Summer Training

at

CARE India Solutions for Sustainable Development

(11th April 2022 to 24thJune 2022)

Male Engagement and Its Role in Contraception Use among Young Low Parity Couples In Bihar.

By

Ayusman Jena

Under guidance of

Dr. Sidharth Sekhar Mishra

PGDM (Hospital and Health Management)

2021-2023

International Institute of Health Management Research, New Delhi

CARE India Solutions for Sustainable Development

Date: 24/06/2022

Internship completion certificate

This is to certify that **Ayusman Jena** pursuing **Post-Graduate Diploma in Hospital and Health Management (PGDM)** at the **International Institute of Health Management Research (IIHMR), Delhi** has completed his internship with **CARE India Solutions for Sustainable Development (CISSD)** from **11/04/2022 to 24/06/2022**.

As a part of this internship, he successfully delivered the following assignments:

1. Literature review, tool development, data collection, data management and analysis of study topic**: Male Engagement and Its Role in Contraception Use among Young Low Parity Couples In Bihar.**
2. Have done In-Depth interviews in three Districts (Patna, Vaishali, and Arwal) of Bihar.
3. Writing the comprehensive Internship report by the contextualization of the analytical findings with the summary of the literature review. Prepared Evidence table, Code dictionary, Themes and Subthemes based on the literature review.
4. Coding of transcripts, thematic extraction, cleaning, and contextualization using Atlas Ti, for preparing the qualitative data for analysis. Exposed to Data management, Data cleaning and analysis using SAS, MS- Excel/Word/PowerPoint.
5. Presentation editing and compilation of slide decks for DMT Outreach project. &
6. Presentation editing of slide decks and compilation of district stories depicting the progression of health and nutrition related indicators in Bihar for 2014-2021.

During this period, he displayed very good adherence to protocols, punctuality, clarity of understanding, writing skill, teamwork, commitment, sincerity and diligence with analytical progress. Based on his learning abilities and efforts, it appears that, given the level of effort and aptitude he has, if given chance he can become a very important contributor in public health research and implementation sector of India.

Wishing her the best for the future,

Dr Tanmay Mahapatra
Team Lead, CML Unit

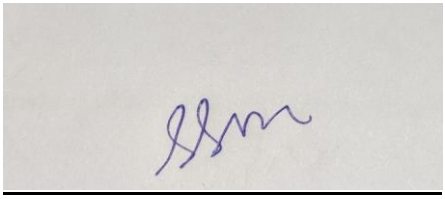
Regards
Dr. Anup Gopalakrishnan Nair
Deputy Director HR & OD

Registered Office:
Module No. 411, 4th Floor
NSIC-MDBP Building
Okhla Industrial Estate
New Delhi - 110020

+91-11-69200000
contactus@careindia.org
www.careindia.org
CIN : U85100DL2008NPL381564

Certificate of Approval

The Summer Internship Project of titled **"Male Engagement and its role on Contraception Use among young low parity couples in Bihar"** at **"IIHMR, DELHI"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein but approve the report only for the purpose it is submitted.



Dr.Sidharth Sekhar Mishra.
Assistant Professor.
IIHMR, New Delhi.

FEEDBACK FORM

(ORGANIZATION SUPERVISOR)

Name of the student: Ayusman Jena

Summer Internship Institution: CARE India Solutions for Sustainable Development

Area of Summer Internship: Male Engagement and Its Role In Contraception Use among Young Low Parity Couples In Bihar.

Attendance: Perfect adherence to internship norms

Objectives Met: The student understood the details of the concept, theoretical underpinning, worked on the literature review, guideline development, study implementation and participated in the analysis and interpretation

Deliverables:
Supported in Presentation of slide decks and compilation of district story of Bihar 2014-21, have done In-Depth interviews in three districts of Bihar, Data management, Data cleaning and analysis, Regression through Software like SAS and MS-excel. Learnt to develop Qualitative tool guide, code dictionary, thematic analysis, and extraction. Supported in presentation of slide decks- DMT Outreach project. Conducted the above deliverables using PowerPoint, ATLAS.TI, SAS, EXCEL, ENDNOTE

Strengths: Sincerity, engagement, concentration, hard work, diligence and eye for details

Suggestions for improvement: Communication skill, scientific writing, subject and programmatic knowledge, analytical thinking and skills

Signature of the Officer-in-charge

Date: 17.06.2022
Place: Patna, Bihar

Local Mentor: Dr Tanmay Mahapatra

Deputy Director HR: Dr Anup G Nair

Registered Office:
Module No. 411, 4th Floor
NSIC-MDBP Building
Okhla Industrial Estate
New Delhi - 110020

+91-11-69200000
contactus@careindia.org
www.careindia.org
CIN : U85100DL2008NPL381564

FEEDBACK FORM (IIHMR MENTOR)

Name of the Student: Brajaraj Tripathy

Summer Internship Institution: CARE India Solutions for Sustainable Development

Area of Summer Internship: Male Engagement and Its Role In Contraception Use among Young Low Parity Couples In Bihar.

