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Original Research Article

Contraceptive decision-making among currently married couples in Kerala: a mixed-methods study

Anusree K. Mukundhan, Sunu C. Thomas*

Department of Public Health, Amrita Institute of Medical Sciences, Kochi, Kerala, India

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***Correspondence:**
Dr. Sunu C. Thomas,
E-mail: drsunuthomas@gmail.com

ABSTRACT

Background: Contraceptive decision making refers to the ability of a women freely choose the contraceptive method they desired through the process of informed decision-making by effectively minimizing unnecessary pressure from important others. Women's autonomy is often constrained by gender power imbalances and sociocultural norms. In Kerala, despite better educational and economic status, limited evidence suggests these advantages enhance their decision-making regarding contraception.
Methods: A community-based mixed-methods study was conducted in Thrissur and Thiruvananthapuram districts in Kerala. Multistage cluster sampling was employed in both the districts to get a total sample of 330 for the quantitative component. Bivariate and multivariable logistic regression were done to estimate the proportion and associated factors. Additionally, 19 in-depth interviews were conducted using purposive sampling to explore decision-making dynamics.
Results: Only 18.2% of women reported making contraceptive decisions independently. Employed women (APR: 2.94, 95% CI: 1.84–4.71, p<0.001) and women with both male and female children were more likely to decide independently (APR: 2.80, 95% CI: 1.46–5.30, p=0.002). Qualitative findings highlighted decision-making process among couples are often hindered due to couples' limited knowledge, misconceptions and fear of side effects.
Conclusions: In Kerala, independent contraceptive decision-making among women remains relatively low. Limited knowledge hindered women's ability to negotiate contraceptive use with their partners, often conform to prevailing social norms. Thus, interventions and policies should focus on raising awareness along with empowering women through financial independence and addressing deep-rooted social and gender norms.

Keywords: Contraceptive decision making, Empowerment, Gender roles, Reproductive autonomy

INTRODUCTION

Contraceptive use is a critical aspect of reproductive health, enabling individuals and couples to plan their families and achieve their desired number of children. The prevention of unintended pregnancies helps to lower maternal ill-health and maternal mortality. This can also benefit the education of girls and create opportunities for women to participate more fully in society, including paid employment.[1] Contraceptive decision making refers to the ability of a women freely choose the contraceptive method they desire through the process of informed decision-making by effectively minimizing unnecessary pressure from others around.[2] Sustainable Development Goals (SDG) 3.7 and SDG 5.6 focuses universal access to sexual and reproductive health-care services, emphasizes women's right to make informed and autonomous decisions regarding sexual and reproductive health.[3] However, too often women are not able to exercise their autonomy on these issues due to harmful and discriminatory social norms and practices compounded by their lack of agency and financial resources.[4,5] Women, especially in patriarchal societies, may face barriers to accessing healthcare, including reproductive

health services, due to their lower social status or lack of decision-making power.[6]

In India, women's contraceptive decision-making is significantly shaped by better socio-economic indicators, with many decisions being dominated by husbands or elders rather than the woman herself.[7] Although Kerala achieved replacement-level fertility, a 2014–15 study in Thiruvananthapuram found that misinformation, distrust of reversible methods and limited decision-making autonomy hindered effective contraceptive use.[8] A critical appraisal on National Family Health Survey (NFHS 1-5) data from Kerala reveals that increased female literacy does not correlate with higher contraceptive use.[9]

In the Indian context, women's agency may be limited and in Kerala, there appears to be a disconnect between women's education, economic status and their empowerment in reproductive health decisions. Decision-making power is an important part of women's empowerment. When women can make decisions independently, they are able to act on their own needs and choices without pressure from others, making their preferences truly visible.[10] In many families, joint decision-making is often seen as a sign of cooperation and equality. On the other hand, joint decision-making can sometimes hide unequal power relations. In many patriarchal societies, the 'joint' decision often reflects the husband's preference rather than a fair agreement.[11]

