



Mother-in-law's influence on Family Planning Decision-Making and Contraceptive Use: A Review of Evidence

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Background and Objective:

Nationally, while family planning (FP) programs have improved women's contraceptive access, there has been limited attention on the role of social networks and key influencers, beyond male partners/husbands, who can affect women's demand and use of contraceptives. Research shows that women's in-laws, particularly the mother-in-law (MIL) affect the quality of their marital relationships and their agency within these relationships. While a growing number of FP interventions include men, few include MILs^{31,32}. Greater clarity on how MILs affect women's reproductive agency and contraceptive use can be useful to guide FP programs³³.

In this brief, we examined the influence of women's MIL's (or male partner's mother) on women's FP choices and contraceptive use based on a systematic review of peer-reviewed research. We aimed to identify learnings on this role that can have implications for FP communication and contraceptive access for young couples and for enhancing young women's agency to seek and use contraception.

Methods:

We conducted a systematic review of peer-reviewed studies using online databases (PubMed Central/Google Scholar/EMBASE) between 2001 and 2021. Studies were included from all locations and of all methodologies, in English language, with participants including women or couples across adolescence and adulthood (13 years and above). A combination of search terms was used connecting '*family planning*' and '*mother in-law*' in their titles and/or abstracts.

On PubMed Central, the search was limited to titles and/or abstracts and yielded 83 results. On Google Scholar, our search yielded 18,200 results, and we ended our scoping after not coming across any relevant studies on four consecutive pages. A total of 260 titles were reviewed and validated as focused on MILs and women's FP or contraceptive behaviors by two researchers for relevance, leading to a shortlist of 27 studies from PubMed Central and 11 additional studies from Google Scholar. These articles were then fully reviewed and the following elements of each paper were extracted: methodology, location, sample, and key findings.

Thematic analyses were conducted to categorize studies based on key study findings across and specific to sub-populations. Upon review, a total of 28 studies were included for analysis.

Findings:

Our review found a total of 28 relevant studies, of which a majority (15) were published after 2016, 18 were qualitative and 26 originated in South Asian countries, with the others from Côte d'Ivoire, Egypt, Ethiopia, Ghana, Kenya and Madagascar, USA, Jordan and Turkey.

Our thematic analyses demonstrated research across five domains:

1. MIL's control over DIL's autonomy that influenced their autonomy;
2. MIL's writ and control as the household head/elder on DIL's fertility intention and reproductive autonomy;
3. MIL's writ and control as the household head/elder on DIL's contraceptive use;
4. MIL-perpetrated reproductive coercion, and,
5. Husband's role in negotiating or reinforcing MIL influence on FP decision-making.

MIL's control over DIL's autonomy that influenced their autonomy.

Available studies showed the pervasive nature of social beliefs and cultural norms around early marriage of girls and efforts made to assimilate them into and follow the authority codes and structures within their marital homes. Girls who married early or in adolescence were particularly vulnerable due to schooling losses, greater financial dependence on their husbands/in-laws and limited agency and mobility, found themselves acquiescing to the strictures imposed by their MILs. This was further facilitated by their socialization that led to internalized norms around childbearing as a way to secure their footing within the family and cementing the marital bond with their husbands^{4,28,30,35}. Studies from India¹, Bangladesh, Ethiopia², the USA³ and Nepal⁴ reported instances of MILs limiting the autonomy and mobility of adolescent brides and determining their social interactions. This social isolation has been an enabling factor in limiting girls from seeking out FP-related information and promoted the acceptability of contraceptive methods that they believed were being used by their close peers or by women in their community.¹ A study from India found that as a result of this limited mobility, MILs and sisters-in-law (SILs) became the chief sources of FP information and their approval became a critical precondition for usage. Mobility restrictions were greater in cases of co-residence with the MIL and if the MIL and DIL did not share the same views regarding their FP intentions.¹

MIL's writ and control as the household head/an elder on DIL's fertility intention and reproductive autonomy

