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Exploring experiences regarding contraception practices among married men in a rural area of West Bengal: A qualitative study

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ABSTRACT

Objective: To explore the experiences of contraceptive use, reasons for discontinuation, and future intent to use modern contraceptives among married men in West Bengal, India.

Methods: A community-based cross-sectional qualitative study was conducted among married men ($n=10$), aged 18 to 50 years by in-depth face-to-face interviews using a predesigned interview guide. The results were transcribed, coded and analysed recognising major themes.

Results: The study identified the following themes as a rationale for men's limited involvement in contraception: insufficient knowledge and education about contraception, cultural and religious barriers, misconceptions, economic hardships, gender-based disparities, and a shortage of male healthcare workers, along with a reluctance to seek help. Limited overall awareness about the specific role of men in reproductive health was also believed to hinder men's meaningful involvement in fertility regulation issues.

Conclusions: Several challenges are identified among married males related to effective contraception use and the findings emphasize the importance of comprehensive education, culturally sensitive strategies, and improving access and affordability of contraceptives to overcome such barriers. These steps are essential for enabling informed reproductive health decisions and improving reproductive health outcomes.

KEYWORDS: Eastern India; Family planning; Male partner; Modern contraceptives; Reproductive health; Role

planning to control unregulated births[2]. Family planning has traditionally been viewed as primarily a woman's responsibility, especially in male-dominated societies like India, as a result, most of the studies on family planning in developing countries have focused on women. Increasingly, it is recognised that achieving progress in family planning requires the active involvement of men too. So, exploring the role of husbands in contraceptive practices is particularly important[2]. Over the decades, there has been considerable expansion and strengthening of the family welfare services across the country; however, the lack of focus on men in reproductive health interventions has reduced the effectiveness of

Key Points

Question: What are the factors associated with male contraception practices and experiences in West Bengal?

Findings: This qualitative study, based on in-depth interviews with 10 married men identified major barriers to male involvement in contraception, including lack of knowledge, cultural and religious constraints, misconceptions, financial difficulties, gender disparities, and inadequate male healthcare support.

Meaning: Addressing these barriers through education, culturally appropriate interventions, and improved contraceptive access is crucial to enhancing male engagement in reproductive health and promoting informed family planning decisions.

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1. Introduction

Although globally, India was the first country to launch a family planning programme in 1951; ironically, it is currently the world's most populous country[1]. An uncontrolled and rapid population growth is a burden on the resources of developing countries like India[2]. Unregulated fertility can compromise the economic development and political stability of a country; many international institutions and organisations have strongly advocated family

these family planning programs making it essential to consider men's perspectives[3].

The current research investigates qualitatively the factors that drive or hinder family planning uptake to explain why some men do not adopt contraceptive methods. There is a significant lack of research on married males, particularly in rural areas of West Bengal regarding their role in contraceptive practices. With this backdrop, the current study aims to explore the experiences of contraceptive use, reasons for discontinuation, and future intent to use modern contraceptives among married men aged 18-50 years in a rural area of West Bengal, India.

2. Methods

2.1. Study design

A qualitative, exploratory research design was used to investigate the complex and subjective experiences of married men regarding contraceptive use. The exploratory nature of the design aimed to uncover insights into the motivations, barriers, and facilitators that influence men's contraceptive behaviours. The community-based cross-sectional study was conducted over a period of four months between March 2023 and June 2023. The study was conducted within the constructivist research paradigm, aligning with a focus on understanding the personal experiences and perspectives of the participants, recognising that multiple realities may exist based on individual backgrounds and contexts. A constructivist approach facilitated a deeper engagement with participants' lived experiences, capturing the meanings they ascribe to contraceptive use.

2.2. Participant recruitment

Local health workers who were familiar with the community facilitated participant recruitment. They helped identify eligible participants and established contact. Participants were personally approached, and the nature of the study was explained to them informally before seeking their formal consent. Married men aged between 18-50 years, residing in the Bishnupur-II block of South 24 Parganas, West Bengal who gave consent to participate in the study were included in this study using a purposive sampling technique.