Evidence from India shows that many women are unable to use contraceptives because of partner opposition-nearly 15% in Uttar Pradesh 12, over 30% in Rajasthan 13, and more than half among HIV-positive women.[14] These findings highlight that women's reproductive choices are frequently overridden by male authority, underscoring the need to strengthen independent decision-making. Studies have shown that women with independent decision-making power are more likely to use maternal health services and contraception, leading to improved health outcomes for themselves and their children.[10,11] Women with independent decision-making power were significantly less likely to report non-use of contraceptives, underlining the direct role of autonomy in shaping reproductive health outcomes.[15]

Promoting women's autonomy ensures their health, rights and choices are genuinely respected, instead of being overshadowed by the 'joint' decisions. While joint decision-making is often framed positively, it is a heterogenous category that can mask unequal power relations. Treating this as equal to women's agency risks overstating empowerment and underlying gendered power imbalances. On the contrary, independent decision-making is a clearer and more valid indicator of women's reproductive autonomy, that aligns with the rights-based framework.[16,17]

Therefore, this study aims to estimate the proportion of women who can independently make contraceptive-decision, its associated factors and to describe the contraceptive decision-making process among currently married couples in Kerala.

METHODS

Study design and study setting

A community based mixed methods study with concurrent parallel design was conducted among currently married couples in the age group 18-35 years residing in Thiruvananthapuram and Thrissur districts of Kerala. The districts were selected based on the overall contraceptive prevalence rate in Kerala: one with high contraceptive prevalence (Thrissur-71%) and another with low prevalence rate (Thiruvanathapuram-41%), compared to the state average (61%).[9]

Sample size and sampling

The sample size for the study was estimated based on an assumed prevalence of contraceptive decision-making of 16%, with an absolute precision of 5%, a 95% confidence level and a design effect of 1.5.[18] The calculated sample size was 312. To ensure equal allocation among 15 clusters in each district, the final sample size was rounded up to 330.The sample size was calculated using OpenEpi Version 3.0.

Multistage cluster sampling technique was employed in both districts. Initially, five panchayats, municipalities or corporations were selected randomly from each district. From these, three wards were randomly selected, resulting in a total of 15 wards per district. Each ward was considered a cluster. From each ward, 11 participants were recruited, yielding a sample of 165 currently married women per district and a total sample size of 330 (Figure 1).

For the qualitative component, a total of 19 in-depth interviews, for six married men and 13 married women were interviewed separately, the number of interviews were based on data saturation.

Study tools and data collection

For the quantitative component, the questionnaire was developed guided by a conceptual framework developed for contraceptive decision-making, developed within the socio-ecological framework to capture individual, interpersonal and social/community level factors.[19] For the qualitative component, an in-depth interview guide was used to collect data on the contraceptive decision-making process among couples in Kerala, capturing the various individual, interpersonal and societal levels that contributed to the decision-making process.

Data collection for the study was carried out from 19th December 2024 to 19th February 2025. A semi-structured interview schedule was used to collect quantitative data

through house-to-house visits among currently married women aged 18 to 35 years. For the qualitative component, in-depth interviews were conducted using a semi-structured, open-ended interview guide among currently married women and men separately. The data were captured through audio recordings of the interviews. All qualitative interviews were audio-recorded with participants' consent, transcribed verbatim and translated into English for analysis.

Women who were pregnant during the time of the study and women whose husbands had not stayed together in the past three months were excluded from the study.

Statistical analysis

Data entered using EpiCollect 5 and analyzed in Stata 14. Categorical variables were summarized as frequencies and percentages. The proportion of women who made contraceptive decisions independently was calculated along with 95% confidence intervals. Factors associated with contraceptive decision-making were analysed using the Chi-square test or Fisher's exact test, as appropriate. Independent variables with $p<0.2$ from the bivariate analysis were included in the multivariable regression analysis. Poisson regression analysis was performed to estimate APRs with 95% confidence intervals. A p value of less than 0.05 was considered statistically significant.