Attendance: Perfect adherence to internship norms.

Objectives met: The student understood the details of the concept, theoretical underpinning, worked on the literature review, guideline development, study implementation and participatedin the analysis and interpretation

Deliverables:

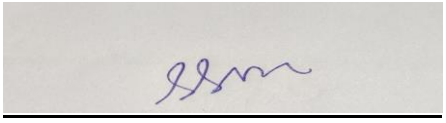
Supported in Presentation of slide decks and compilation of district story of Bihar 2014-21, have done In-Depth interviews in three districts of Bihar, Data management, Data cleaning and analysis,Regression through Software like SAS and MS-excel. Learnt to develop Qualitative tool guide, code dictionary, thematic analysis, and extraction. Conducted the above deliverables using PowerPoint, ATLAS.TI, SAS, EXCEL, ENDNOTE.

Strengths: Sincerity, ready wit, concentration, hard work, diligence and eye for details.

Suggestions for Improvement: Communication skill, scientific writing, subject andprogrammatic knowledge, analytical thinking and skills.

Date: 09-08-2022

Place: Delhi



Dr.Sidharth Sekhar Mishra.
Assistant Professor.
IIHMR, New Delhi.

Signature of the Officer-in-Charge (Internship)

ACKNOWLEDGEMENT

The internship opportunity I had with CARE India Solutions for Sustainable Development, Bihar was a great chance for my learning and professional development. Therefore, I consider myself a very fortunate individual as I was provided with an opportunity to be a part of it. I am also grateful for having a chance to meet so many wonderful people and professionals who led me through this internship period.

I am using this opportunity to express my deepest gratitude and special thanks to Mrs Annie Misra (MLE Manager, FP) who despite being extraordinarily busy with her duties, took time out to hear, guide and keep me on the correct path and allowed me to carry out my project at their esteemed organization and extending during the training.

I express my deepest thanks to Dr Tanmay Mahapatra (Team Lead, CISSD Bihar),

Mrs Sangeeta Das (MLE Officer, Quality Control), Mr Mukesh Kumar (MLE Officer, Quality Control), and Mr Mohd Irsad Ali (Dissemination Specialist) for taking part in useful decisions & giving necessary advice and guidance and arranged all facilities to make my project easier. I choose this moment to acknowledge their contribution gratefully.

It is my radiant sentiment to place on record my best regards, and deepest sense of gratitude to Dr. Sutapa Bandyopadhyay Neogi, (Director, IIHMR Delhi), Dr. Sumesh Kumar (Associate Dean Academics and students Affairs, IIHMR Delhi) and my mentor Dr.Sidharth Sekhar Mishra (Assistant Professor, IIHMR Delhi) for their careful and precious guidance which were extremely valuable for my study both theoretically and practically.

I perceive as this opportunity as a big milestone in my career development. I will strive to use gained skills and knowledge in the best possible way, and I will continue to work on their improvement, to attain my desired career objectives. Hope to continue cooperation with all of you in the future.

Sincerely,

Ayusman Jena.

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ACRONYMS/ABBREVIATION

FP-Family Planning

TFR-Total fertility rate

MMR-Maternal mortality rate

NFHS-National Family Health Survey

ICPD- International conference on population development.

RH- Reproductive Health

GE-Gender Equity

SC/ST- Schedule Caste / Schedule Tribe

IUCDs- Intrauterine contraceptive devices.

FGD- focused group discussion

IUDs- Intrauterine Devices.

FLWs- Frontline Health Workers.

ASHA- Accredited social health activists

ANM- Auxiliary Nursing Midwifery

ANC- antenatal care

ZLP- zero low parity

SLP- single low parity

IEC- information education and communication

IVF- Invitro fertilization

NSV-non scalpel vasectomy

IPV- intimate partner violence

HIV- human immunodeficency virus.

SBCC- social and behaviour change communication.

INTRODUCTION:

Insufficient FP development in India has been believed to be due to extra dependency on Tubectomy as the desired, and often only, form of modern contraception, as well as less female command over contraception, especially among young and rural wedded women. In India, out of 49% of women who are married and are sexually active and are at child bearing age, only 11.1% use modern contraceptives and 3.5% use contraceptives for spacing. (1)

Males involvement in contraceptive control and the necessity to increase gender parity in this setting, men's participation in FP interventions should be prioritised. Furthermore, no model of FP adoption that includes male participation has been exhaustively studied for India. (1)

Around the globe, several governments and private partners have given importance to funding to escalate ingress to and utilisation of any methods of family planning. Evidence suggests family planning can result in a reduction in maternal death by reducing the possibility of unintentional pregnancies, vulnerable abortions, and the possible health threat of high parity and short interval pregnancies. (2)

The significance of Family planning is seen in numerous United Nations Sustainable Development Goals targets for 2030: 3.1 reduction in the universal MMR, 3.7 Certaining universal ingress to sexual and reproductive healthcare assistance, and 5.6 Universal ingress to sexual and reproductive rights.