Available studies showed that MILs played a proactive role in expropriating reproductive control on their DILs through the former's writ and control in the household.^{2-6,9,16,18-20,23,25-26,31} In this, MILs communicated to their DILs the importance of childbearing, either directly or through their sons, reminded young brides of their childbearing role, probed repeatedly whether she was attempting to conceive or was pregnant, and dissuaded her from using contraception or prevented its use. This control was particularly severe early in marriage when young married women were adapting to family dynamics and exercised limited power or agency to counter social expectations. Without a child, they found themselves in a precarious position. Their acceptance into the family was predicated on their reproductive success and was substantially higher if they gave birth to a male child.¹¹⁻¹⁴ The reproductive control exercised by MILs also manifested in their role within the household as a gatekeeper of traditional family norms and of the social interactions and health access of young women. Across contexts,

studies^{3,4,6,7,24-27} found that MILs often policed the behavior of young brides to ensure childbearing at the earliest. Studies in Bangladesh⁶, India¹¹ and Ethiopia² reported that delays in pregnancy led to a charge of engaging in extramarital affairs on young women.

MILs too experienced the pressure of prevailing social beliefs around pronatalism and early childbearing as furthering the family lineage in the community. A study in Nepal found MILs voicing fears, shame and social ridicule in the community for not having a grandchild, in particular, a grandson.⁵ These fears stemmed from concerns regarding health of the mother to talk within the community and stigma around infertility and subsequent social backlash.⁵ While MILs of many adolescent girls believed in deferring pregnancy till they had physically and emotionally matured and/or completed their education, the dread of community gossip prevented them from following up on their convictions.⁵ Delays in fertility were also compounded by unsubstantiated fears of the DIL's intentions to elope, as reported in Bangladesh⁶, Ethiopia² and Ivory Coast.⁷ In Ghana, in-laws threatened the DIL with desertion if she failed to conceive as per their expectations.⁸ Migration of men, common in Nepal, also impacted childbearing within families^{3,5,9} and there was pressure on women to have children before their husbands migrated. In some cases, a wife was not allowed to leave her marital home by her in-laws if she did not have a child. In Pakistan, MILs invoked religion to prevent their DILs from FP, even as some DILs felt that FP was in consonance with the principles of Islam.¹⁰

Education and participation in income-generating activities served as the main routes through which young women negotiated a delay in pregnancy in some contexts while proving their worth to their marital homes. In the slums of Dhaka, Bangladesh, fending off poverty took primacy over fertility expectations.⁶ Educational attainment among MILs too was associated with a delay in childbearing in rural Bangladesh.¹⁵

The reproductive control exercised by MILs also extended to DILs following norms around an ideal family size and male child preference.^{12,33-34} One study in India showed that pressure for a male child by MILs was more notable three years into the marriage¹². In India, norms around an ideal family size that originated in FP policy messaging were also voiced by the MIL¹⁶ but the same was not noted in other contexts. In Pakistan, for instance, MILs expressed their desire for a large family^{10,34} and her clout was higher in families where the DIL's husband was the only male child.¹⁰

MIL's writ and control as the household head/an elder on DIL's contraceptive use

While MILs had a say on fertility discussion and timing, a study from India showed that this influence did not always extend to contraceptive use. Beyond conveying their desired family size, MILs did not concern themselves with contraceptive use for spacing of pregnancies, nor did they always have a say in these matters. However, all three (MIL, husband and wife) concurred on female sterilization once the desired family size and sex composition was attained.¹³

Available studies show that the role of MILs in influencing contraceptive use of their DILs varied by the latter's age and parity. A study from Mali reported that older women played an active role in encouraging childbearing among younger brides and in supporting initiation and continuation of contraceptive use among older DILs.¹⁷ Having a supportive family ecosystem was a precursor to continuing with postpartum intrauterine contraceptive device (PPIUCD) use¹⁸. Similarly, studies also showed in-laws as a source of both information and beliefs related to contraceptive use, including beliefs that contraception led to infertility if used before first birth^{18,19,35}. In a study from north India, modern contraceptive use was lower in co-residence households.³²

Studies from Kenya¹⁹ and India²⁰ reported MIL beliefs and resistance to their DIL's use of contraception, with the former blaming contraception for sluggishness and shirking off domestic work. This led to a number of young women using contraceptives covertly.¹⁸⁻²⁰ Similarly, limited communication with the MILs often encouraged women to seek abortions privately, particularly, if their pregnancy was not desired or was too closely spaced with a recent delivery. A study from Maharashtra showed that young women did not confide to MILs regarding their gynecological problems and were more likely to raise these matters with their husbands.¹⁶ However, while husbands were often lax about these concerns, MILs, whenever informed, tended to view such problems with much greater seriousness and ensured that treatment for any ailment which could potentially impact fertility was promptly sought¹⁶. This was important since studies have shown that women did not always have full autonomy over their health-seeking and needed family support for accessing medical care⁹. MILs also did not hesitate to proceed with the DIL's infertility treatment including from faith healers if they perceived any substantial delay in their first pregnancy.¹⁶

While a large number of studies have drawn out the MIL role as ensuring family lineage, a few studies showed that in some cases MILs responded to their DIL's fertility desires and choices.