Qualitative data analysis followed a thematic analysis approach. Audio-recorded interviews were transcribed verbatim and translated from Malayalam to English. The interview transcripts were coded inductively through repeated readings using WEFT QDA software. Microsoft Excel was used to compile and combine codes with similar meanings into axial codes. These axial codes were grouped to form the themes.

RESULTS

The sociodemographic characteristics of the participants are present in Table 1. The median age of the participants was 29.5 years. Table 2 shows the current contraceptive use and the perceptions regarding contraceptive use. Among the 330 respondents, 37.27% were not using any contraceptive method at the time of the survey, 40.61% were using female methods and 22.12% male methods. About 35% of women said they preferred female methods, 35% had no specific preference and 31% preferred male methods. Only 22.42% of women believed contraceptives were safe, 25.45% felt contraceptives were not safe and more than half (52.12%) were not sure.

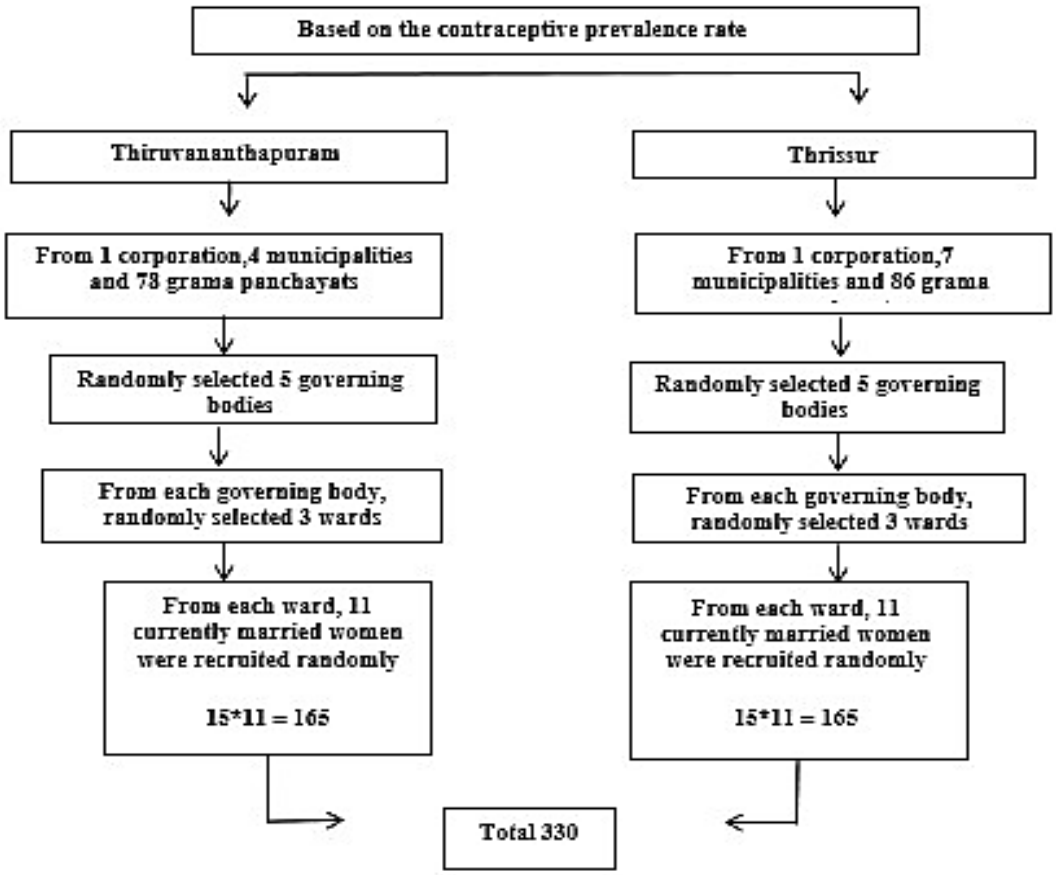

Figure 1: Sample selection process.