India has a population of 1.37 billion and a total fertility rate (TFR) of 2.0 (and some state-level TFRs as elevated as 3.3), India is a Major Patron to the FP2020 goals. In the most recent NFHS-5 (2019-21), in Bihar, the Total Fertility Rate (TFR) is 3.0 children per woman, which is higher than the replacement level of fertility. The median age at first marriage for women aged 20-49 is 17.4 years, 17.7 years for women aged 25-29, and 17 years for women aged 25-49. 41% of women aged 20-24 years get married before reaching the acceptable least age of 18 years, which is almost constant from NFHS-4. One-fifth (21%) of women aged 20-24 years are

never wedded, compared to 69 per cent of males in the same age group, indicating that women marry at a far younger age than men. Before reaching the acceptable least age of 21, (31 %) of males aged 25-29 get wedded, which is a 5 percentage point decrease from NFHS-4. (3)

Almost two-thirds (65%) of presently married women and 70% of currently married males aged 15-49 years desire no more children, have already been sterilised, or have a sterile spouse. Bihar has a high inclination towards sons. Around one-third (31%) of women and fewer than one-quarter (22%) of men prefer sons over daughters; 2% of women and 3% of men prefer daughters over sons. In Bihar People are well aware about and have knowledge on Contraception. Some approaches, however, remain unknown like 98.8% of women and 99.2% of men are aware of any modern method and Nearly 49.6% of males agree that contraception is a women's business and men shouldn't have to worry about it. However, only 13.6% of males agree that female who use any kind of contraceptive method may become promiscuous. Whereas only around 55.7% of males were found to be present at any Antenatal checkup with their partner. (3)

BACKGROUND:

While both men and women are involved in reproduction, only some methods of contraception require men's active engagement. since the 1960s, Organised family planning efforts in the developing world, as well as global initiatives such as FP2020, have focused essentially on women, with men receiving little consideration. (4)

However, it is becoming esclatingly evident that family planning can't be effective without the involvement of males, and that "change will be gradual as men are actively engaged in promoting greater health and well-being for families and the development of women...",

At the 1994 International Conference on Population and Development (ICPD), attention to gender evolved in assemblance to engage men more effectively in reproductive health, though some questioned whether focusing on males would divert attention from meeting female's reproductive health requirements. This broader view on family planning programmes has resulted in a variety of ways to engage Males in family planning and reproductive health since the ICPD. However, the ICPD was framed in such a way that it highlighted men as partners in supporting women's autonomy in reproductive health decisions, with little respect for men's reproductive health and rights. (4)

Data suggests that including males in reproductive health as supportive spouses improves healthcare. Perhaps in recent times, attempts to broaden the definition of positive male engagement have shifted from inspiring males to be supportive partners in female's health care to concentrate on meeting males own reproductive health conditions and trying to engage males as contraceptive users and change agents in their communities & Families. In recent programming environment, little is known about reaching males as family planning customers. Men's participation in reproductive health as supportive partners has been shown to improve health outcomes. In today's programming environment, there is little information regarding addressing males as family planning clients. (5)

Although family planning has generally been thought a woman's domain, well that is changing. Men & boys have an essential character to play in family planning, according to a new study, both to satisfy their own reproductive health requirements and to promote and ease their partners' ingress and usage. (6)

Gender standards and other balance of power shape how female and male access, utilise and choose family planning technologies. Women and girls may deficit liberty, portability, and opportunity as well as resources for family planning services; may experience bias from healthcare providers; perhaps they may face relatives and friends, societal pressure on family planning. Health care facilities may be seen negatively by men and boys are not male-friendly and may cause discomfort trying to discuss fertility and contraception choices tactics with their partner, or they may be misled by social standards that state that family planning is the responsibility of women. (6)

Given these facts, including men & boys is important to ensuring that everybody who desire it has ingress to and uses family planning, as well as to carry on to address unfair gender and power relations. Male participation benefits not just women's and girls' health and well-being, but also males and their children's health.

Male participation in FP refers to the participation of men & boys at various phases of their lives as a) clients/users, b) supporting partners, and c) change agents. Male participation goes beyond just including men & boys as programme users. (7)

To enhance men's & women's RH and contribute to gender equality results, FP programmes that include males, pay conscious observation to addressing unequal power dynamics and modifying detrimental aspects of virility (e.g., men’s control over decision-making).

Involving men & boys, in particular, involves larger efforts to improve empathy and hold up for women's rights and well-being, as well as the promotion of norms (e.g., equal ingress to educational possibilities for boys and girls) that conduct to more

fairness between males and females in their relationships, families, and responsibilities as parents and caregivers while preserving an emphasis on universalism and sensible alternatives as a basic concept of FP programmes. Finally, this strategy seeks to enhance FP & RH consequences for men & women in a manner that safeguard and support females autonomy. (7)

Boys, young men, & men have diverse degrees of FP understanding and RH requirements throughout their lives. Our study defines "men" as males aged 26 and above who would be more probably to make life choices based on their declared reproductive wishes and are concerned about preparing for their present or future children. "Young men" are males aged 18 to 25 who are more likely to be developing thoughts about marital relationships and intended fecundity.

