

A systematic review on barriers to the use of contraceptive services and other family planning services among married couples in South Asia

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ABSTRACT

Introduction: There is a dearth of research in terms of systematic review to explore the barriers to contraceptives faced by married couples in South Asia. This systematic review explores the evidence on issues faced by married couples in South Asia regarding the use of contraceptives and other family planning services.

Materials and Methods: A systematic literature review was conducted using PubMed, EBSCO, and Web of Science databases. Articles published in English between 2011 and 2025 were included. Inclusion criteria were: South Asian married couples, forms of contraception, barriers to using contraception and other family planning services. A directed qualitative content analysis approach was employed, using Andersen's Behavioral Model to classify findings into predisposing, enabling, and need-based factors. Risk Of Bias assessment was done using CASP tool.

Results: Out of 301 records identified, 65 studies were finally included following screening and full-text assessment. Among these, 62% identified cultural and gender-related barriers, 54% highlighted religious influences (especially in Pakistan and Afghanistan), and 48% noted misinformation and knowledge gaps. Additional themes included service inaccessibility, provider bias, and poor outreach, particularly in Nepal and rural India.

Conclusion: In South Asian countries, there are major barriers to the use of contraception and other family planning services, mostly due to the overall lack of knowledge, religious factors and allowing myths and misinformation to discourage the use of contraceptives.

KEYWORDS:

Family planning, contraceptive, barriers, married couple, South Asia, review

INTRODUCTION

In 2012, the Family Planning 2020 (FP2020) initiative was launched to address the issue of family planning.¹ The purpose of this effort was to facilitate family planning globally. Since the launch of the family planning initiative,

the use of family planning practices has risen to a considerable level. As a result of these global efforts, in the past two decades, the number of women who wish to use family planning has increased from 900 million to more than 1 billion globally. According to estimates, by 2030, 70 million more women will require family planning services. Now, family planning is considered a sustainable global development goal and, moreover, it can be considered a cog in a wheel when it comes to environmental sustainability.

According to Pradhan, still there is a lacking in terms of use of family planning in South Asian region with the use of contraceptive prevalence rate of mere 37% and unmet need still sits at 12% in this region.² However, due to extensive intervention from the relevance stakeholders, use of contraceptive has raised significantly, though in Asian region this improvement remained sluggish and showed mere improvement from 51 percent to 51.8 percent for the years 2012 to 2017.¹

According to Phiri, it is of utmost importance to have good estimates of women who use family planning in order to face the challenges of maternal and child health.³ According to Najafi there is a dearth of comprehensive research to identify the barriers to contraceptives.⁴ Given the fact that every part of the world has its own demographic and socio-economic factors, which react to different health scenarios, a systematic review specifically focused on the South Asian region could be especially important for family planning policy in this region. Moreover, such a review is essential so that a good level of evidence can be produced, which can be useful for future planning in the region.

This systematic review was conducted with the aim of identifying barriers to the use of contraceptive services and other family planning services among married couples, as they represent the dominant user group in most South Asian societies, where contraceptive decisions are largely influenced by marital dynamics. This review also aimed to compare and analyze the similarities and differences among South Asian countries regarding family planning services. This review can be the first step to the development of a focused intervention to reduce morbidities and mortalities connected to the practice of family planning. Our systematic review brings out

This article was accepted: 9 June 2026

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Table I: PICO concepts used in the review

PICO	Concept
Population	Couples in South Asia
Intervention	Contraceptive services and other family planning services
Control	Not applicable
Outcome	Barriers to service utilization of contraceptive and other family planning services

Given the PICO concepts in Table I, the keywords and MESH terms presented in Table II were used to search for articles for this systematic review in PubMed. While the PubMed search included both free keywords and MESH terms, the search in EBSCO and WOS used free keywords only.