Out of the 330 married women surveyed, only 18.18% reported they made decisions about contraceptive use on their own. About 81.82% said the decision was made non-independently i.e., either jointly, partner alone, a family member or by health care workers. Factors associated with contraceptive decision making are given in table 3. In the multivariable regression model, women who were employed and those who had both male and female children were more likely to make independent decisions. Employed women were 2.94 times more likely to make decisions independently (95% CI: 1.84–4.71, p<0.001) compared to women who were not employed. Similarly, women who had both male and female children were 2.8 times more likely to decide on contraceptive use independently (95% CI: 1.46–5.3, p = 0.002) than those who had only male children.

Findings of qualitative data analysis

Table 4 shows socio demographic characteristics of in-depth interview participants (n=19). The findings from the qualitative interviews were organized into key themes that explore the process of contraceptive decision-making among participants, highlighting the reasons that influence their decisions, communication dynamics among partners and individual agency.

Misinformation and knowledge gaps hindering couple communication

The narratives of the participants show that contraceptive discussions were not happening among the couples mainly because of gaps in their knowledge, especially men's. Women said that their partner's inadequate knowledge forced them to make independent decision on contraception.

"Many of us don't know about contraception related things" Male participant 6." "No. we won't talk much about that. He doesn't know anything about it" Female participant 7.

Women who made decisions independently or together with their partner, forced to choose or avoid a contraceptive method particularly because of false information and misconceptions especially regarding intrauterine devices (IUDs) like CuT (Copper-T).

"CuT is also not safe. I have heard that. many women who have put CuT, got pregnant again. Then why do I use that" Female participant 13.

"Maybe my wife will put CuT. Actually, she is afraid to put" Male participant 4."

"No I am scared of CuT. I have heard that there will be irregular periods etc" Female participant 6

Social stigma and judgement limit access to contraceptives

Women described several practical and social barriers that made it difficult to access and use contraceptives, especially condoms. Some women mentioned feeling uncomfortable asking for condoms at shops, as it was not seen as socially acceptable for women to do so.

"You know our society will always judge, especially when women go out for these things. They will say that women are in another relationship like that" Female Participant 9.

"I've tried to get condoms once, but it was really difficult. It's not easy to just go and ask at a store. There's a certain discomfort, especially for women. Accessing contraceptives feels like an extra challenge" Female Participant 13.

Women also expressed difficulty in discussing about contraceptive use, "Nobody says that if they are using condoms...May be because it's their personal thing" Female participant 1.

Socio cultural and familial influence

Some participants had the opinion that family or the social circumstances has a role in deciding the family structure.

"Since I have only one female child, my relatives say I should have a male child to keep the generation forward. If I only have one girl child and do sterilization, people will consider me a fool". Male participant 2. "We make decisions together, but the decision for tubal ligation was made by her and her family" Male Participant 5.

Family expectations also play a significant role, another participant noted, "Yes, in many families, family expectations do influence contraceptive decision-making" Male Participant 5. "I have pressure from both the families like I have already crossed 30, my son is 3 years old, need to think of another otherwise there will be complication like that" Female participant 13.

Religious beliefs in certain communities were also hindering their contraceptive choice and decisions "Yes, there are some barriers, one of my friends when she got married has said that her husband was not willing to use these methods, since that was against their beliefs. We cannot change their attitude" Female participant 5.

Male disengagement and women's silent negotiation in contraceptive decisions

While discussing contraceptive decision-making among couples, it was found that men played a very limited in the decision-making even if they have knowledge about it. In some cases, men showed a lack of interest to use

contraceptives, even when their wives expressed an interest to use it. This refusal discouraged open discussions between partners.