Worldwide 63.6% of in union and married women revealed that they us any kind of modern method and/or traditional male-controlled method, female-controlled, or mutual contraception. In Africa there is a usage of only 33.4% of Contraception, whereas use in Southern Asia is comparable to worldwide levels at 58.6 percent. The worldwide unmet requirement for spacing and limitation is 12.0 percent, in Africa it is about 22.0 percent, and in Southern Asian region it is about 14%.

Either developed or developing areas the prevalence of modern male contraception is less than the modern female contraception among in-union and married women. The compound prevalence of male sterilisation (1.2%) as well as use of male condom (6.4%) found to be 7.6 percent in South Asian Regions, when associated to 42.7 percent for female-controlled procedures. (7)

These findings Indicate to a huge opportunity where increasing male usage may help to meet a large unmet need when enabling aspects for men's acceptance for and usage of contraception surpass the barriers.

After all, men & boys depict many characters in the lives of girls and women, as well as in society as a whole. Engaging males involves exploring the various roles that men & boys depict in the lives of girls & women. Within families and

partnerships, such roles may exist as a partner, a father, grandfather, an uncle, a brother, a nephew, a cousin, a son, or a grandchild. Men & boys also perform numerous characters in the locality as cultural & religious leaders; in the market as workers, managers, or bankers; as political spokesperson; as teachers, physicians, and other professions; and as military and keeper, typically directed by strongly gendered norms and expectations. Once such role has been recognised and put within their cultural settings, it is necessary to explore the idea of power, both in terms of how it is exerted within the execution of these diverse characters and as a personality trait unrelated to characters. Men and boys holding authority have an influence on women and girls in all circumstances. Keeping these power dynamics clear just to girls & womens via authorization processes, but also to men & boys via male engagement is initial approach to comprehension how gender-guided balance of power may be modified to become gradually more fair and equal. (4)

REVIEW OF LITERATURE:

1.) A cluster randomised control trial by Raj A, et al. (2016) evaluated gender equality and FP arbitration for married men & couples in rural India. Findings were that there is a need for FP education to remove persistent beliefs about the health impacts of spacing contraceptives, as well as GE societal norm modification initiatives relating to assumptions of pregnancy, early in marriage, preference for male child, and a shortage of male participation in FP, and more male or in-law dominance over FP decision-making compared to female control and Over three months, the CHARM intervention, which consists of three GE+FP counselling sessions provided by male healthcare professionals to married male alone and with their spouses found to be an productive method to involve men in family planning, enhance marital contraceptive conversation and utilisation, and decrease male execution of sexual violence.

2.) Jain M et al., found there is a significant decrease (59%) among high understanding of modern contraceptive techniques and willingness to utilise, as well as an extra but lesser fall off from intent to the real usage (9%). Women who wish to restrict their pregnancy have greater intent and use than those who want to space their children. Female sterilisation was more likely to be chosen by older women, whereas condoms were preferred by younger women. Unlike Hindus, Muslims were less likely to want to use permanent procedures such as sterilisation but were more likely to use condoms and tablets. The literacy of the woman and husband in their desire to use various FP techniques only interest for condoms. Marginalised Communities like SC/ST's were more reasonably to intend to be sterilised but less reasonably to want to utilise IUCDs. The desire to use sterilisation and tablets was favourably related to socioeconomic position. Those who were unaware of alternatives to female sterilisation and condoms were more likely to utilise female sterilisation and condoms, respectively. Men engage in additional conversations with friends inside

the village and are connected to external information, while their mother-in-law has a village neighbour network.

There are three probable FP routes. The combination of societal rules, risk discernment, thoughts about side effects, guilt, and other beliefs leads families to 1. Entirely avoid FP, 2. choose a temporary approach and ultimately a constant one, or 3. choose a short term approach but also abandon FP entirely.

3.) Subramanian L et al., found the greatest prevailing contraceptive utilisation of 43 percent among married females living in PRACHAR Phase I implementation areas—intervening at numerous periods in the life cycle—had substantial effects on contraception uptake. Females who previously had used contraception before their first pregnancy were extra reasonable to utilise contraception after their first delivery than those who had never earlier used contraception.

Using behaviour change theory confirms existing findings from a variety of situations that show that using a socioecological framework with various strengthening treatments at multiple levels might improve contraceptive use behaviour in young married couples. Contraceptive usage increased when both young husband and wife were subjected to project treatments. In a conservative environment, thorough programming with gender-accompanied treatments customised to particular life stages and focused at various stages of the socioecological model can successfully boost contraceptive usage among young married people.