Table II: Keywords and MESH terms used in the search in databases

Database	Search strategy
PubMed	("married couples"[MeSH Terms] OR "spouses"[MeSH Terms] OR "husband and wife" OR "married men" OR "married women" OR "living together") AND ("contraceptive agents"[MeSH Terms] OR "contraception"[MeSH Terms] OR "birth control" OR "family planning" OR "reproductive health services"[MeSH Terms]) AND "barriers" OR "access"[MeSH Terms] OR "health services accessibility"[MeSH Terms] OR "misinformation" OR "religion" OR "cultural factors" OR "knowledge, attitudes, practice"[MeSH Terms]) AND ("South Asia" OR "Pakistan"[MeSH Terms] OR "India"[MeSH Terms] OR "Bangladesh"[MeSH Terms] OR "Nepal"[MeSH Terms] OR "Afghanistan"[MeSH Terms] OR "Sri Lanka"[MeSH Terms] OR "Maldives"[MeSH Terms] OR "Bhutan"[MeSH Terms]) Filters: English, 2011–2025
EBSCO	(TI OR AB): ("married couples" OR "spouses" OR "husband and wife" OR "married men" OR "married women") AND (TI OR AB): ("contraceptive use" OR "family planning" OR "birth control" OR "reproductive health services") AND (TI OR AB): ("barriers" OR "access" OR "misinformation" OR "religious belief" OR "cultural norms" OR "awareness" OR "stigma") AND (TI OR AB): ("South Asia" OR "Pakistan" OR "India" OR "Nepal" OR "Afghanistan" OR "Bangladesh" OR "Sri Lanka" OR "Bhutan" OR "Maldives") Limiters: Peer-reviewed, English, Publication Date: 2011–2025
Web of Science	TOPIC: ("married couples" OR "married men" OR "married women" OR "spouses") AND TOPIC: ("contraception" OR "family planning" OR "birth control" OR "reproductive services") AND TOPIC: ("barriers" OR "cultural norms" OR "religious influence" OR "myths" OR "awareness" OR "access") AND TOPIC: ("South Asia" OR "India" OR "Pakistan" OR "Nepal" OR "Bangladesh" OR "Sri Lanka" OR "Bhutan" OR "Maldives" OR "Afghanistan") Timespan: 2011–2025 Languages: English Document Types: Article

a holistic approach toward these barriers, focusing on the South Asia region as a whole. Despite extensive searching, no relevant peer-reviewed articles from Sri Lanka and Maldives met the inclusion criteria for the specified time period, which may indicate a need for more published data from these countries in future research.

MATERIALS AND METHODS

Systematic literature review is a scientific method to examine and appraise the available knowledge in a particular area per predefined criteria.⁵ It helps reduce bias during searching and provides reliable findings and meaningful results for readers to draw conclusions.⁶

For this particular study, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines

were used for reporting the review methodology and results. We also used the PRISMA checklist to ensure the quality of our review, which is considered an important standard in healthcare review-based research.⁷ Using PRISMA helps ensure that the research is not only unbiased but also captures useful information and that reporting is done in a balanced manner. The review was carried out from June 2021 to March 2025. Prior to the review, a research protocol was agreed upon. The research protocol was neither registered nor published.

Search strategy

The search for relevant articles was carried out in PubMed, EBSCO and WOS, which are commonly used in systematic reviews in the field of healthcare and provide up-to-date information on high-quality research.⁸ We used the Population, Intervention, Control and Outcome (PICO) framework to create a search syntax. Search query using the

Table III: Major barriers to the use of contraceptive services and other family planning services identified in the review

Country	Types of barriers
Afghanistan	• Lack of health services¹¹⁻¹³ • Lack of knowledge
Bangladesh	• Place of residence, religion, number of household members, woman's age, occupation, husband's education.¹⁴ • Living status with wife, total children ever died were significantly associated with contraception
India	• Service efficiency, social gender preference, desire to have another child, lack of education, working long hours in the fields. Fertility and family planning in Uttar Pradesh, India: major progress and persistent gaps.¹⁵⁻⁴⁷ • General feelings of shame to procure contraceptives for women and men. • Inability to procure contraceptives due to inaccessibility to health facilities and stigma to procure when husband was away. • Lack of control over family planning and family size decision- making relative to husbands. • Family resistance to adopt contraceptives, lack of husband's involvement in family planning issues, myths, misconceptions, and religious issues.
Maldives	No study found
Nepal	• Geographical and financial access, provider bias, poor method choice availability, the lower status of women.⁴⁸⁻⁵⁹ • Cultural norms perceived embarrassment of asking for services from the opposite gender. • Poor coverage of health facilities, lack of outreach services.
Pakistan	• Religious and financial limitations, poor knowledge about contraceptives, social and religious factors. family stigma, limited female mobility.⁶⁰⁻⁷⁶ • Lack of communication among couples.
Sri Lanka	No information was found on barriers to contraception.
South Asia	Accessing quality reproductive health services. Lack of confidentiality, privacy and poor staffing at health facilities. ⁷⁸⁻⁸⁰

PICO concepts was applied to highlight the current unanswered issues in community settings.⁹ The application of the PICO framework to select keywords in this review is summarized in table I below. The complete list of search strategies used in each database is provided in table II.