"Contraception…who cares about these things" Male participant 3.

"I don't think there is a need of contraceptives" Male participant 4.

Men added that instead of discussing it together and making decisions, they leave the decision to women or they avoid the topic completely.

"There is no decision like that. It is a practice all women after 2 or 3 pregnancy they will do sterilization" Male participant 3.

"I said am not forcing her, if she wants, she can put CuT" Male participant 4.

Male ignorance often leads women quietly manage their reproductive health decisions, often without involving or informing their husbands.

"I was staying with my family. That time I went and put copper T. My husband doesn't know about it still" Female participant 2. "In my case, it was my decision to put CuT and my family also suggested to do so. My husband has no opinion on that" Female participant 5.

Male dominance and limited autonomy in reproductive decision-making

Several women expressed a clear lack of autonomy in decisions related to family planning and contraceptive use. Despite personal preferences for smaller families or delaying another pregnancy, their choices were often overridden by their husbands' opinions. "Whatever it is they will be taking the final decision and finally we have to adjust with that" Female participant 6. "My husband mostly takes decision on contraception or reproductive related things". "Yes, I prefer to use, actually my husband is not willing to use any method. So am not using any methods now" Female participant 3. "My wife doesn't know anything. So, I will be taking decision. It is not a problem that who decides" Male participant 4.

Marriage duration and parity as facilitators of contraceptive decision-making

The length of marriage and having children play an important role in how couples engage in contraceptive decision-making. In the early stages of marriage, couples often felt uncomfortable. As time passes and especially after having one or more children, couples were more comfortable expressing their views and priorities regarding family planning. "Beginning it was not comfortable. Later we discuss together" Female participant 8.

Table 1: Socio-demographic characteristics of married women aged 18-35 years in Kerala (n=330).

Variables	Frequency	%
Respondents age (years)		
<30	152	46.06
≥30	178	53.94
Partners age (years)		
<35	134	40.61
≥35	196	59.39
Respondents education		
Up to secondary	94	28.48
Higher	236	71.56
Partners education		
Up to secondary	163	49.39
Higher	167	50.61
Respondents occupation		
Not employed	200	60.61
Employed	130	39.39
Partners occupation		
Not employed	1	0.30
Employed	329	99.70
Religion		
Hindu	236	71.52
Muslim	54	16.36
Christian	40	12.12
Caste		
General category	108	32.73

Continued.

Variables	Frequency	%
Other backward caste	181	54.85
Scheduled caste	41	12.42
Number of child/children		
None	39	11.82
1	109	33.03
≥2	182	55.15
Sex of child/children		
Male only	95	28.79
Female only	98	29.70
Both	98	29.70
No child	39	11.82
Socio-economic status		
APL (above poverty line)	194	58.79
BPL (below poverty line)	136	41.21
Duration of current marriage (in years)		
≤5	102	30.91
>5	228	69.09

Table 2: Current contraceptive use and the perceptions regarding contraceptive use among currently married women in Kerala (n=330).

Variables	Frequency	%
Currently using contraceptives		
No	123	37.27
Yes	207	62.73
Contraceptive method currently being used		
Male methods	73	22.12
Female methods	134	40.61
No methods	123	37.27
Reason for not using contraceptives		
Concern about side effects	30	24.39
Lack of knowledge	17	13.82
Partner disapproval	6	4.88
Others*	70	56.91
Preferred method of contraception		
Male methods	102	30.91
Female methods	114	34.55
No preferred method	114	34.55
Consider contraceptives are important for family planning		
No	146	44.24
Yes	184	55.76
Consider contraceptives safe		
No	84	25.45
Yes	74	22.42
Don’t know	172	52.12
Contraceptive method considered safe (n=74)		
Male condoms	37	50.00
IUD (Intrauterine device)- CuT	29	39.19
Tubal ligation	7	9.46
Vasectomy	1	1.35
Contraceptive method considered not safe (n=84)		
Emergency contraceptive pills	11	13.10
Injectable contraceptives	2	2.38
IUD (Intrauterine device)- CuT	62	73.81
Oral contraceptive pills	7	8.33

Continued.

