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A Study To Identify The Barriers Of Family Planning Methods In A View To Create And Train Self-Help Groups Among Married Women

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Abstract:
Introduction: *The number and timing of pregnancies can be managed by the use of family planning methods. For effectively access and use of these methods, individuals must overcome some barriers to family planning approaches.*
Aims/Objectives: *The study aims to explore the barriers to the use of family planning methods among married women, to identify self-help groups for training married women on family planning methods, and to develop and implement a training programme through these self-help groups to enhance knowledge and utilization of family planning practices.*
Methodology: *Qualitative explorative approach based on grounded theory, was used. 40 women with more than 2 children, selected through purposive sampling. Data collected using a socio-demographic profile and a self-structured interview. Data was analysed using Colaizzi's seven-step thematic analysis approach.*
Results: *The findings showed lack of awareness, social factors like participants were subordinate to their husbands and feeling shy to buy these products, Individual Factors like participants complaint that they faced side effects after using these methods, Perception factor like Participants agree that use of these techniques is a private affair they shouldn't discuss with others, were the major barriers for not using family planning methods.*
Conclusions: *This study shows barriers regarding family planning methods. There is a need for creating awareness for effective use of these methods.*
Key-words *Qualitative study, barriers, family planning methods.*

INTRODUCTION

Family planning that is voluntary and safe is a fundamental human right and a necessary health service. A fundamental component of gender equality, family planning is essential to the health and welfare of individuals, families, and communities. However, each year millions of people around the world are denied access to appropriate family planning services due to legal, social, educational, and physical restrictions. Everyone, everywhere, may have access to person-centred family planning services by recognizing the obstacles and putting evidence-based solutions into practice.[1]

Both the outcome of each pregnancy and the health and well-being of the woman are directly impacted by her capacity to space and/or limit her pregnancies. One important component in reducing maternal mortality and increasing child survival is family planning. It is indisputable that FP is important for any plan aimed at ensuring healthy maternity and child survival.

Stabilizing the world's population depends on removing barriers to universal access to high-quality contraception and FP services. The significance of going beyond physical access to consider hurdles resulting from psychosocial, administrative, cognitive, and cultural issues in addition to physical barriers and method-related barriers has been emphasized by prior studies on the obstacles to using FP services.[2]

By giving women and children the ability to choose when and how often to get pregnant, FP helps lower rates of maternal and infant mortality, avoid unintended births, and improve the social and financial well-being of families. Effective FP practices are linked to fewer health risks for moms and kids as well as wider societal advantages including increased economic growth and gender equality. Family planning usage barriers have been found in a variety of settings, with some commonality and some particular difficulties

based on the area and people. These obstacles include misperceptions regarding contraception, low perceived risk of pregnancy, fear of side effects, and rejection from the spouse. Attitudes on FP are greatly influenced by cultural and religious beliefs, especially in Sub-Saharan Africa, which frequently restricts its usage and acceptance.[3]

In 2021, there will be 1.9 billion women of reproductive age (15–49 years) globally; 1.1 billion of them will require family planning; 874 million of them will use contemporary methods of contraception, while 164 million will not. The fundamental human right to freely and responsibly choose how many children to have and how far apart to have them is supported by access to contraception. By lowering associated health risks and preventing unwanted pregnancies, it also offers substantial health benefits. A wide range of contraceptive techniques, including both permanent and temporary (reversible) treatments, are available to prevent unwanted pregnancy. Condoms, the only means of contraception, are effective in preventing HIV infection and conception.[4]

The right to make educated decisions regarding one's sexual and reproductive health is supported by the availability of family planning. Through its support of education, economic opportunity, gender equality, and health promotion, it plays a critical role in attaining broader development goals. These contributions directly align with SDG 3.7, which calls for universal access to family planning and other sexual and reproductive health care.[4]

Even with advancements, many people still have trouble getting family planning services. These include obstacles relating to age, income, or marital status, as well as the restricted availability of specific techniques, especially in rural or low-resource environments. Use may be discouraged by societal or religious resistance, false information, and fear of ill effects. Health services can occasionally be of low quality, or clinicians may oppose particular approaches out of bias. Another factor is gender inequity, since some people require their partner's approval or are afraid of being stigmatized.[5]

By developing evidence-based standards on safety and service delivery, as well as on protecting human rights in contraceptive programs, WHO is attempting to increase access to and use of contraception. WHO helps nations adopt and use these resources. WHO also takes part in the creation of novel contraceptive technology. We conduct and direct research to enhance the way individuals obtain and utilize contraceptive information and services.[4]

METHODOLOGY

The qualitative explorative approach based on grounded theory, was used in this study. The sample consisted of 40 women with more than two children, selected through purposive sampling. The study was caried out in Dhankaur village, Greater Noida. Data was gathered using a socio-demographic profile and a self-structured interview. Responses were recorded, transcribed, and analyzed using Colaizzi's seven-step thematic analysis approach to identify key barriers to family planning methods.