Inclusion and exclusion Criteria: Studies conducted among married couples of South Asia, using any form of contraception, examined the barriers which affect the access and use of family planning. Articles which were written only in English language and published from 2011 till 2025. Any studies which did not qualify under this selection criteria were not included, such as country of interest not in South Asia, postpartum contraceptive, no barriers investigated, articles in any language other than English and any article published before 2011

Selection procedure

The screening procedure included three phases. During the first phase, the titles and abstracts of all publications found in the search were screened by two reviewers independently, and the results were compared. Differences were discussed to determine if a given publication should be included. During the second screening phase, the full texts of publications found relevant in the first phase were reviewed by two reviewers, and differences were discussed. During the third screening phase, the reference lists of papers selected for review were screened.

Method of analysis

To have a better understanding of the barriers to contraception, the Andersen Behavioral Model (1995) was used to extract and code the relevant information from each of the articles.¹⁰ This model uses two key categories: Predisposing factors (e.g., demographic, cultural, and belief systems) and enabling factors (e.g., financial, logistic, and healthcare access). Data extraction was conducted independently by three reviewers using a predefined matrix aligned with Andersen's Behavioral Model. Each study was

reviewed and coded into predisposing, enabling, and need-based factors. To ensure consistency, a pilot extraction was performed on five studies, and discrepancies were discussed and resolved by consensus.

Inter-rater reliability was maintained through regular cross-checking and joint discussions. The directed qualitative content analysis followed a deductive approach, where predefined categories from Andersen's model guided thematic coding of each study's findings. We used a directed qualitative content analysis approach where each included article was evaluated for content matching any of these three domains. These were predefined into an extraction matrix before analysis

Risk of bias assessment

To evaluate the quality and internal validity of included studies, we conducted a risk of bias assessment using appropriate checklists from the Critical Appraisal Skills Program (CASP). Each study was reviewed using the CASP tool that matched its study design i.e. qualitative, cross-sectional (treated as observational/cohort-style), or mixed-methods (evaluated using both tools where applicable). Three reviewers independently assessed all included studies, and any discrepancies were resolved through consensus and voting. Each study was rated as low, moderate, or high risk of bias based on clarity of methodology, reporting, sampling strategy, and overall rigor.

RESULTS

Out of 301 articles screened, 65 met the inclusion criteria. Among these, 62% identified cultural and gender-related barriers, 54% highlighted religious influences (especially in Pakistan and Afghanistan), and 48% noted misinformation and knowledge gaps. Additional themes included service inaccessibility, provider bias, and poor outreach, particularly in Nepal and rural India. A total of 301 publications were retrieved and were then assessed based on our inclusion and