Variables	Frequency	%
Tubal ligation	2	2.38
Attained desired family size		
No	144	43.64
Yes	186	56.36
Discuss about contraceptive use with partner		
No	34	10.30
Yes	296	89.70
Whether comfortable discussing contraceptive choices with partner		
No	38	11.52
Yes	292	88.48
Partner respects contraceptive preference		
No	52	15.76
Yes	278	84.24
Family influence to have children		
No	210	63.64
Yes	120	36.36
Family preference for male child		
No	309	93.64
Yes	21	6.36
Respondents' preference for male child		
No	315	95.45
Yes	15	4.55
Whether religious belief discourage contraceptive use		
No	7	2.12
Yes	323	97.88
Whether peers influence contraceptive decision		
No	121	36.67
Yes	209	63.33
Whether women are judged for accessing contraceptives		
No	108	32.73
Yes	152	46.06
Don't know	70	21.21
Whether community prioritize child bearing over women's health		
No	66	20.00
Yes	227	68.79
Don't know	37	11.21

*Others: Not interested, planning for pregnancy, planning to use temporary and permanent methods, history of infertility.

Table 3: Factors associated with independent contraceptive decision making: results of bivariate and multivariable regression analysis (n=330).

Variables	Contraceptive decision making		UPR (95%CI)	APR (95% CI)
	Independently N (%)	Non-Independently N (%)		
Respondents' age				
<30	23 (15.13)	129 (84.87)	Ref.	-
≥30	37 (20.79)	141 (79.21)	1.37 (0.85-2.20)	-
Respondents' education				
Up to secondary level	13 (13.83)	81 (86.17)	Ref.	-
Higher	47 (19.92)	189 (80.08)	1.44 (0.81-2.53)	-
Partners' education				
Up to secondary level	20 (12.27)	143 (87.73)	Ref.	Ref.
Higher	40 (23.95)	127 (76.05)	1.95 (1.19-3.19)	1.08 (0.80-1.45)
Respondents' occupation				
Not employed	19 (9.50)	181 (90.50)		

Continued.

Variables	Contraceptive decision making		UPR (95%CI)	APR (95% CI)
	Independently N (%)	Non-Independently N (%)		
Employed	41 (31.54)	89 (68.46)	3.31 (2.01 -5.45)	2.94 (1.84-4.71)
Religion				
Hindu	41 (17.37)	195 (82.63)		
Muslim	7 (12.96)	47 (87.04)	1.34 (0.63-2.82)	0.85 (0.40-1.76)
Christian	12 (30.0)	28 (70.0)	2.31(1.00-5.34)	1.20 (0.54-2.65)
Sex of children				
Male only	10 (10.53)	85 (89.47)		
Female only	18 (18.37)	80 (81.63)	1.74 (.84-3.58)	1.49 (0.78-2.85)
Both	23 (23.47)	75 (76.53)	2.22 (1.12-4.43)	2.80 (1.46-5.3)
No child	9 (23.08)	30 (76.92)	2.19 (0.96-4.97)	1.09 (0.51-2.34)
Contraceptive method used				
Male methods	27 (36.99)	46 (63.01)		
Female methods	19 (14.18)	115 (85.82)	0.38 (0.22-0.64)	0.45 (0.18-1.10)
No methods	14 (11.38)	109 (88.62)	0.30 (0.17-0.54)	0.45 (0.18-1.15)
Contraceptives are important for family planning				
No	15 (10.27)	131 (89.73)		
Yes	45 (24.46)	139 (75.54)	2.38 (1.38-4.09)	1.63 (0.82-3.23)
Contraceptives are safe				
No	24 (32.43)	50 (67.57)		-
Yes	20 (11.63)	152 (88.37)	0.35 (0.21-0.60)	-
Don't know	16 (19.05)	68 (80.95)	0.58 (0.33-1.01)	-
Preferred contraceptive method				
Male methods	32 (31.37)	70 (68.63)		
Female methods	15 (13.16)	99 (86.84)	0.41 (0.24-0.72)	0.70 (0.26-1.90)
No preferred method	13 (11.40)	101 (88.60)	0.36 (0.20-0.65)	0.89 (0.29-2.73)
Comfortable discussing contraceptive choices				
No	9 (17.31)	43 (82.69)		
Yes	51 (18.35)	227 (81.65)	2.47 (0.81-7.5)	-
Women judged on accessing contraceptives				
No	81 (75.0)	27 (25.0)		
Yes	123 (80.92)	29 (19.08)	0.76 (0.48-1.21)	-
Don't know	66 (94.29)	4 (5.71)	0.28 (0.08-0.62)	-
Community prioritizing child bearing over women's health				
No	48 (72.73)	18 (27.27)		
Yes	188 (82.82)	39 (17.18)	0.62 (0.38-1.02)	-
Don't know	34 (91.89)	3 (8.11)	0.29 (0.09-0.94)	-