RESULTS

The main study included 40 Men and women residents with more than 2 children's of Dhankaur village of greater Noida, UP.

The demographic variables of study participants were analyzed with a specific focus on men and women who have more than two children, providing detailed findings about their age, education, occupation, and family structure. Qualitative analysis of verbatim responses from these individuals enabled the exploration and identification of themes and subthemes, which highlighted various barriers to adopting family planning methods. Additionally, the level of knowledge among members of the community Self Help Group (SHG) was assessed, demonstrating the mean difference in knowledge levels within this group.

Table 1

Frequency and Percentage Distribution of Demographic variables of Men and women with more than 2 children

(n=40)

S. No	DEMOGRAPHIC VARIABLES	FREQUENCY	PERCENTAGE
1	**Age**		
	1. 21-28	25	62.5

	2. 29-36	6	15.0
	3. 36+	9	22.5
2	**Gender**		
	1. Male	0	0
	2. Female	40	100.0
3	**Span of marriage**		
	1. 3 years	5	12.5
	2. 4 years	0	0
	3. 5 years and more	35	87.5
4	**Number of children**		
	1. 3	31	77.5
	2. 4	2	5.0
	3. 5 and more	7	17.5
5.	**Gender of children**		
	1. Male	5	12.5
	2. Female	2	5.0
	3. Both	33	82.5
6.	**Educational status of participant**		
	1. Primary	11	27.5
	2. Secondary	22	55.0
	3. Graduate	7	17.5
	4. Above graduate	0	0
7.	**Educational status of spouse**		
	1. Primary	6	15.0
	2. Secondary	17	42.5
	3. Graduate	17	42.5
	4. Above graduate	0	0
8.	**Employment status of participant**		
	1. Labour work/farmer	0	0
	2. Home maker	40	100.0
	3. Govt. employee	0	0
	4. Private Employee	0	0
9.	**Employment status of spouse**		
	1. Labour work/farmer	23	57.5
	2. Home Maker	0	0
	3. Govt. employee	0	0
	4. Private Employee	17	42.5
10.	**Monthly Income**		
	1. Up to 10,000	4	10.0
	2. 10,001-20,000	34	85.0
	3. Above 20001	2	5.0
11.	**Religion**		
	1. Hindu	23	57.5
	2. Muslim	17	42.5

12.	**Residence**		
	1. Rural	40	100.0
	2. Urban	0	0
13.1	**Do you know about family planning methods? If yes, mention the media.**		
	1. Yes	17	42.5
	2. No	23	57.5
13.2	**If yes mention the media**		
	1. Asha-worker	1	2.5
	2. Friends	4	10.0
	3. Hospital	2	5.0
	4. Spouse	6	15.0
	5. TV	4	10.0
	6. NA	23	57.5

Table 1 represent that Most (62.5%) participants are young women under age group 21-28, 22.5% are under 36 and above and only 15% are under 29-36 age group. All respondents are female. Nearly all (87.5%) participants have been married for 5+ years, few of them married for 3 years and none of them are married for 4 years. Most participants (77.5%) have 3 children, 17.5 % are having 5 and more children and few of them (5%) are having 4 children. Most (82.5%) families have both male and female children, 12.5% have male child and only 5% have female child. Most (55%) have secondary education, 27.5% have primary education, 175 are graduate and no one is above graduate level. Spouses are generally more educated, with many (42.5%) having secondary education and graduate level education, only 15% are having primary education and none of them are having education level above graduation. All women are homemakers. Majority (57.5%) spouses are farmers or labourers, 42.5% are private employee and none of them are home maker and govt. employee. Mostly 85% participants are having ₹10,001–20,000 monthly income, 10% are having up to 10,000 and only 5 % are having above 20001. Majority (57%) participants were Hindu, 42.5% were Muslim and none of participants were from Christian and other religions. All participants live in rural areas as comparison to urban area. Over half (57.5%) participants are unaware and 42.5% were aware about family planning methods through spouse 15%, through friends and TV 10%, from hospital 5% and 2.5% aware from ASHA workers. Only 25% participants have used family planning method and 57.5% have not used. Condoms are the most used method (17.5%), copper-T (5%) and 2.5% participants have used both male condom & Copper-T.

