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Male Involvement in Family Planning: Contraceptive Use and Fertility Awareness among Tribal Men in Odisha

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ABSTRACT

Background: Tribal areas in India have historically lacked development, leading to persistent inequalities in health outcomes, particularly in sexual and reproductive health. Despite ongoing family planning efforts, low rates of contraception usage are still seen among tribal populations. According to the NFHS 5 (2019–21), overall, 49% of women in Odisha are using contraception, while the percentage is much lower among the tribal. This discrepancy raises questions regarding awareness, accessibility, and men's participation in family planning.

Objectives: This study aims to explore the knowledge and usage patterns of contraception among Odisha's tribal males.

Methods: Based on NFHS 5 data, the study was based on a sample of 3865 tribal men from Odisha. Bivariate and multivariate statistical methods were used to assess district-level variations, method preferences, information sources, and fertility cycle knowledge.

Findings: In Odisha, 31.36% of tribal men and their partners are using any contraceptive methods, with Anugul district the highest (47%) and lowest in Nuapada district (22%). Around 3% are male methods, such as 0.21% male sterilization and 3.03% male condom, respectively. It was also found that around one-fifth of the tribal men and their partners were using the traditional method. About 38% of men were aware of the contraceptive methods through media like radio, TV, and newspapers. Regarding knowledge about the fertility period of their partner, only 17% of the men were aware of the fertile period after delivery, before the return of menstruation.

Implications: These findings highlight the critical gaps in male engagement and reproductive health understanding among tribal males in Odisha, underscoring the urgent need for culturally responsive and male-inclusive family planning programs.

Introduction

India is home to one of the biggest tribal populations in the world, with over 700 Scheduled Tribes recognized by the constitution, contributing to the vast ethnic, cultural, and linguistic variety of the nation. These groups accounted for 8.6% of India's overall population, according to the 2011 Census, and 22.85% of the 62 distinct tribes of Odisha, making it one of the states with the largest concentration of tribal populations. These communities, which are mostly found in mountainous, wooded, and remote places, continue to have poor health outcomes due to significant socioeconomic concerns such as poor infrastructure, low literacy rates, nutritional insecurity, and restricted access to healthcare. In this setting, reproductive health remains a significant concern, with a disproportionate impact on indigenous males. In rural India, just 13.1% of males

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utilize male family planning methods like sterilization or condoms, and tribal men in Odisha contribute even less (Parija et al., 2022). Community cultural taboos, parental hesitancy, and the belief that sterilization weakens the body all hinder adoption. The most vulnerable tribal tribes are also the most disadvantaged. Given the prevalence of undernutrition, low maternal healthcare utilization, and a strong reliance on traditional birth attendants among populations such as the Odisha Juangs, Kanrar and Goswami (2020) have shown the urgent need for culturally sensitive reproductive health and nutrition interventions.

In India, family planning has historically been the responsibility of women, which upholds gendered accountability norms. Poor mother and child health outcomes have been cemented in tribal regions where high fertility, early conception, and inadequate contraceptive usage persist. Compared to female sterilization, temporary spacing procedures are less well-known. Age, length of marriage, and access to government services all have a substantial impact on contraceptive awareness, according to southern Indian researchers Muralidhar et al. (2024). Indigenous women's access to reproductive services is further restricted by cultural and financial barriers. According to Rai et al. (2025), a continuous reliance on traditional medicine and birthing practices, poor contraceptive usage, and insufficient prenatal care are all made worse by health services that are both culturally and geographically unavailable. These trends are reinforced by health initiatives that have mostly targeted women throughout the years. Singh and Jaswal (2022) claim that a lack of male-sensitive facilities, cultural hurdles, marital rituals, and communication channels prevents males from participating in conversations about reproductive health. This absence is important because it undermines the goal of shared responsibility in family planning. Overall, 49% of Odisha's women use contraception, with a somewhat higher percentage in rural regions. However, these averages conceal more pronounced differences across tribal groups, according to NFHS-5 (2019–21). Female sterilization remains the most popular procedure, even though only 3% of males use condoms, and less than 1% of men have a vasectomy. This is a prime example of the significant inequality where women are disproportionately responsible for fertility management. However, Bhowmick and Ghosh (2023) demonstrate that even women's utilization of prenatal care remains low in disadvantaged tribal locations, highlighting the persistence of disparities after behavioural interventions. Inherent patriarchy perpetuates the notion that women are responsible for family planning. Traditional gender norms and a lack of male sexual health education are cited by Sreedevi et al. (2022) as barriers to contraceptive use. According to Bharali et al. (2016), tribal women often know, but poverty and social isolation still restrict their adoption. Men's access to knowledge is restricted by low literacy, linguistic isolation, inadequate transportation, and limited media exposure. Palo et al. (2020) showed that just 17% of tribal men in Odisha could properly identify fertile periods, indicating that the use of contraception is further limited by cultural taboos, fear of spousal remarriage, early marriages, and reliance on traditional healers.