Table 4: Socio demographic characteristics of in-depth interview participants (n=19).

Participants	Sex	Age (years)	Education	Occupation	Current contraceptive method	Contraceptive decision
Participant 1	Female	30	Higher	Not employed	Condoms	Female partner
Participant 2	Female	35	Up to secondary	Employed	Copper T	Male partner
Participant 3	Female	26	Higher	Not employed	No methods	Male partner
Participant 4	Female	29	Higher	Not employed	No methods	Jointly
Participant 5	Female	25	Higher	Employed	Copper T	Female partner
Participant 6	Female	32	Higher	Employed	No methods	Jointly
Participant 7	Female	21	Higher	Not employed	No methods	Female partner
Participant 8	Female	29	Higher	Not employed	No methods	Jointly
Participant 9	Female	26	Higher	Employed	Condoms	Jointly
Participant 10	Female	31	Higher	Not employed	No methods	Jointly
Participant 11	Female	32	Higher	Employed	i pill	Male partner

Continued.

Participants	Sex	Age (years)	Education	Occupation	Current contraceptive method	Contraceptive decision
Participant 12	Female	35	Higher	Employed	Condoms	Jointly
Participant 13	Female	30	Higher	Not employed	Natural methods	Jointly
Participant 14	Male	32	Higher	Employed	Condoms	Jointly
Participant 15	Male	35	Higher	Employed	Condoms	Jointly
Participant 16	Male	35	Up to secondary	Employed	Tubectomy	Jointly
Participant 17	Male	33	Up to secondary	Employed	No methods	Male partner
Participant 18	Male	34	Higher	Employed	Tubectomy	Jointly
Participant 19	Male	35	Higher	Employed	Tubectomy	Jointly

"In the beginning it will be always difficult for everyone. Especially women. Husbands should take the initiative. After having child or after few months, we will also begin to express our priorities" Female participant 6. "Beginning of marriage, it is difficult to talk about these things. And we also don't know much about this" Female participant 1.