Qualitative analysis of verbatims by men and women with more than 2 children

a. To explore the barriers of family planning methods.
b. To identify theme and subtheme-based barriers of family planning methods.

The data collected through interview was analysed by using Colaizzi (seven step method) thematic analysis. The interview of all participants was recorded with their permission and transcribed in verbatim. Married women verbatim statements were transcribed and then subjected to an analysis procedure that included the creation of themes and subthemes.

Steps of thematic analysis

1. **Getting familiar with the data**
   This is the first level in thematic analysis to get familiarize with the data. The researcher transcribed the data after completing data collection. After familiarizing oneself with the data, read the text several times over and made notes on the initial concepts. Specific attention was paid towards the pattern that occurs by identifying the repeated issues in one or more interviews. A list of likely codes was compiled prior to reviewing the interview transcripts. Taking notes during the process of familiarizing oneself with the data allowed for the initial development of possible codes. This made it easier to find potential themes.
2. **Generating initial codes**

The researcher identified the relevant phenomena, collected different examples and analysed the collected phenomenon to find similarities, differences and patterns. Then initial codes were generated from reoccurring pattern of data.

3. **Searching the themes**
   Firstly, focused the broader patterns of the data and the coded data was combined with proposed themes. During this step, the researcher considered the relationship between codes and themes as well as differences among themes.
4. **Reviewing themes**
   To make sure the data form a logical pattern, go back and reread every passage that fits within each theme. Subsequently, the investigator went over and improved the topics, identifying trends and a few of them being further subdivided into smaller themes.
5. **Defining and naming the themes**
   In this step, the researcher analysed each theme and narrated after continuous revision of the themes in relation to the gathered data. Finally, described each theme in two sentences, defined and named the themes.
6. **Compiling the report**
   After carefully examining each topic and its justifications, the researcher produced a final report by summarizing the themes and their relevant contributions to the study issue.
7. **Thematic Interpretation**
   Finally, a thematic interpretation of the study participants' results was conducted that included the creation of themes and subthemes.

Table 2 Frequency and Percentage Distribution of Family Planning Barriers by Theme

S.NO	THEME	SUB-THEME	FREQUENCY	PERCENTAGE
1.	Knowledge and Awareness factor	**A.** Physical method	8	20%
		B. Hormonal method	11	27.5%
		C. Natural method	9	22.5%
		D. Permanent method	12	30%
		Total	**40**	
2.	Social factors	**A.** Social embarrassment	7	17.5%
		B. Social reluctance	14	35%
		C. Social isolation	2	5%
		D. Social patriarchy	17	42.5%
		Total	**40**	
3.	Individual factors	**A.** Health adversities	6	15%
		B. Subordination	5	12.5%
		C. Apathy	20	50%
		Total	**40**	
4.	Perception factors	**A.** Privacy concerns	5	12.5%
		B. Misconceptions	30	75%
		C. Discomfort	5	12.5%
		Total	**40**	
5.	Influencing factors	**A.** Negative influence	8	20%
		B. Spousal disapproval	32	80%
		Total	**40**	
6.	Family factors	**A.** Gender stereotyping	4	10%
		B. Coercion	20	50%
		C. Stonewalling	16	40%
		Total	**40**	