A study in Pakistan showed that a few DILs were able to convince their respective MILs about using modern contraception. This study reported MIL openness to understanding their DIL's perspective, and even allowed a difference of opinion in the matter, without resorting to punitive measures.¹⁰ In a study from urban slums of Karachi, Pakistan, openness to discussions on FP and contraception between MILs and DILs was associated with greater contraceptive usage among the latter.²¹ Additionally, in Kenya, MILs narrated their own lived experience and hence recognized the need for their DIL's reproductive choice in light of their family's economic situation.¹⁹ In Madagascar, female relatives including MILs, mothers and SILs played a supportive role including providing emotional and psychological guidance to first-time young parents.²²

MIL-perpetrated reproductive coercion

Among the available literature, 10 of the 28 studies reported reproductive coercion (RC) perpetrated by the MIL or their male partner's mother, including studies in Bangladesh and India,²³⁻²⁵ Pakistan,²⁶ a study among Indian immigrants in the USA,³ Jordan²⁷ and Ivory Coast.⁷ Pregnancy coercion was the most common form of RC reported experienced before first birth. These studies reported pressures on women to 'prove' their fertility and disprove the tags of '*infertility*' and '*barrenness*' with experiences of verbal, physical and emotional abuse in the initial years of marriage²⁸. In studies from the Ivory Coast⁷ and the USA³ – abuse was combined with the threats of abandonment by the MIL and frequently supported by the husband. In a study from Nepal, coercion was noted as fear of being exposed for use of contraception before the community and of disapproval by the entire clan.¹⁸ Studies also reported MIL supervision on their DILs' use of contraceptives, especially oral contraceptive pills (OCPs).²⁹ Both MILs and husbands were also found to engage in contraceptive sabotage,²⁷ and these efforts were more successful if the husband sided with his mother³⁰. Instances of RC were also associated with intimate partner violence (IPV) and abuse perpetrated by the partner as well as in-laws³⁰. Resorting to covert contraceptive use and seeking abortions furtively were means of exercising reproductive choice when existing power structures in the household did not allow women to openly exercise their fertility intention.

Available studies showed that the MIL's desire for controlling pregnancy outcomes was often driven by their desire for a male grandchild, particularly if their DIL had only had female children. A study among Indian immigrants in the USA³ found reports of women being forced to undergo sex-selective ultrasounds and subsequent abortions.

The inability to exercise reproductive agency and resist family's pregnancy coercion coupled with verbal and physical abuse by the MIL meant that these women faced multiple closely spaced pregnancies, even at the cost to their own health. Co-residence with the MIL and residence in a new country away from their natal homes exacerbated vulnerabilities of young women.³ IPV by in-laws, including the MIL, was also amplified by physical abuse by the son towards his spouse or partner. In one study, this experience of violence was cyclical – the MIL castigated the DIL and encouraged stricter forms of control, leading to episodes of violence, which in turn, emboldened the husband to exercise physical force.³ In contrast, as noted in urban Bangladesh, RC was a means to prevent DILs from conceiving too soon after marriage as the economic contributions of these women from their work gained precedence over their reproductive responsibility.³⁰ In this study, both in-laws and husbands compelled women to delay their pregnancy and forced abortions, despite the woman desiring to conceive.³⁰