There are relatively few possibilities for men themselves. Mitra and Kshatriya (2014) state that vasectomy and condoms are the most common means of male contraception. Despite their scientific potential, hormonal treatments are not often used due to limited industry investment, cultural opposition, and adverse effects of anxiety. According to Appiah et al. (2019), men in many parts of Africa and Asia exhibit a high awareness of family planning but low actual engagement because of patriarchal practices and healthcare systems that prioritize women. According to Mudi et al. (2023), cultural norms that limit male participation are reflected in the unfavourable attitudes and lack of information about contraceptives held by Juang males in Odisha. Only 38% of tribal males said they had ever seen family planning messaging in the media, which is in line with findings from a nationwide survey that reveals a serious communication outreach gap. Policy actions have reinforced this imbalance. Both India's National Population Policy of 2000 and Mission Parivar Vikas promote voluntary contraception; however, they disproportionately affect women. Male sterilization dropped from 3.5 percent in 1992–1993 to barely 0.3 percent in 2015–2016, despite an increase in female sterilization (Prusty& Begum, 2023). Only Himachal Pradesh and Telangana record somewhat higher rates of male vasectomy involvement than Odisha, which continues to rank among the states with the lowest rates. Gender equity, education, and media access are all substantially associated with the use of contraceptives (Panda et al., 2023), yet indigenous groups in the east and northeast are constantly lacking in these areas. Displaced women have been disproportionately affected. Many indigenous women who have been relocated have severe unmet needs, 57% are ignorant of the significance of spacing children, and over half of them are victims of domestic abuse. Furthermore, Sahoo and Pradhan (2021) claim that inadequate communal institutions further erode their reproductive autonomy. Smitha et al. (2021) discovered that favourable sentiments are offset by a lack of clarity, fear of adverse effects, and socio-religious hurdles. In Odisha, only 24 to 46 percent of married women utilized contemporary methods of contraception, predominantly oral tablets. In Odisha, approximately half of married women knew very little about contraception. The importance of disaggregation is evident when examining patterns across states. The usage of contemporary contraceptives rose from 29 percent in 2005–06 to 43 percent in 2019–21 in Northeast India,

with somewhat higher rates in Arunachal Pradesh and Nagaland, according to Mondal et al. (2024).