Table 2 represent that under the Knowledge and Awareness factor, participants showed varying levels of familiarity with different contraceptive methods. The Permanent method was the most known (30%), followed by the Hormonal method (27.5%), Natural method (22.5%), and Physical method (20%). Social factors emerged as significant barriers, with social patriarchy dominating at 42.5%, highlighting the deep-rooted influence of gendered societal norms. Social reluctance (35%) and social embarrassment (17.5%) also play critical roles, revealing the discomfort and hesitancy many individuals feel when addressing reproductive matters. Social isolation was noted by a smaller proportion (5%). In terms of Individual factors, Apathy was overwhelmingly cited (50%), suggesting a lack of motivation or interest in taking initiative regarding reproductive health. Other contributing factors were Health adversities (15%) and Subordination (12.5%). Perception factors were dominated by Misconceptions (75%), clearly indicating a widespread lack of accurate knowledge, which can significantly distort understanding and decision-making. Privacy concerns and Discomfort, both at 12.5%, suggest that fear of judgment and personal unease further restrict open conversations and informed choices. Influencing factors also played a major role, particularly Spousal disapproval (80%), which highlights the significant impact of partner dynamics on contraceptive choices. Negative influence from others, though lower (20%), also contributes to the pressure individuals face in making independent decisions. Lastly, Family factors revealed critical intra-family barriers. Coercion (50%) and Stonewalling (40%) were commonly experienced, indicating control and lack of communication within families. Gender stereotyping (10%) also reflects persistent traditional expectations that limit reproductive autonomy.

The analysis of barriers to family planning methods among men and women with more than two children revealed several prominent themes. Knowledge and awareness gaps were common, with participants reporting limited understanding of physical, hormonal, natural, and permanent methods of contraception, such as condoms, copper-T, oral and emergency pills, injections, calendar methods, and sterilization procedures. Social factors included embarrassment or reluctance to discuss or purchase family planning products, social isolation of users, and male dominance in contraceptive decision-making. Individual factors were evident in health adversities like abdominal pain, infection, and discomfort, privacy concerns regarding personal practices, subordination to husbands' preferences, and apathy towards expressing opinions. Perception-based barriers involved viewing family planning as a private matter, misconceptions about side effects, and discomfort with condom use. Negative influences were reported from peers and relatives, with spouses frequently discouraging use of these methods. Family dynamics contributed further challenges, including gender stereotyping that pressures women to have male children, direct coercion from in-laws against contraceptive use, and lack of spousal communication on these matters. Overall, these findings highlight multi-layered barriers to family planning among married couples, rooted in insufficient knowledge, social norms, individual health perceptions, relational influences, and family pressures.

Representation of level of knowledge among Community self-help group (CSHG)

a. Mean difference related to level of knowledge among Community Self Help Group.

Out of 40 women the researcher identified a Community Self-Help Group (CSHG) consisting of five women each having three children, a similar span of marriage (5 years and more), monthly income i.e. 10,001-20,00, and falling in the same age group that is above 36 years. Most participants and their spouses have moderate to high education levels, and while the women are unemployed or informally employed (home-maker), most spouses are employed like 4 of them were farmers or labourer and one of them was government employee. All participants belong to the Hindu religion and rural residence and all have children of mixed gender that is both male and female. Notably, four participants are aware of family planning methods, while one is not, which aligns with her having no media exposure

Table 3. Mean, Standard deviation and t test of pre-interventional and post-interventional knowledge level among Community Self Help Group

(n=5)

	Mean ± SD	**T value**	**Df**	**P value**
PRE-TEST	7.80 ± 1.48	12.944	4	0.000
POST- TEST 1	14.4 ± 1.34			

POST- TEST 2	20.6± 2.50	-10.660	4	0.000
POST- TEST 3	25.6±2.30	-13.494	4	0.000
POST- TEST 4	29.2± 2.50	-15.989	4	0.000
POST- TEST 5	29.4±1.79	-19.869	4	0.000
POST- TEST 6	29.8±0.44	-31.113	4	0.000

Table 3 depicts that P value of 0.000 (which is actually < 0.001) means the results are highly statistically significant. The scores increase steadily from Pre-intervention (7.80) to post-intervention 6 (29.8), indicating continuous improvement. The intervention or training program was highly effective in increasing knowledge or performance over time.