Husband's role in negotiating MIL influence on FP decision-making

Available studies showed that MILs often channelize their authority through their sons. Studies in India and Nepal suggested that husbands worked as mediums to convey expectations around childbearing and family size.^{5,16} Studies also showed that across the contexts in South Asia (Pakistan³⁴, India¹³ and Nepal⁵), Africa (Ethiopia² and Ivory Coast⁷) and the USA, husbands moderated in-law influence, abuse and coercion on their wives. Their tacit or active resistance against or support for their family's behavior mitigated or aggravated in-law pressure, respectively. A study among immigrants showed that husband's acquiescence to their mother's pressure on wives for a male child emboldened the demand for sex-determination tests and abortions in case of a female fetus.³ A study from Ethiopia reported that in some cases, husbands agreed with their mother's beliefs that their wives desire to delay conception may be linked to an extramarital affair.² Among certain populations, wife's infertility were grounds for abandonment or seeking newer partnerships.⁶⁻⁸ A study from Ivory Coast reported cases where the in-laws encouraged their son to have a baby with any other woman, if his wife failed in childbearing, also putting their wives at additional risk of contracting sexually transmitted infections (STIs).⁷

In nearly all studies where a husband's influence was explored, husbands demonstrated the agency and choice to stand up to in-law pressure and limit

his family or mother's influence in his wife's reproductive decisions. This was particularly noted as studies consistently found that a husband's consent and control over his wife's use of modern contraception and spacing decisions was more important than the MIL's. However, in case the MIL and DIL agreed on contraceptive use and he shared a different opinion, he had to concede to the women in the family.¹⁶

The main issue that led to friction between the in-laws, husband and wife in relation to contraceptive use was the matter of household domestic work. In Kenya, MILs complained that the use of injectables made the DILs more lethargic, due to which the latter would shirk household work¹⁹. If husbands agreed, it would lead to contraceptive discontinuation¹⁹. In a study from India, higher parity women also reported opting for covert termination of their pregnancy due to the inability to take time off from household work, even though they felt that getting an abortion was shameful.²⁰ In Pakistan, a study reported greater harmony between the mother and son on fertility preferences than with the wife, with the latter being expected to harmonize her fertility desires with the former two.¹⁰ Ironically, we also found that in India participation of the MIL increased couple communication on FP on ideal family size, particularly before the birth of the first child.²³

What are our learnings for FP programming and interventions?

Available evidence shows that prescriptive patriarchal beliefs and norms around early marriage and pro-natalism continue to dictate the lives of women – especially young and newly married women - across contexts through MIL's influences and pressures. Childbearing thus remains the dominant proof of women's worth as brides and DILs. These beliefs, extending from South Asia to sub-Saharan Africa and among immigrant populations in the USA, are pervasive, view women from the prism of procreation, and perpetuate inequitable gender norms and fertility pressures. Through childhood to adulthood, girls are also socialized and hence internalize social beliefs on their marital and childbearing roles as a means of gaining status in the household. Unequal power dynamics in the household, including MILs' dominance over DILs, combined with prenatal norms, further limit women's reproductive agency for contraceptive use.

Our findings based on the literature on the role of the MIL show her ubiquitous presence in the lives of married women, especially young brides.

This influence manifests through their communicating fertility expectations to a young bride, their role in contraceptive communication and decision-making for young couples, as well as indirectly through their general authority on the agency and mobility of young brides.

Our analysis shows five potential pathways of MIL influence and control – their authority and control on young brides' autonomy, their control on their DIL's fertility intention and contraceptive use, respectively, MIL-perpetrated reproductive coercion and their influence through the husband. We found that while DILs often engaged and voiced their fertility desire, in most cases, they found themselves socially isolated, and at risk of violence and abandonment. While limited, there is some evidence that covert use of contraception and seeking clandestine abortions allowed women temporary reprieve and allowed some exercise of their agency, even as these instances demonstrated the powerlessness of these young women in terms of their sexual and reproductive agency. IPV by the MIL was the most serious transgression that put a strain on the DIL's reproductive agency and choice.^{3,7,24,27,29-30}

In the past few decades, FP program implementation globally has focused on improving access to sexual and reproductive health services for women belonging to various socio-demographic groups, especially among marginalized communities. However, sexual and reproductive agency and rights that are deeply connected to improving health access cannot be realized without programs engaging with families, key decision-makers and the wider social contexts that drive or enable fertility choices and contraceptive use.