4.) A study by Tekou B Koffi, Marthe Adjoko, E Mensah, Karen Weidert et al. uses FGD Technique to focus on Positive and negative perspectives on family planning. Found Men's involvement in family planning is driven by social-economic motivations, men strongly oppose major decisions by women to use family planning, misunderstandings about modern methods can inhibit information about family planning, and men’s participation in FP is hampered by a lack of method choice, inadequate Places to receive the service, and few messages directed at men.

5.) A descriptive Cross-sectional Quantitative Study (by Iván Mejía-Guevara) found, that in India, 19.4% of married women with any need for family planning went unmet 8.5 percent for spacing, and 10.9 percent for limiting the number of children. Among the remaining 80.6 percent of women who said they used contraception, the vast majority (71.8 percent) used modern contraceptives, with 54.2 percent opting for female sterilization over traditional (8.8 percent).

OBJECTIVES OF THE STUDY:

a. To develop an understanding of male participation and the role of gender in family planning with a focus on men & boys.

b. To explore the knowledge, awareness, perception and practises of FP from a male perspective.

c. To understand the enablers and barriers for FP-related practises from a male perspective.

METHODOLOGY:

A. STUDY DESIGN-

- Exploratory study.

B. STUDY SETTING-

- in the state of BIHAR, within 3 districts namely PATNA, ARWAL & VAISHALI

C. STUDY POPULATION-

- Men residing in Rural households of various villages of Patna, ARWAL & VAISHALI district.

D. SELECTION CRITERIA-

- Inclusion Criteria- it is done in 2 categories:-
  - Married Men's whose age is 18-25 (younger males)
  - Married Men's whose age is 26-35 (elder males)
  - Migrant or non-migrant men who reside in villages of PATNA, ARWAL & Vaishali.
  - Between May 2022 and June 2022.
- Exclusion criteria-
  - Married Men who are not Available at their home while interviewing.
  - Married Men's whose age is above 35.
  - Men who refuse to provide consent or record their interview.

E. SAMPLE SIZE-

- The sample size was 24 (12 each for both age groups) because until we reach saturation we continue.

F. SAMPLING METHOD-

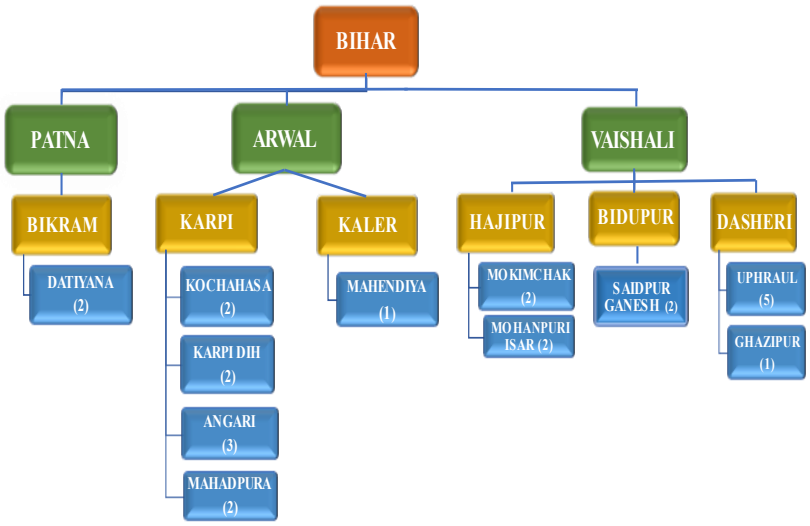
- Random sampling was done to select the districts of Bihar, then blocks of Arwal and Vaishali and its villages but convenience sampling was done to select the study population.

G. METHODS OF DATA COLLECTION-

- Through self-prepared Qualitative Tool guide and audio recorder.

H. DATA ANALYSIS-

- Data is analysed through ATLAS-TI software



FINDINGS:

The findings have been framed according to the study objectives:

UNDERSTANDING OF MALE ENGAGEMENT AND THE ROLE OF GENDER IN FAMILY PLANNING, WITH A SPECIAL FOCUS ON MEN IN THE AGE GROUP OF 26-35.

FP, Morden contraceptive & Traditional use:

In our study except for one respondent, almost all respondents knew about family planning respondents had some knowledge about male and female sterilization, and in female contraception, most of the respondents are less informed about oral tablets, injections, and IUDs, and in male contraception, condoms. At the community level, there are various misconceptions regarding condoms.

Traditional methods were not known to most of the respondents and one of them suggested intake of a unique fruit (baluri) that regulates periods, and one amongst them said that he followed his ancestors for any FP-related methods.

"Gharelu upay ye he ki kisiko mahina kahrab he na.. to log jese ghar paribar me bolte he ki humko ase ase hua purana baluri leke ao usko pani me dalta he. pani me dal ne ka karan usko kapada me chanke paniya ke chan ke… jese hum log chaye kese chante he… To chaye-pati alag hota he… kese wo alag hojati he… jo ledish mahina kharap huato subhe uthegi bahar jayegi bahar se ayegi kuli kulaye karke sab khaliye pet me ..wo piyegi kahegi mera mahina safh ho gaya….. mahin a safh hogana to baal bacha apko"

-Respondent 1, kochasa, karpi, Arwal.