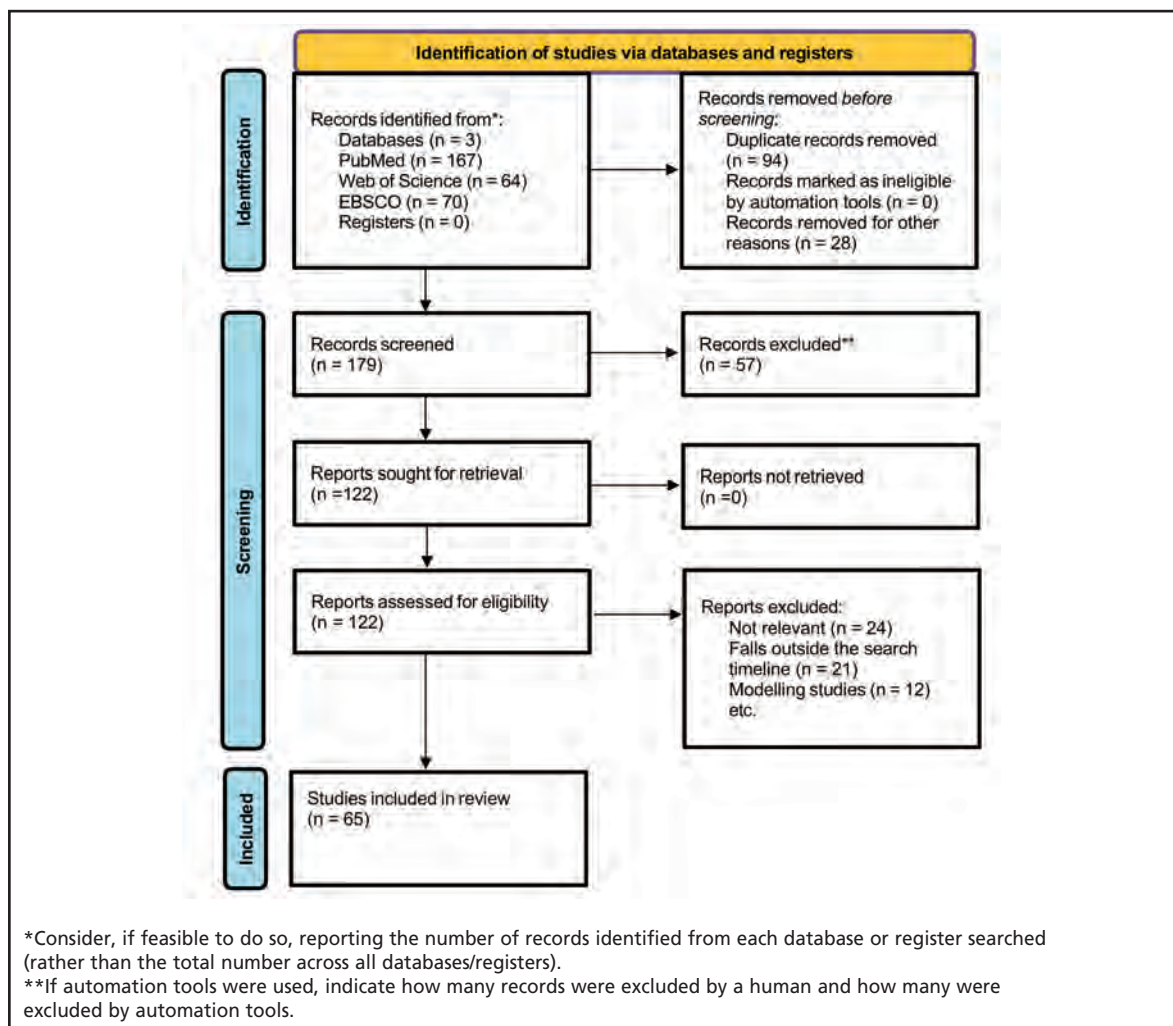


Fig. 1: PRISMA flow chart on the selected articles were retrieved and filtered based on our inclusion and exclusion criteria

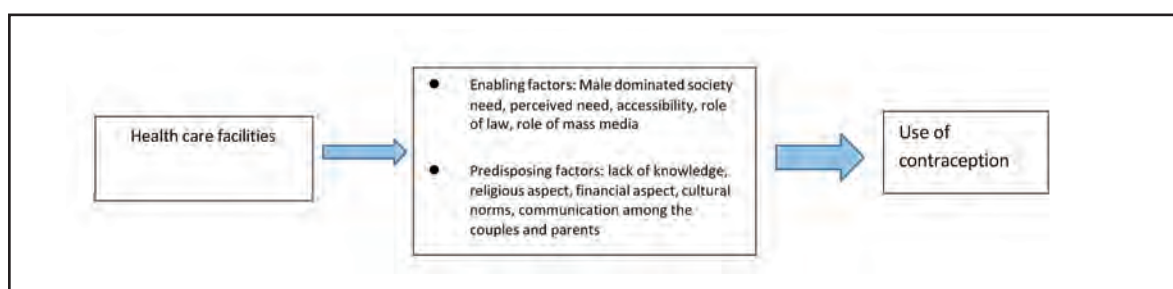


Fig. 2: Key barriers to the use of contraceptive services among married couples in South Asia

exclusion criteria. Of those publications, 94 articles were removed as duplications and 207 were filtered out as they did not meet the inclusion criteria for this review. Thus, 65 of the 301 articles were accepted for review. Figure 1 showed how the selected articles were retrieved and filtered based on our inclusion and exclusion criteria.