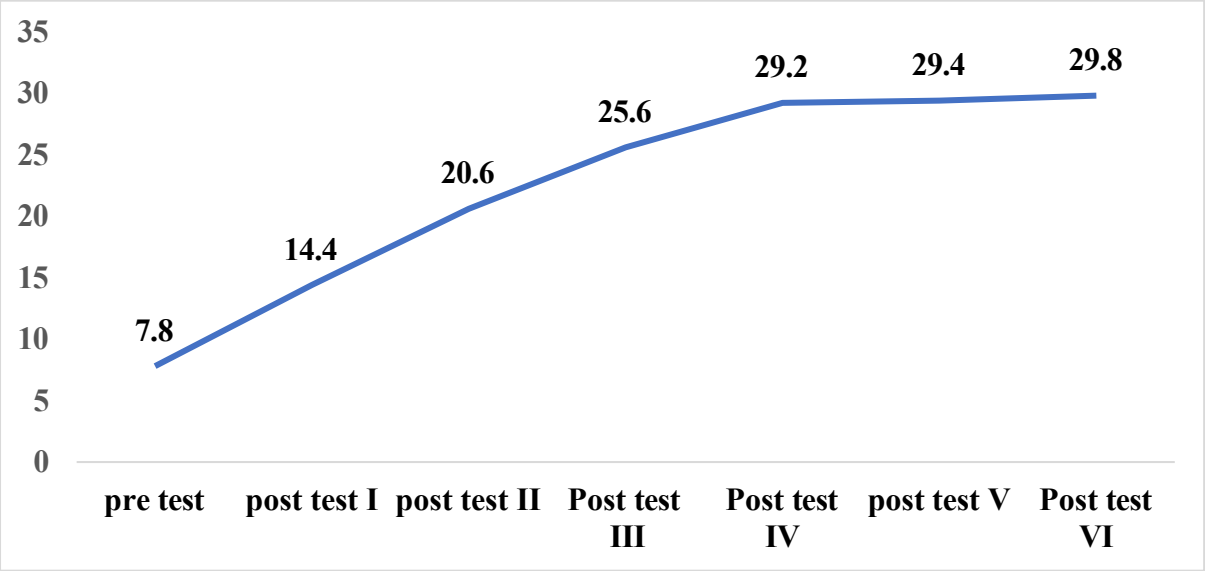

Figure No. 2. *Mean knowledge score of community self-help group during pre-test, post-test 1, post-test 2, post-test-3, post-test-4, post-test-5 and post-test 6*

DISCUSSION:

The purpose of this qualitative study was to investigate the reasons why people not following family planning techniques. A structured interviewing technique was used to collect data from women in order to gain insight into the present state of family planning use. Based on our findings, family planning practices in Dhankaur village are influenced by a variety of underlying social and personal issues that require careful consideration.

Our study found that most participants didn't have enough knowledge about family planning methods. This matches with a study done by Gagan Lata, Liza Gupta, and Moneet Walia in 2024, which showed that more people knew about condoms (56%), birth control pills (50%), IUDs (43%), and sterilization (43%). However, fewer people knew about natural methods (37%) and injectable contraceptives (12%). Overall, awareness and use of these methods were low. This shows the need to educate and encourage couples to use family planning[6].

In our study, 9 participants said their husbands don't feel comfortable using condoms. Many participants had unmet needs when it came to condom use—they didn't think condoms were important, didn't know much about them, and lacked communication with their partners. They also felt that using condoms might reduce sexual pleasure.

Some participants believed they had to follow their husband's decisions when it came to family planning. The husbands were the ones who decided what method to use. A similar study by Soley S. Bender and others found that only 43% of couples actually talked to each other about family planning. While over half of the women and nearly half of the men believed their partner supported using contraceptives, some still thought their partner disapproved[7].

Our study also showed that many participants had false beliefs about family planning. Out of 40 women, 11 said they avoided methods like sterilization or birth control pills because they were afraid of side effects. Some thought the pills could make them feel weak or cause infections and swelling. A similar study from Tamil Nadu by Naveen TS and others found that women were scared of health issues after hearing stories from others—for example, someone said their daughter got pus after getting an IUD, so they left the hospital without telling anyone[8].

Finally, some participants in our study didn't want to talk about their family planning choices. They felt it was a private matter between husband and wife. A study by Jeanne L. Alhusen and others in 2020 found similar results[9]. Some women, especially those with disabilities, didn't feel comfortable sharing their thoughts about contraception with others.

CONCLUSION:

Study concluded that, a sizable percentage of participants maintain conventional views regarding gender roles, family planning, and social expectations. It is evident that people are reluctant to talk about their private habits and feel ashamed about buying particular products. Furthermore, some individuals mention that family planning methods have detrimental physical side effects. This implies that their opinions and behaviour around family planning are influenced by social and cultural factors as well as health issues. Raising awareness of the proper application of these family planning techniques is necessary to encourage couples and their kids to have healthy lives.

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