Traditional method means, if someone has irregular periods. then if someone says they have this issue in a family, then we suggest them to bring "Baluri fruit" and dip it in water and filter it like we separate tea granules from milk..so the woman who has irregular periods can take this drink and gargle it in empty stomach and she will say my irregular periods got cured and if the periods are fine then she can give birth.

-Respondent 1, kochasa, karpi, Arwal.

knowledge on sterilization:

Sterilization should be performed by both males and females as agreed by respondents except for two who thought sterilization is only for females. The community's approach towards performing sterilization is that the males only contribute about 10% and the rest is performed by females as stated by one.

Periods And Fertility:

Majority of respondents had improper knowledge of safe and unsafe periods for sex, except for two respondents who had correct information

Joint Decision Making:

Most husbands make their own decisions, but there are some husbands who take decisions together with their wives.

Supportive Partner:

As a supportive partner, the husband allows his wife to use any FP method she wants.

Role during Pregnancy:

Respondents took their wife for ANC visit, helped her by not letting her lift weights, help her in kitchen, they asked their mother to help their wife, and some they themselves took care of their wife and one of them said that there are members in the family who can take care of her so there is less requirement of him.

Responsibility as parents:

Males became self-aware of their roles and responsibilities toward their children, and whether the child was a girl or a boy, they would educate, nurture, and enrol them in a good school.

Son preference & gender equality:

Men prefer both the child equally and there is no son preference seen yet.

Community perception towards equitable gender varies while some preferred both the child equally and some prioritized a male child over a female one. As said by respondent.

Promoting gender equality:

Respondents stated that they do not have a preference between boy and girl children. One of them even stated that different communities had different perceptions toward girl child. They think that if a girl child is born, they should bear her expenditures during the marriage.

"aajkal ke dehata ka jo generation kharaab chal rahi hai koi ladka hai ladki hai friend hai sab hai usse har gaurdian sochta hai shadi jaldi karke usko.... ki shadi sahar me apne aap par depend hai dehaat me gaurdian pe depend hai, fir waha education hai yahan education nahi hai anatar aata hai"

-Respondent 3, angari, Arwal.

Younger Generation in villages nowadays are not good, a female and a male become friend so their parents think to get the girl married soon. In cities, for marriage you depend on yourselves but in villages they depend on their guardians, because education is available there and here it's not that's the difference.

- Respondent 3, angari, Arwal.

Female autonomy:

Most of the respondents agreed that female has the right to take their own decisions, and two of the respondents even agreed that female should have the right to their own body and whether to have kids or not to have them. Another factor is literacy which determines female autonomy, the educated ones can make their own decision but the one who doesn't, depend on their husband and in-laws for any decision related to FP.

"*nai sahar ke jo mahila jo padhal -likhal hai wo decision le sakti hai jo anpadh hoti hai kam padhi hai garib hai jo gauridan pe depend jo pati pe depend hai wo kya bolegi*

har koi ladki chhati hai shadi ke baad apna situation dekh ke achha pariwaar me shadi aur mere pariwar me hua toh aadmi ghar me bandha hua hai jo pati kahega wo sunega us tarah se patni ka khaish mar jata hai".

- Respondent 3, angari,arwal,karpi

female from cities who is educated can take her own decisions, the one who is uneducated, who is poor, who is depended on her guardian and husband. what can she say. Every girl thinks that after marriage she will be into a good family and in my own family the male is at home and whatever the husband says wife has to listen it and with that female's wish disappears.

- Respondent 3, angari,arwal,karpi

Knowledge of healthy timing and spacing:

Respondents have agreed that there should be two years of delay for the first child after marriage and the gap between 1st and 2nd child ranges between 3 – 5 years. Except for one who did not agree on spacing. And when asked about the benefit of spacing respondents have replied that it will lead to the good health of mother and child.

Community perception towards delaying of two years each seen a negative manner woman is considered infertile if she has delayed her pregnancy for two years.

Information delivered by FLWs:

ASHA / ANM delivered FP-related advice to most of the respondents but some denied that there was no interaction between them and the FLWs.

Accessibility and acceptability of modern contraceptives:

Accessibility to the healthcare facility to most of the respondents which was private but some has the exposure to public health facility.

FLW interaction:

There was FLW visit to respondents home but the lack the knowledge because they had not given any information about FP. Some had the exposure and some did not.

Belief on FP, Future use:

Respondents believed that FP was effective and some did not and some also said that they follow their paternal norms. Future use of contraception was there among males some preferred condoms and while some preferred sterilization.

Advice to ZLP:

Respondents stated there is no need for advice to any ZLP couple as they are mostly aware of this except for some who denied this fact and some stated that there is a need for advice but there are no proper health workers who can convey FP-related services.