However, dropout rates were high, and male method uptake remained low. Studies like Diamond-Smith et al. (2024) on the TARANG pilot in rural India show the feasibility of couple-based interventions that significantly improved spousal communication and reproductive health knowledge, even though work demands and migration pressures remained barriers to participation. This is in line with earlier studies by Collumbien et al. (2001) and Jungari et al. (2020), which showed that female sterilization still predominates in tribal homes even if spacing procedures are still rare due to a lack of knowledge, unmet demand, and insufficient service delivery. According to Jayalakshmi et al. (2002), persistent son preference standards also limit the use of male contraceptives. These trends demonstrate how gender inequality continues to be a major factor in India's family planning predicament. The research reveals a long-standing discrepancy in the tribal reproductive health of Odisha when taken as a whole. Men are often the ones who make fertility decisions in their households yet often don't know much about or actively use contraception. Contrarily, women endure the social and physical burden of reproduction, and female sterilization predominates among contraceptive options despite indications of unmet demands for temporary alternatives. District-level study is required to address the gaps among the 62 tribal groups in Odisha since state or national averages are inadequate as guides for interventions due to differences in geography, culture, literacy, and service accessibility. Understanding distinct cultural practices, challenges, and possibilities requires local research. The research can inform male-friendly service delivery, couple-centred counselling, and targeted awareness efforts, increasing access to reproductive healthcare for males and shifting accountability from a historically female-only field. Gender equity, maternal health, and the prevalence of contraception can all be improved by doing this. Addressing men's ignorance and lack of supporting involvement in family planning will be crucial to achieving the Sustainable Development Goals, particularly Goal 3, which calls for universal access to reproductive healthcare. Men in the tribal regions of Odisha must be integrated as equal and informed stakeholders in reproductive health if family planning is to become a shared duty rather than a gendered burden.

Data & Methods

Study Area and Population

The study was conducted in the state of Odisha, which has a substantial tribal population and significant regional variations in reproductive health outcomes. Tribal men between the ages of 15 and 54 comprised the research group; understanding male involvement in family planning requires an understanding of these individuals.

Data Source

The information comes from the National Family Health Survey (NFHS-5, 2019–21), which was carried out by the International Institute for Population Sciences (IIPS) in Mumbai. From the dataset, 3,865 tribal guys were selected. The study only included married or cohabiting individuals who had some knowledge about fertility and contraception.

Data Analysis

Descriptive statistics were used to summarize the contraceptive techniques. Bivariate research assessed the relationship between men's fertility knowledge, contraceptive usage, and background characteristics. To control for confounding factors and ascertain the independent influence of sociodemographic characteristics on these outcomes, multivariate logistic regression was employed.

Variables

It is essential to comprehend reproductive cycles, the types of contraception that are accessible, and the risks associated with getting pregnant before menstruation returns after delivering a child. The usage of contraceptives was separated into two groups: modern (condoms, pills, sterilization) and traditional (withdrawal, periodic abstinence). Additionally, sociodemographic factors such as domicile, wealth index, age, and education were included.

Results

The evolution of male contraceptive usage in Figure 1 reveals a clear adoption gap. It is disturbing that 68% of men said they did not use any kind of birth control, indicating a lack of interest in family planning. Nowadays, the most popular methods are the pill (5%), male condoms (4%), and female sterilization (8%). Male sterilisation (less than 1%) and injections (less than 1%), together with IUDs (less than 1%), are the least popular procedures, on the other hand. The fact that the old withdrawal method is significantly more successful than even certain contemporary substitutes (less than 9%) suggests that less dependable methods are still being used. Not many people employ other conventional techniques like the female condom (less than 1%), the usual days approach (less than 1%), and periodic abstention (4%). According to this distribution, men utilize contemporary contraception at a low rate and consistently choose conventional methods or none. The results highlight the critical need for tailored awareness efforts, culturally relevant treatments, and easily available services to enable men to make knowledgeable decisions regarding contraception.

Figure 2 shows significant trends in male family planning behaviour and age-group-specific variations in

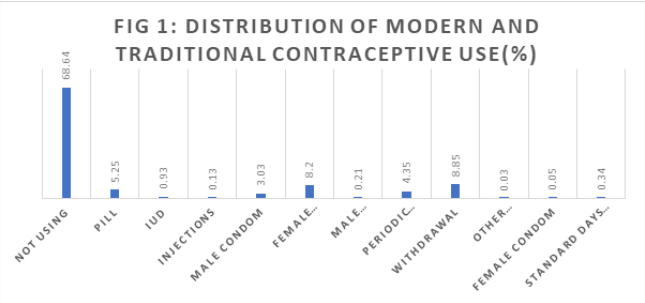

Figure : 1 Distribution of Modern and Traditional Contraceptive use (5%)