2.3. Data collection

An in-depth interview was conducted at the participant's residence or preferred place to ensure the participant's comfort. Privacy and confidentiality were given utmost importance, keeping the topic's sensitivity in mind. The participants were first familiarised, and a rapport was built before commencing the in-depth interview. They were allowed to speak their mind, and necessary probing was done for more clarification of a statement or if they strayed from the topic. The in-depth-interview continued for about 45-60 minutes

per participant. A total of 10 participants were interviewed until no new insights emerged. The interviews were audio-recorded with permission from the participants. The interviews were transcribed verbatim. The progress was discussed weekly among the authors, and necessary improvements were made if required.

2.4. Data analysis

AK, RS, and MG analysed the data independently, and any disputes were discussed among them. The final coding and themes were reviewed and verified by JP and SS. This ensured the reduction of bias, and quality enhancement of the process. We first familiarised ourselves by reading the transcripts repeatedly before generating codes. Initial codes were repeatedly checked and updated as required. Then, these codes were grouped under broader themes representing key ideas or patterns. Themes were again reviewed and updated as required, aligning with the context, accuracy, coherence, participants' view, and expert opinion, *etc.*, *e.g.*, overlapping themes were merged, sub-theme "lack of information" was interpreted as meant by the participant, *etc.* The themes were analysed in relation to the research questions and the constructivist paradigm, providing insights into the subjective experiences and social contexts that shape men's contraceptive behaviour. The entire analysis process was iterative, with the researchers constantly comparing the emerging themes to the data and reflecting on how their own perspectives might influence the interpretation. Reflectivity was practised throughout the analysis to minimize researcher bias and ensure trustworthiness.

2.5. Ethical consideration

Ethical clearance was taken from the Institutional Ethics Committee of the Institute of Health and Family Welfare, West Bengal (IEC No. IHFW/IEC/2821, dated 13/04/2023). Written informed consent was obtained from participants prior to the study.

3. Results

3.1. Characteristics of participants

A sample of 10 respondents, ranging from 18 to 50 years of age, with a mean age of (37.3±5.8) years, was selected, and the majority of the respondents belonged to the Hindu religion (80%) and General Caste (70%). Most respondents had an education level at the higher secondary level and above (60%). The majority were independent workers (40%) running their own business or farming (Table 1).

Participants were sexually active, with most having heard about contraception, primarily about oral contraceptive pills (OCPs) and condoms. Decision-making was mostly done independently, with a preference for the wife to be the user.

3.2. Emerged themes

Multi-level factors influencing male involvement in the decisions regarding family planning services emerged from the individual interviews. The in-depth face-to-face interviews were conducted with 10 participants with different occupations, and six major themes emerged from the interviews (Table 2).

3.2.1. Knowledge gap, unawareness, and erroneous idea

3.2.1.1. Lack of information

Few of the respondents said that they did not have much knowledge about different types of contraception and their uses, methods of use, benefits, side effects. Mr Das (name changed) said,

"I don't know about the different contraceptive methods, how effective they are, or how to use them correctly..."

3.2.1.2. Lack of awareness generation at the school level

As per the response of a few respondents, they did not have much education and no one in school told them properly about contraception. Hence, their knowledge regarding the same was not adequate. There were some misconceptions and wrong beliefs. Mr M Roy (name changed) said,

"We did not get any information about it at schools. A piece of timely information and education on it might have helped us better."

"Provide training for teachers to deliver effective sexual education lessons. Equip them with appropriate resources, and teaching materials, and give access to up-to-date information on contraception to ensure that they are well-informed and can address students' questions and concerns..."