2. ENABLERS AND BARRIERS FOR FP-RELATED PRACTISES:

ENABLERS:

Source of information:

TV and IEC materials being the most prioritized source among respondents followed by peers friends, internet and expect one who agreed that source of information was gained by common meeting points at the village.

"*poster… har ek choraha pe poster har ek matlab jagha pe poster isko diyajayega usme safh safh likhajayega iske dwara v ho sakta he… aur sakhsyam he to aap prachar v karwa sakte he.. he na"*

-Respondent 10, uphraul,Deshri,Vaishali.

Stick posters are at every junction at every place and clearly its should mention the contents. By this way we can and if you are able then you can publicitize it, is'int it..

- Respondent 10, uphraul,Deshri,Vaishali.

Peers educations:

Our respondents did not need any help from peers regarding information about FP they are self-aware and some of the peers had improper knowledge which lead to spreading misconceptions and some gained help from their peers regarding FP.

Spousal communication:

Respondents spare time with their spouses but during this time only some agreed that they talk about FP during this time and most of them denied it.

Decision-making and reproductive autonomy:

Most of the respondents agreed that they take joint decisions with their wives and even support the reproductive autonomy of their wives by not forcing them to get pregnant.

Going against the family:

Respondents agreed that they support their wives and can go against their families to support their wives.

Understanding perception:

They denied that having multiple children doesn't make a man masculine, except for one who believed that this perception even continues today in some villages too.

IPV And financial autonomy:

Respondents stated that IPV results due to delays in serving food, or doing something against their wish and permission. Some said that they don't support IPV and resolve the situation through communication. Respondents share their finance with their wife and even if she doesn't listen to their husband they does not make her financially disable and surprisingly one respondent agreed that her wife is the owner of the house and she has financial autonomy.

Covert use:

Respondents denied the support for covert use and if a female does, she should take permission from her husband. When asked about husbands reaction towards wives covert use some of them agreed that they will allow their wife to continue the use of contraception except for one who said covert use if countered could lead to domestic violence.

Forcing and quitting:

If there is a need of contraception use then she can use or else she can quit if she doesn't require. Respondents were against forceful pregnancy.

Infertility and 2nd marriage:

Respondents said that they will support their wife even if she is infertile and will support her for any kind of checkups and visit to the doctors to cure infertility. If even after several checkups if she could not conceive they will treat it as gods wish

and will remain childless forever. Most of the respondents do not support second marriage and one of them even suggested the adoption of a child.

Barriers:

Female FP provide for male:

FLW interaction is less with the males, Except for two who agreed that take help from ASHA regarding FP. And even ask condom to her whenever she visits his home. Another one said that ASHAs inform his wife about FP methods and convince her to pass the knowledge to her husband.

Side effects method failure experience of others:

Most of the males agreed that they did not face any kind of side effects during the use of male contraceptive methods and they are unaware of the side effects of female contraceptive methods. Except for two who stated that the use of condoms and performing sterilization could lead to several infections at that particular site. Method failure is mostly not seen by any of the respondent except to one who agreed that method failure does occur, he stated that method failure can occur due to bursting of condom while having intercourse and also when condom get stuck inside female vagina and can result into infection.

Social pressure:

No social pressure have been seen by the respondent soon after marriage but after 2 to 3 years if the couple is unable to conceive a child then family and society pressurize the couple. In such cases the female is projected as infertile by the community.

Rumors and misconceptions regarding FP:

In the community people, preference is to have a child within a year of marriage.

Sterilization in males can cause infection and one of them stated if a male perform sterilization then he will be unable to physically satisfy his wife as a result his wife may have relation with another male.

Buying behaviour:

There was no issue faced by any of the respondents while buying any kind of contraceptive.

Desired family size:

Respondents agreed that number of children should be two, except one who did not believed that there should be any desired family size.

DISCUSSION:

Our study explored men's knowledge of and partners contraceptive planning and use and the role of gender in FP. Here we found men as partners are supporting their partner's use of contraception if it is safe enough and has no side effects.

As earlier studies have found, Men may resist contraception usage owing to a lack of awareness and worries about adverse effects or difficulties and studies also have indicated that males are likewise particularly worried about modern contraceptive's perceived ability to strengthen women's reproductive autonomy. Engaging men and aggressively resolving their beliefs about virility and gender equality might have the ability to diminish their aversion to obtain benefits in women's reproductive autonomy and promote their positive engagement as allies & partners. (8)

Our study completely agrees on this point as we found men don't support the beliefs about masculinity norms rather they support respecting women's autonomy and believe in gender equality as males make a joint decision with their wife and equally prefer boy and girl child and if women don't want to use any contraceptive male support the fact and agreed to use male contraception by themselves, by this we can say men can be seen as getting positively engaged as a supportive partner.