Based on our findings, we recommend the following directions for exploration for FP research and programs that can utilize a life-course lens and a social-ecological perspective in their engagement with young women and their eco-system to enhance reproductive agency and choice. These include:

1. Engaging with adolescent development programs supporting girls' higher education, delays in marriage, increasing young women's economic agency and resiliency to enable and negotiate marital choices and marital agency.
2. Strengthening FP health systems, especially counseling to engage with couples, in-laws and communities in order to understand and, where needed, modify fertility and FP beliefs and norms around early fertility, spacing, ideal family size and son preference.

3. Exploring the role of social network-based interventions including self-help groups that engage women of diverse age groups on issues related to spacing and limiting children, contraceptive beliefs, delaying first birth and son preference.
 - Improving current evidence to understand women and men's social networks and influence of family or friends in enabling or limiting FP choices.
 - Efforts to engage boys and men through the lifespan from adolescence to adulthood using social and behavioral communication interventions to alter traditional gender norms around marriage, sex, family and work, as well as linking male engagement in FP with interventions to prevent violence and coercion against women.
4. Enhancing FP knowledge and communication through interventions with families and communities to improve spousal and intergenerational communication on FP, fertility timing and use of contraception.
5. Understanding issues and beliefs related to fertility and infertility in the community and covert use of contraception and abortion.

REFERENCES

1. Anukriti S, Herrera-Almanza C, Pathak PK, Karra M. Curse of the Mummy-ji: the influence of mothers-in-law on women in India. *American Journal of Agricultural Economics* 2020; 102(5): 1328-51.
2. Ketema H, Erulkar A. Married adolescents and family planning in rural Ethiopia: understanding barriers and opportunities. *African Journal of Reproductive Health* 2018; 22(4): 26-34.
3. Puri S, Adams V, Ivey S, Nachtigall RD. "There is such a thing as too many daughters, but not too many sons": A qualitative study of son preference and fetal sex selection among Indian immigrants in the United States. *Social science & medicine* 2011; 72(7): 1169-76.
4. Sekine K, Khadka N, Carandang RR, Ong KIC, Tamang A, Jimba M. Multilevel factors influencing contraceptive use and childbearing among adolescent girls in Bara district of Nepal: a qualitative study using the socioecological model. *BMJ open* 2021; 11(10): e046156.
5. Diamond-Smith N, Plaza N, Puri M, Dahal M, Weiser SD, Harper CC. Perceived conflicting desires to delay the first birth: A household-level exploration in Nepal. *International perspectives on sexual and reproductive health* 2020; 46: 125.
6. Samandari G, Sarker BK, Grant C, et al. Understanding individual, family and community perspectives on delaying early birth among adolescent girls: findings from a formative evaluation in rural Bangladesh. *BMC Women's Health* 2020; 20(1): 1-10.
7. Gupta J, Falb K, Kpebo D, Annan J. Abuse from in-laws and associations with attempts to control reproductive decisions among rural women in Côte d'Ivoire: a cross-sectional study. *BJOG: An International Journal of Obstetrics & Gynaecology* 2012; 119(9): 1058-66.