3.2.1.3. Misconception

Sanjit Halder (name changed) was a 38-year-old man in state government service for the last 10 years. He had a baby boy of 1 year and was living a happy life with his wife. When he was asked about his knowledge regarding contraception, he answered,

"Contraceptives are good, but they have lots of side effects. I have come to know from my friends as well as from my relatives, and the best example is myself only, my first wife used to use OCPs regularly without fail during our early marital life, and after 2 years of living together, we decided to extend the family. After that, we tried for a long 2 years without any protection. Our married life became very miserable during

that period, and she left, blaming me that I forced her to take pills, and because of that she can't conceive. After 2 years of that, I had a second marriage and I haven't used any contraception from the beginning this time and after one year of my second marriage, I have become a father"

3.2.2. Lack of interest in enhancing knowledge

Some respondents lacked awareness about family planning. However, they believed their knowledge of contraceptive methods was sufficient and did not require further information. Mr Sk Aminur (name changed) said,

"No need, we know much regarding family planning from our relatives and friends. They are happy with their practices so we will also be happy. The Government is trying to misguide us..."

3.2.3. Cultural or religious beliefs

One of the respondents, Akram Mondal (name changed), a 44-year-old primary school teacher, surprisingly shared his belief that family extension should purely be by God's decision and men had nothing to do with it.

"There is no need to educate men about contraception; instead, we should accept God's will. Yes, I believe that culture and religion have a significant influence..."

3.2.4. Financial hardship

3.2.4.1. Lack of affordability

One of the respondents Mr S Ali (name changed), said that contraceptive methods should be free of cost and should be provided door to door or they should be provided at a reasonable price if anyone wished to buy it from a private shop.

"Ensure contraception is affordable and accessible by offering subsidies for contraceptives or providing them at no cost..."

3.2.4.2. Poverty

One of the respondents, Mr Jabbar Sk. (name changed), 42 years old man, working as a daily wage labourer replied that the government should think of bread and butter of all first and then family planning.

"I don't want to tell anything regarding family planning but one thing I want to tell our Govt. The Govt. should think that we don't want the idea of family planning, but bread and butter to eat, to live, a shelter to stay. Govt. should think of it first. The Govt. is unable to provide these and is thinking about family planning! ..."

Table 1. Participants' characteristics.

Participant	Age (years)	Religion	Caste	Education	Occupation	Socioeconomic status (Modified BG Prasad scale 2023) ^[41]
No. 1	44	Hindu	Scheduled Caste	Masters	Primary school teachers	Upper class
No. 2	32	Hindu	General Caste	Masters	Serviceman	Upper class
No. 3	42	Hindu	General Caste	Primary school pass	Work for daily wages	Lower class
No. 4	38	Hindu	General Caste	Masters and above	State government service	Upper class
No. 5	38	Muslim	Other Backward Caste	Graduate	Daily labourer	Middle class
No. 6	33	Hindu	General Caste	Higher secondary	Barber (own shop)	Lower middle class
No. 7	31	Muslim	General Caste	Secondary school pass	Labour	Lower class
No. 8	46	Hindu	Scheduled Caste	Secondary school pass	Self-employed	Lower middle class
No. 9	29	Hindu	General Caste	Graduate	Shopkeeper (own shop)	Middle class
No. 10	40	Hindu	General Caste	Illiterate	Farmer (own land)	Lower class

Table 2. Key themes and sub-themes influencing male experiences of contraction practices.

Themes	Subthemes	Descriptions
Knowledge gap, unawareness, and erroneous ideas	Lack of information	Participants expressed a lack of knowledge regarding health and contraceptive options.
	Lack of awareness generation at the school level	Limited exposure to sexual education during school years contributed to the lack of awareness.
	Misconceptions	Misunderstandings about the safety and efficacy of contraceptives were common.
Lack of interest in enhancing knowledge	-	There was a general lack of interest in actively seeking more information about health.
Cultural or religious beliefs	-	Cultural and religious influences were seen as significant barriers to discussing health issues openly.
Financial hardship	Lack of affordability	Financial constraints, particularly the cost of medications and services, were major concerns.
	Poverty	Participants emphasised poverty as a priority concern over specialized health services.
Patriarchal norms and attitudes	Male dominating behaviour	Patriarchal norms led to the belief that women were more responsible for contraception.
	Embarrassment to buy contraceptives	Social stigma and embarrassment were prevalent when buying contraceptives.
Lack of male healthcare workers	-	The absence of male healthcare workers led to discomfort in discussing sensitive health matters.