Previous research found views and conditioning on virility act out in a twofold way; although they grant a better social standing to males, they also urge men to achieve a variety of societal expectations. Peer pressure promotes unmarried men to indulge in unsafe sexual conduct, for instance, having several sexual partners are generally considered a sign of masculine virility, and for married men perform their role as a procreator. All those who don't satisfy these standards are mocked. Men also judge themselves based on certain indicators of masculinity and difficulty in performing up to these beliefs becomes a source of pain.

Gender-based violence, physical abuse of women and homophobia in manifestations of virility are a few of the frequently reported harmful repercussions, (9) but on the contrary, our study found men's considered having multiple sexual partners as a sin

and considered its unlawful activity and men's masculinity is not defined by only procreation but giving proper education and nutrition to the child and males don't support the fact that men's masculinity is defined by its ability to produce multiple progenies and even men don't support the ideology of intimate partner violence and are against such behaviour and it does not specify a man's masculinity.

Men's adoption of contraceptives may be adversely impacted by a partner's contraception usage, especially if the technique was begun without the husband's concern, which is a reported cause of pressure and mistrust in relationships as cited by a study previously. (8) Similarly our study agrees with the earlier study as the covert use of contraception by females is not promoted by their male partners, they thought it unethical and unlawful to use contraception without their knowledge but supported the usage if the husband's concern is taken.

A study of the PRACHAR initiative performed in rural Bihar, India, demonstrates the pervasive worry that the ability of conceiving may drop with age and village doctors and together with local health workers also disseminate this idea, (9) our study acknowledged this as most of the younger couples got conceived within a year of marriage there was no delaying for the first child, as there is a misconception of fertility being reduced and complications may result during pregnancy that could lead to stillbirth because of delaying and spacing as the age of couples to conceive gets reduced. Even one of the male respondents was against the concept of delaying as her wife had spontaneous abortions, his suggestions were only after having one child we can think of using contraception but not before that.

Another research found genuinely joint and cooperative decision-making stays idealistic, particularly when it comes to problems regarding contraceptive usage and family planning. There is not adequate data to show that couples that conduct household decisions jointly would also demonstrate the same equitability when it relates to FP communication and decisions. Younger women who claimed autonomy in terms of family decision-making and access to finance were more likely to have received adequate prenatal care, even after family financial status and women's education were adjusted. (8) Similarly, our research found even though couples

preferred joint decision-making but when it comes to FP the data is indistinct. Some cases had males supporting the choice of contraception and some did not, interspousal communication played a vital role here but communication about FP with partners was infrequently sighted, but to the contrary, no males have claimed that women had the autonomy to take household decisions but they had access to finance through husbands will.

A study concurred that males are essential decision-makers and when it comes to the intervention they shouldn't be treated as an afterthought and their boundaries and channels of communication are not the same as their partners so there is a need to highlight the effects of financial risk on family health and wellbeing, (10) through our intervention we have found men are aware and prepared enough mentally and physically about financial stability and risks that may incur after having a child, males are more conscious about physical wellbeing of both mother and child during and after pregnancy. So this intervention could be a key message to emphasize for males.

LIMITATIONS:

Our study has few limitations as it's based on only three districts of Bihar, so we can't generalize our findings to the whole state or country. Secondly, as FP is a sensitive topic there might be social desirability bias among the respondents. The education level of the respondents was vulnerable to cause bias. As our study has seen Males are getting reluctant to use any kind of contraception there is still lot more efforts needed to be done to engage men as a client/beneficiary. Further research needed to be done why males are not getting engaged as a beneficiary and what are the factors that stops them.

CONCLUSIONS:

As our study has seen a slight shift in the attitude of men toward the orientation of the use of FP methods, FP is no more seen as a female-oriented method because males are equally taking part as supportive partners in FP. But still, there is a necessity to start quickly by reaching adolescent boys and young men with various health programmes, that involves boys/men individually, as a group or as a couple. Engaging boys and men using the SBCC (social and behaviour change communication) approach could be beneficial. Further interventions should focus on how to raise willingness to use modern contraceptives instead of just focusing on awareness, by modifying important factors that influence our behaviour.

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WAY FORWARD /SUGGESTIONS:

According to the current scenario, we can suggest policymakers focus on the three categories of the Greene framework i.e,

- Men as a client-

  -Policy needs to get to men with FP services and spread the message at places at common meeting points of men where they gather.

  -IEC strategies to escalate men's knowledge.

  -Prevasectomy counselling services to notify men about the potency of NSV and about its side effects too and to make sure it doesn't protect from HIV.

- Men as a supportive partners-

  -Policy should provide techniques for training personnel to advise couples and identify potentially dominating or aggressive conduct by a spouse,

  -if a woman wishes to involve her husband, to establish safe places where men and women may receive family planning services and information together,

  -greater knowledge of reproductive health and rights for women and girls, as well as techniques for providing this information.

- Men as agents of change-

  -Policy should instruct family planning programmes to recruit and teach male influencers and FP advocates—these men may help debunk misunderstandings about male-specific contraceptive services and inspire more men to take accountability for the establishment of healthy families.

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