8. Ofosu-Budu D, Hanninen V. Living as an infertile woman: the case of southern and northern Ghana. *Reproductive health* 2020; 17(1): 1-9.
9. Shattuck D, Wasti SP, Limbu N, Chipanta NS, Riley C. Men on the move and the wives left behind: the impact of migration on family planning in Nepal. *Sexual and reproductive health matters* 2019; 27(1): 248-61.
10. Kadir MM, Fikree FF, Khan A, Sajjan F. Do mothers-in-law matter? Family dynamics and fertility decision-making in urban squatter settlements of Karachi, Pakistan. *Journal of biosocial science* 2003; 35(4): 545-58.
11. Ghule M, Raj A, Palaye P, et al. Barriers to use contraceptive methods among rural young married couples in Maharashtra, India: qualitative findings. *Asian journal of research in social sciences and humanities* 2015; 5(6): 18.
12. Robitaille M-C, Chatterjee I. Mothers-in-law and son preference in India. Available at SSRN 2208354 2014.
13. Char A, Saavala M, Kulmala T. Influence of mothers-in-law on young couples' family planning decisions in rural India. *Reproductive health matters* 2010; 18(35): 154-62.
14. Farid H, Siddique SM, Bachmann G, Janevic T, Pichika A. Practice of and attitudes towards family planning among South Asian American immigrants. *Contraception* 2013; 88(4): 518-22.
15. Bates LM, Maselko J, Schuler SR. Women's education and the timing of marriage and childbearing in the next generation: evidence from rural Bangladesh. *Studies in FP* 2007; 38(2): 101-12.
16. Barua A, Kurz K. Reproductive health-seeking by married adolescent girls in Maharashtra, India. *Reproductive health matters* 2001; 9(17): 53-62.
17. Madhavan S, Adams A, Simon D. Women's networks and the social world of fertility behavior. *International FP perspectives* 2003: 58-68.
18. Puri MC, Joshi S, Khadka A, Pearson E, Dhungel Y, Shah IH. Exploring reasons for discontinuing use of immediate post-partum intrauterine device in Nepal: a qualitative study. *Reproductive Health* 2020; 17(1): 1-6.
19. Burke H, Ambasa-Shisanya C. Qualitative study of reasons for discontinuation of injectable contraceptives among users and salient reference groups in Kenya. *African journal of reproductive health* 2011; 15(2).
20. Ravindran TS. Safe, accessible medical abortion in a rural Tamil Nadu clinic, India, but what about sexual and reproductive rights? *Reproductive health matters* 2015; 22(44): 134-43.
21. Fikree FF, Khan A, Kadir MM, Sajjan F, Rahbar MH. What influences contraceptive use among young women in urban squatter settlements of Karachi, Pakistan? *International family planning perspectives* 2001: 130-6.
22. Igras S, Yahner M, Ralaison H, et al. Reaching the youngest moms and dads: a socio-ecological view of actors and factors influencing first-time young parents' use of sexual and reproductive health services in Madagascar. *African Journal of Reproductive Health* 2019; 23(3): 19-29.
23. Dixit A, Bhan N, Benmarhnia T, et al. The association between early in marriage fertility pressure from in-laws' and family planning behaviors, among married adolescent girls in Bihar and Uttar Pradesh, India. *Reproductive health* 2021; 18(1): 1-9.
24. Tomar S, Dehingia N, Dey AK, Chandurkar D, Raj A, Silverman JG. Associations of intimate partner violence and reproductive coercion with contraceptive use in Uttar Pradesh, India: How associations differ across contraceptive methods. *PLoS one* 2020; 15(10): e0241008.
25. Bhilwar M, Lal P, Sharma N, Bhalla P, Kumar A. Prevalence of induced abortions and contraceptive use among married women in an urban slum of Delhi, India. *International Journal of Gynecology & Obstetrics* 2017; 136(1): 29-32.
26. Shah NZ, Ali TS, Jehan I, Gul X. Struggling with long-time low uptake of modern contraceptives in Pakistan. *Eastern Mediterranean Health Journal* 2020; 26(3): 297.
27. Clark CJ, Silverman J, Khalaf IA, et al. Intimate partner violence and interference with women's efforts to avoid pregnancy in Jordan. *Studies in FP* 2008; 39(2): 123-32.
28. Boyacıoğlu AÖ, Türkmen A. Social and cultural dimensions of pregnancy and childbirth in eastern Turkey. *Culture, health & sexuality* 2008; 10(3): 277-85.
29. Pearson E, Andersen KL, Biswas K, Chowdhury R, Sherman SG, Decker MR. Intimate partner violence and constraints to reproductive autonomy and reproductive health among women seeking abortion services in Bangladesh. *International Journal of Gynecology & Obstetrics* 2017; 136(3): 290-7.
30. Rashid SF. Emerging changes in reproductive behaviour among married adolescent girls in an urban slum in Dhaka, Bangladesh. *Reproductive health matters* 2006; 14(27): 151-9
31. Determinants of Life Satisfaction: Role of Living Arrangements, Social Status, and Perceived Satisfaction in Women
32. Bryant, C. M., Conger, R. D., & Meehan, J. M. (2001). The influence of in-laws on change in marital success. *Journal of Marriage and Family*, 63(3), 614-626.
33. Cavallaro, F. L., Benova, L., Owolabi, O. O., & Ali, M. (2020). A systematic review of the effectiveness of counselling strategies for modern contraceptive methods: what works and what doesn't?. *BMJ sexual & reproductive health*, 46(4), 254-269.



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For **resources** on understanding gender equity in FP:

- <https://emerge.ucsd.edu/gem-fp/>
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