3.2.5. Patriarchal norms and attitudes

3.2.5.1. Male-dominant behaviour

One of the respondents, Mr Kanailal Mondal (name changed), aged about 38 years and a businessman by profession, said that women should primarily be responsible for family planning and using contraceptive methods.

"Only women can give birth to a child, so yes, of course, women are more responsible or aware about contraception in my opinion."

3.2.5.2. Embarrassment to buy contraceptives

One of the respondents, Mr Sayan Dey (name changed), a 32-year-old serviceman, hesitantly mentioned that he did not have much time to buy condoms or other contraceptive methods available at the medical store, so he felt that the responsibility should fall to the female.

"I feel embarrassed to buy condoms and am busy with my job, so I think my wife should always handle it. It should be her responsibility to purchase contraceptives."

A potential social view on contraception and "taboo" is likely to play its role here.

3.2.6. Lack of male healthcare workers

Some of the respondents stated that there was a huge gap related to male health workers visiting door-to-door and providing the service. They added that most of the time when female ASHA (Accredited Social Health Activist) visited their homes, they felt shy to ask anything and their doubts remained.

"Only female health workers, specifically ASHA didis, visit our home. Personally, I don't feel comfortable discussing contraceptives with them because of the personal and sensitive nature of the topic."

4. Discussion

Family planning and contraception practices are integrated with social, and cultural beliefs and customs[5–7]. It is not only driven by commonly identified sociodemographic factors like education, socioeconomic class, information and service gap, but also by region-specific societal beliefs, gender roles, views of the local leaders and influential characters, customs, traditions, gender equity and many more social factors. The interplay of these several explored, less-explored sociodemographic factors affects people's family planning practices. Though often gender roles, gender equity, finance and economic forces have been reported to be key players, somehow people's very belief systems remain driving all these.

The current study revealed that a lack of information on contraception among respondents might have contributed to lower usage and effectiveness, as limitations of knowledge about available methods, their use, benefits, and side effects persisted generously. Additionally, some respondents indicated that their lack of education and proper information about contraception had led to misconceptions and incorrect beliefs. A 2012 study, among married youth in Pakistan, revealed several myths and misconceptions about male contraceptive methods, including beliefs that condoms and vasectomy cause impotence in males and that condoms can lead to infections, backache, headaches, and joint pains for both partners, highlighting significant misinformation[8]. A study in 2015 in selected areas of Madhya Pradesh, India, revealed that male sterilisation was deemed unacceptable by participants, as they believed it would lead to weakness and negatively impact men's physical work performance[9]. Similar findings had also been reported in a study of 2017 among married Ugandan men which reported that the study participants had limited accurate knowledge

of contraceptive methods, often held misconceptions about side effects, and primarily relied on their partners for information rather than healthcare providers. Additionally, men were concerned about the effectiveness and safety of contraceptives, particularly regarding potential negative impacts on their partner's health[10]. Similarly, a respondent in the current study believed that contraceptives have significant side effects, influenced by his first wife's experience with hormonal pills.

Additionally, respondents noted a gap in services since family planning services are being provided predominantly by female health workers, and due to hesitancy, many doubts remain unsolved. Similarly, a study of 2021 among young married men in rural Odisha, India, found that many young men were hesitant to seek contraception services due to the predominance of female frontline health workers. These findings underscore the need for the health system to more effectively involve young married men in contraception decision-making and to include male frontline health workers who can better engage with young men on sexual and reproductive health issues[11].

In the current study, a respondent expressed that women are primarily responsible for family planning and contraception. A study in 2002 revealed similar findings among men, showing a generally positive attitude towards family planning and contraception, but with the persistent belief that it was the wife's responsibility[12].