Assessment of bias across studies

Of the 65 included studies, 19 were qualitative, 41 were quantitative and 5 were mixed methods. Based on CASP

assessments, 33 studies (55%) were rated as having low risk of bias, 30 studies (46%) had a moderate risk, and 2 studies (3%) showed high risk of bias, primarily due to unclear sampling or weak data reporting. Qualitative studies generally demonstrated strong thematic clarity and reflexivity, while cross-sectional studies often lacked detailed justification for sample size and confounder control. Mixed-methods studies were rated moderate due to imbalanced integration of qualitative and quantitative components.

Analysis results

The most frequently reported barriers across studies were cultural and social factors (reported in 62% of studies), religious influences (54%), misinformation or lack of awareness (48%), health system access issues (39%), and gender-related power dynamics (36%). These proportions are based on coding under Andersen's Behavioral Model. While reviewing the country-wise literature, India accounted for the highest number of studies (n=32), followed by Pakistan (n=16), Nepal (n=12), Afghanistan (n=3) and South Asia (02). No eligible peer-reviewed studies from Sri Lanka and Maldives were found during the specified timeframe. Most themes were consistent across countries, although religious concerns were more prominent in Pakistan and Afghanistan, while health system-related barriers were more frequent in Nepal.

Thematic saturation was reached as recurring categories (cultural stigma, gender power imbalance, service inaccessibility, and religious beliefs) appeared consistently across included studies. We acknowledged heterogeneity in study settings and populations by using a narrative synthesis approach guided by the Andersen Model to group barriers into predisposing and enabling factors. This ensured coherence in interpretation despite variability.

Summary of evidence

Table III summarizes the major barriers to the use of contraceptive services identified in the review. The barriers are presented in every country. In Bangladesh, distance from the health facilities, women's age, breastfeeding status, and the number of children alive were among the reasons for not using contraceptives.¹¹ While reviewing the literature for India, barriers such as low literacy and long working hours were also identified. When it comes to family planning, Nepal shows the same barriers that are prevalent in other South Asian countries such as India, Pakistan, Bangladesh, and Afghanistan. In addition, structural barriers, religion, social norms, and side effects of fear are also barriers to family planning in Nepal. Pakistan showed more religious concern over the use of family planning, while communication within the couple was also a barrier.¹¹ For the Maldives and Sri Lanka, no articles could be found for our given time frame. Broadly for the South Asian context, multiple factors such as service qualities, poor staffing and a few other factors have been shown as a constraint in obtaining family planning services.¹²

DISCUSSION

This review explored the barriers to the use of contraceptives and other family planning services in South Asia. For some countries, like India, Pakistan, Bangladesh, and Afghanistan, detailed information could be extracted; for others, like Maldives and Sri Lanka, no related study could be found. Nevertheless, the review indicated some similarities in terms of religion and cultural preferences, such as male child preference, as well as health care access, knowledge gap, and economic challenges in this South Asian region.

According to our review, religion and culture were prominent barriers. For example, multiple studies from Pakistan, India, and Nepal linked religious beliefs and family opposition with

low contraceptive uptake. These findings were consistent across both qualitative and quantitative studies. These findings about religion and culture are also supported by external literature. For instance, Gedicks, et. al. argued that religion may not always be a limiting factor, while Azanawet, et al. found otherwise.⁸⁰⁻⁸¹ Several studies showed religious barriers are context-specific, varying across regions and belief systems. However, these external studies were not part of our review and are cited here to support or contrast our findings.⁸²

While analyzing the barriers to contraception, accessible health care and adequate health facilities also appear to be important factors. Our review highlighted these system-level issues, particularly in Nepal and rural India. These were most often coded as enabling barriers under the Andersen model.⁸³⁻

