same village (ref: study #2,17). HCPs are either unknown, unavailable or treat service seekers unfairly (ref: study #8,17,19,26). Additionally, HCPs are rude to users and/or dismissive of their concerns/fears thus couples do not feel supported by the system (ref: study #2,17). Men do not feel welcome at FP centers. or are uncomfortable speaking to a female provider regarding FP (ref: study #26).

This theme covers research questions aiming to explore whether a shared community with YC helps create better relationships. For example, do couples feel comfortable sharing their concerns with YCs (ref: study #2,17)? How do men's experiences during the counselling, group meetings and visits to healthcare facilities differ from women's (ref: study #26)?

Barriers

- **Women do not think ASHAs will maintain privacy since they are from the same village, and decide not to seek them for FP information or contraception.** [2][17]
- **FP is made available to women and not men, and men do not take any action to procure it.** [24]
- **HCPs are either unknown, unavailable or treat service seekers unfairly, so couples avoid seeking support.** [8][17][19][26]
- **HCPs are rude to users and dismissive of their concerns/fears, therefore couples do not feel supported by the system.** [2][17]
- **Men do not feel welcome at FP centers, or feel uncomfortable speaking to a female provider regarding FP.** [26]

CONFIDENCE AND CAPACITY

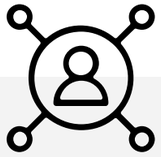
Confidence and Capacity includes barriers identified around service providers' limited capacity, resources and belief in their ability to provide FP related services.

These barriers reflect the tangible and intangible capabilities of HCPs to effectively deliver FP-related information and services. For example, HCPs are unable to provide the requisite material, knowledge or emotional support to those seeking or desiring FP (ref: study #1,8). Further, HCPs are unaware of the procedures to use LARCs so only SARCs is promoted for use (ref: study #1,16).

This theme covers research questions aiming to assess if training builds adequate capacity to deliver all interventions. For example, do YCs feel they have the requisite support to do their work (ref: study #1,8)? Do YCs feel confident in their ability to offer counselling (ref: study #15,16,25)? Do YCs have adequate knowledge of all FP methods (ref: study #1,16)?

Barriers

- **HCPs are unable to provide the requisite material, knowledge, or emotional support to those seeking/desiring FP.** [1][8]
- **There is a shortage of skilled HCPs at health centers, leading to a lack of support for couples in their FP journey.** [15][16][25]
- **HCPs are unaware of the procedures to use LARCs, thus only SARCs are promoted for use.** [1][16]



ENSURING SUPPLY

Ensuring supply covers barriers associated with women's mobility, and availability of contraceptives at health centers.

These barriers cover material access to FP services and products. For example, individuals want to use contraceptives but they are too far or don't have FP methods available (ref: study #15,16,18,25,26). Women cannot leave the house unaccompanied or without the consent of either their husband or MIL (ref: study #9). There is also a shortage of skilled HCPs at health centers, hindering support for couples in their FP journey (ref: study #15,16,25).

This theme covers research questions aimed at assessing whether introducing home-based supply influenced FP use (ref: study #9). Is there good coordination and role-sharing between the YCs and HCPs in providing services (ref: study #15,16,25)?

Barriers

- **While individuals may desire or want to use contraceptives, procurement is a challenge due to unavailability or distance.** [26][25][19][16][15]
- **Women cannot leave the house unaccompanied or without the consent of their husbands or MILs, therefore cannot procure FP methods.** [9]
- **There is a shortage of skilled HCPs at health centers able to support couples in their FP journey.** [15][16][25]
- **Experiencing negative health consequences of contraceptives without adequate support can prevent usage (for instance IUDs cause longer or infrequent periods, or other FP methods cause discomfort during sex).** [11]

Summary and Conclusion

It is evident from existing literature that family planning decisions in LMICs are besotted with strong barriers, which underscore the need for intervention programs like YUVAA. There is a further need for streamlining and matching barriers to the right kinds of interventions targeted towards the most relevant group (say, couples vs. HCPs). In this exercise, the first of these steps was attempted by providing a theme-based framework to effectively group and consequently target barriers. In the context of this project, these research themes offer a clear and consistent lens to group findings from existing literature and provide a starting point for developing field research protocols.

Taking this a step further and effectively utilizing the value offered by these themes, a key research aim for YUVAA qualitative assessment will be to validate these themes (along with the underlying barriers) in the target population through qualitative field research. They will directly inform our method selection and instrument design for the assessment, and further define the framework used to analyze field insights. At the end of this exercise, we should be able to comment on the prevalence of these themes across Bihar and Maharashtra, and compare the two states.

List of Papers

[Tabular Format]

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