The current study revealed surprising insights into the barriers to contraceptive use, including affordability and cultural beliefs. It was suggested that contraceptive methods should be made affordable, either by providing them free of charge, door-to-door or by ensuring reasonable prices at private shops. Additionally, some respondents expressed a belief in divine will, stating that they see no need for contraception due to the absence of complications in their families, highlighting the significant influence of cultural and religious beliefs on contraceptive decisions. A study conducted in rural India in 2022 found that men who were above the poverty line and had higher levels of education were more likely to be actively involved in family planning[13]. In a study conducted in 2012 in rural Pakistan examining the barriers to contraceptive use, the findings revealed that men identified financial and cultural factors as their primary barriers. Financial constraints, including the high cost of contraceptive methods, were a significant deterrent, while cultural and religious beliefs, such as the notion of divine will or the influence of traditional norms, also played a critical role in shaping their attitudes toward contraception. These barriers contributed to the low uptake of contraceptive practices in the region[5]. In a study conducted among men in a rural community in Maharashtra, it was revealed that the low acceptance of male contraceptive methods was due to a lack of motivation, misconceptions, limited awareness and access to services[14,15].

The role of schools and teachers was questioned by some participants. This should be addressed by the government for better outcomes of family planning-related issues. Additionally, the engagement of male health workers in family planning services could be of help to males by clearing their doubts regarding

contraception. In a patriarchal society like India, it is not so unexpected that the role of male partners would be avoided just by pressing the fact that females are the ones who bear children. Several studies highlighted this issue too, where due to male dominance, their wives were not able to make decisions about their reproductive health[16,17]. The role of men in the reproductive health of both as a couple and changes in coercive attitudes should be focused on in the long run to achieve better outcomes related to reproductive health. It is high time to emphasise this behaviour change, as a healthy family can only emerge from a healthy relationship, whether in overall decision-making or matters related to reproductive health. We generally do not seek representativeness in qualitative studies but rather search for potential driving factors and phenomena. The themes identified in a rural area may not apply to urban or semi-urban areas or might represent them in different forms altogether. Different states may have various barriers or the same barrier represented in different ways, which will require further research to understand.

There are some limitations in the study. This qualitative study provides valuable insights into contraception-related barriers in a rural setting, though certain limitations should be considered. The experiences of males in other areas might differ from these findings. The reliance on self-reported data introduces potential biases, including social desirability and reluctance to discuss sensitive topics. Additionally, some structural and policy-level factors might have remained underexplored, and the study's cross-sectional design prevents analysis of changing attitudes over time.

In conclusion, the findings have highlighted several critical barriers to the effective use of contraception among the respondents. The lack of education and proper information has led to widespread misconceptions, contributing to a low level of awareness and knowledge about contraceptive methods, their benefits, and potential side effects. Cultural and religious beliefs further reinforce the resistance to contraception. Economic factors, including poverty and the affordability of contraceptives, have been identified as significant concerns along with the need for more accessible and affordable contraceptive options to encourage wider usage. The hesitation among some men to purchase contraceptives and the dominant role of males in decision-making have been noted as additional obstacles. The lack of male healthcare workers has been identified as a significant gap in the provision of information and services, particularly as some respondents felt uncomfortable seeking advice from female health workers. This gap further perpetuates the cycle of misinformation and reluctance to use contraception.

Overall, these findings underscore the need for comprehensive educational campaigns starting from the school level, culturally sensitive approaches, and targeted efforts to improve access and affordability of contraceptives. Incorporating male health workers or more innovative approaches like peer education can be thought of too. Addressing these barriers is crucial for enhancing male engagement in family planning efforts and ensuring that couples can make informed decisions about their reproductive health.

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Conflict of interest statement

The authors declare no competing interests.

Authors' contributions

Anil Karmakar contributed to concept, methodology, acquisition, analysis, interpretation, and draft. Jayita Pal performed methodology, analysis, interpretation, review, and supervision. Rakhi Saha contributed to analysis, manuscript writing, and editing. Sankalpa Satapathy contributed to methodology, analysis, interpretation, review, and editing. Manoj Ghosh contributed to methodology, analysis, interpretation, and editing.

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