⁸⁴ Similar external research, such as by Nagai, describes such access barriers in the Philippines.⁸⁵ A study conducted in Nigeria also highlights how service utilization can be affected due to cultural sensitivities and personal choices.⁸⁶ Moreover, multiple researches also highlight issues of supply and demand can be a challenge in providing consumers with their required family planning methods.^{53,87} Poor provision of facilities for the consumer to get hold of family planning services also plays its role in accessing and practicing family planning.⁸⁸ According to Peterson, 34% of women remained deprived of family planning facilities merely due to service provider issues.⁸⁹

Another important aspect addressed in the papers reviewed refers to the knowledge gap at an individual level. A study conducted in Nigeria highlights the importance of reducing the knowledge gap and disseminating evidence-based information to deal with misconceptions and wrong information about contraception.⁹⁰ Turkey, which is considered a modern culture, however, research also shows knowledge gaps that are manifested as barriers to family planning practice. A study by Sothornwit, et al. states that due to the lack of knowledge, Thai women abstained from the use of contraceptives.⁹⁰⁻⁹¹ Another study by Mwaisaka, et al. also emphasizes that there is a need to address the knowledge gap challenges surrounding family planning practices because they are a major hurdle in the practice of family planning.⁹²

Initiatives for reducing the knowledge gap need to focus on both women and men. As indicated

in our review that in South Asia, predominantly husband determines the couple's family planning choices. According to Prata et al., the husband plays a pivotal role in supporting the use of family planning.⁹³ In addition, the review's results suggest that better communication within couples may increase the use of family planning. A study conducted in Uganda also mentions the importance of role of gender norms when it comes to the practice of family planning.⁹⁴ Another research done in Zambia mentions that the male partner's approach towards family size, sexual satisfaction and perceived side effects of contraception manifests its effects as barriers.⁹⁵

In today's world, we cannot ignore the importance of mass media. While our review showed limited direct evidence on this factor, external literature has shown the influence of

media on promoting contraceptive behavior.⁹⁶ These references are meant to frame potential strategies but were not part of the included studies. The economic situation is also a major factor in South Asia when it comes to deciding on the use of family planning. Our review found this most commonly in rural areas of India and Pakistan. Male economic dominance and lack of household control by women were identified as enabling barriers. While some comparative studies show similar global trends, these were cited only for contrast.⁹⁷

Based on the Andersen behavioral model, if we assess the major issues of family planning (Figure 2), we can categorize them into two factors, i.e., enabling and predisposing factors. According to our findings, the husband's opinion on family planning, coupled with cultural taboos and myths, were core predisposing factors, while access issues and affordability formed the enabling component.

Based on literature it can be deduced that there is a lack of political will, issues in supply and demand, and willingness, and different barriers that become part of a vicious cycle to achieve the desired results. While this conclusion draws partly from the literature reviewed, references to regional policy implementation are external and used here to frame context not to extend the scope of our review.

LIMITATIONS

This review has some limitations that we need to acknowledge. Relatively less research is available from Maldives and Sri Lanka, which limits the assessment of the magnitude of the problem in this region. Also, we cannot entirely exclude bias related to the search strategy because we only searched in selected academic databases and limited our search to English language publications and a specific period. As a result, we might have missed relevant publications in other languages as well as earlier publications. We cannot entirely exclude selection bias because one researcher extracted the information and assessed the papers. However, we diminished that bias to a certain extent by having a second researcher who checked the excluded publications.

CONCLUSION

In this systematic review, we looked at the barriers to the use of contraceptives and family planning in South Asian countries. The results of this review indicate that access to contraceptive and family planning methods remains a challenge in South Asian countries. There are several barriers in the region, including financial issues, poor supply and demand, cultural and religious values, and a lack of information. One of the core barriers was gender inequality and the role of male partners in family planning decision-making.

These findings suggest that policymakers and family medicine practitioners in South Asia should prioritize culturally sensitive education campaigns and community engagement, particularly involving men. Training programs should also be developed for frontline health workers,

especially in rural and underserved areas, to address misinformation, promote respectful communication, and overcome provider-level bias.

Lastly, political will and leadership play a vital role in improving these services and removing the barriers in the way of proper delivery of family planning services. Strengthening primary care systems and incorporating family planning modules in basic medical training can enhance outreach, particularly where barriers are strongest. It is important to note that no eligible studies from Bhutan, Maldives, or Sri Lanka were found, and therefore, findings may not fully represent the entire South Asian region.

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