DISCUSSION

The study employed a mixed-methods approach to estimate the proportion of women who make independent decision on contraception, its associated factors and explore the decision-making dynamics among couples in Kerala. Findings from this study highlighted the interplay of socio-demographic factors, knowledge, preferences and couple dynamics that influence reproductive choices and decisions. The study found that a significant proportion (62.73%) of married women aged 18-35 years were currently using contraceptives, which is comparable to the national average of 66.4% according to NFHS-5 data and which also aligns with the National family health survey-5 (NFHS-5) data for Kerala that reported 68.1% contraceptive use among currently married women.[9,20] Another finding from this study is that only 18.18% of women reported making contraceptive decisions independently, which is almost similar to a study done in rural, with the majority (81.82%) reporting non-independent decision-making processes involving joint decision, partners, family members or healthcare workers.[18] This low level of autonomous decision-making aligns with studies from other parts of India where women's reproductive autonomy remains constrained by patriarchal norms and power.[21] Among those who are not using contraceptives (37.27%), the most common reasons were planning for pregnancy, preference for specific methods in the future or infertility history. Concern about side effects (24.39%) was another significant barrier, which is consistent with findings from studies in similar settings where women who were concerned about side effects were less likely to adopt contraception.[22] The limited knowledge about contraceptive methods (13.82%) and partner disapproval (4.88%) further added to the contraceptive non-use.

The multivariable regression analysis revealed that women's employment status was significantly associated with independent decision-making. This finding is consistent with other studies that financial independence strengthens women's position in household decision-making.[23,24] Although women's education level did not show statistical significance in the multivariable analysis, partners' education emerged as significant in the univariate analysis. Partners with higher education were more likely to support women's independent decision-making, suggesting that educated partners may hold more positive attitude regarding reproductive responsibilities.[23]

Women who had both male and female children were more likely to make independent contraceptive decisions compared to those with only male children. Qualitative data also shows marriage duration and parity as a positive indicator of contraceptive communication. This suggests that once couples achieve a balanced family composition, women gain greater autonomy in contraceptive decision-making, likely due to having fulfilled sociocultural expectations regarding family structure.[25] The qualitative findings of this study highlight significant communication gaps, misinformation, male dominance and socio-cultural influences that hinder contraceptive decision-making discussions or communication among couples. The lack of spousal communication was largely due to knowledge gaps and misinformation, particularly among men.

While 89.70% of women reported discussing contraception with their partners and 88.48% felt comfortable in such discussions. But the findings from qualitative interviews contradicted this as both men and women expressed that there is limited or poor communication regarding contraception. Also, despite the joint decision that was reported, the decision was mostly male dominated. Some women reported difficulty in negotiating condom use with partners. This power asymmetry in reproductive decision-making has been reported across in India.[26,27] Qualitative findings highlight significant knowledge gaps regarding contraceptive methods in both men and women but particularly among men. This knowledge deficit aligns with studies from other Indian states showing inadequate contraceptive

awareness.[28,29] At the same time, in some instances, men's lack of knowledge and negative attitude influence women in choosing methods secretly. The silent negotiation shows lack of communication within relationships. A study on factors influencing modern contraceptive use, women agreeing to their husbands' preferences, sometimes leading to secret contraceptive use.[30] The study revealed that many women lacked autonomy in making reproductive decisions. Decision-making was heavily influenced by husbands, family members and cultural pressures, with women often unable to make independent.[31]

Fear and misconceptions about side effects especially about CuT (Copper T) emerged as significant barriers. Other studies also show misconceptions and fear of side effects as major barriers to contraceptive uptake.[32,33] The qualitative findings also revealed social stigma surrounding contraceptive access, particularly for women. This stigmatization is discouraging women's agency in accessing contraceptives independently.[34,35]

Overall, findings indicate lack of adequate contraceptive knowledge among both men and women, even among the young and educated, emphasizing the need for strengthened awareness, accessible information and open communication between partners in decision-making. While couple dynamics were explored, the study primarily focused on women's perspectives. The absence of direct male participation in the survey may have limited a complete understanding of male attitudes and behaviours regarding contraceptive decision-making.

CONCLUSION

This study highlights the complex individual, interpersonal and sociocultural factors influencing contraceptive decision-making among married couples in Kerala. Despite high literacy and strong health indicators, women's independent decision-making remains limited. Addressing knowledge gaps, socio-cultural norms and gender power imbalances at individual, couple and community levels is crucial to enhancing reproductive autonomy and promoting equitable contraceptive choices.

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