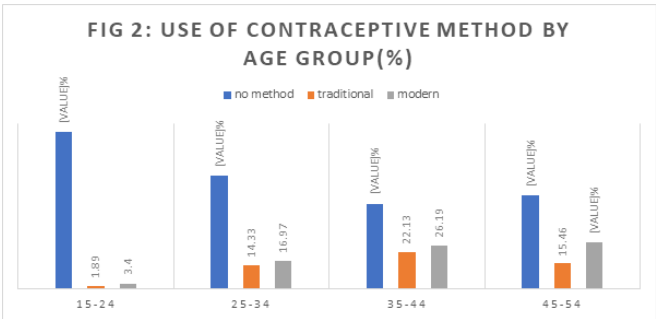

Figure : 2 Use of Contraceptive Method by Age Group (%)

contraceptive usage. With a stunning 95% of respondents saying they do not use contraception, with 2% utilizing ancient methods, and 3% using contemporary techniques, the youngest age group (15–24 years old) had the lowest degree of engagement. People are less likely to not utilize contraceptives and more likely to do so as they get older. Men between the ages of 25 and 34 who used traditional and contemporary techniques increased to 14% and 16%, respectively, while those who used no methods fell to 68%. Just 51% of individuals in the 35–44 age range do not employ any strategies, whereas a higher proportion employ both old (22%) and modern (26%) approaches. It's interesting to note that older males (45–54 years old) are more involved in and informed about the contraceptive sector. They are the most likely to employ current techniques (28%) and the least likely to do otherwise (56%). These patterns imply that people use contraceptives more often as they become older, most likely due to reproductive responsibilities, secure marriages, and more understanding. However, the shockingly high percentage of non-use among younger males points to a serious lack of information and access, highlighting the need for youth-friendly reproductive health services, awareness programs, and early intervention.

Socio-Demographic Variations in the Use of Contraceptive Methods

Significant sociodemographic differences in men's contraceptive use are displayed in Table 1, which also demonstrates how caste, ethnicity, wealth, and education affect reproductive health behaviours.

Wealth Index

The rate of not utilizing a contraceptive technique is significant (around 68%) across all income levels, regardless of affluence, which may indicate limited availability or awareness. However, the usage of contemporary techniques rises modestly with economic position, from 17% among the poor to 19% among the affluent, suggesting that access to current contraceptive treatments may be improved by financial means. A dependence on non-clinical remedies may be implied by the fact that the poor employ the traditional way the most (14%).

Religion

Non-Hindus employ contemporary (19%) and traditional (15%) family planning methods somewhat more than Hindu males (69%), which may reflect cultural or community-level disparities in family planning practices.

Education

Education has a major impact on the usage of contraception. As demonstrated by the fact that males with only a primary education report utilizing current procedures the most (25%), even a minimal understanding raises awareness of reproductive health risks. Interestingly, the largest non-use rate (72%), which may be related to delayed marriage or slower fertility planning, is seen among males with secondary or higher education. The high preference for the past (19%) among illiterate males suggests that they are either unaware of or have little access to contemporary possibilities.

Caste

General caste men have the greatest non-use rate (70%) compared to Scheduled Tribes (STs), who had the lowest contemporary method use (16%) and the highest traditional usage (15%). This points to structural inequalities in the outreach and teaching of contraceptive services to underserved groups. Both traditional and modern methods are used, according to the OBC and SC populations.

Ethnicity

The largest disparity is shown between guys who are tribal and those who are not. Tribal males are less likely to employ contemporary ways (14%) and more likely to rely on traditional methods (16%) than non-tribal men (about 19%). This indicates that formal medical services, cultural beliefs, and health infrastructure may be lacking in native communities.

Modern Contraceptive Usage Across Odisha's Districts

Significant regional differences are highlighted in Figure

Table 1: Socio-Demographic Variations in the Use of Contraceptive Methods

Wealth index	*No method (%)*	*Traditional method (%)*	*Modern method (%)*
Poor	68.46	14.23	17.3
Middle	69.68	11.39	18.93
Rich	68.68	12.14	19.17
		Religion	
Hindu	68.89	13.13	17.97
Other's	65.68	15.24	19.08
		Education	
Illiterate	61.97	19.41	18.61
Primary	56.05	18.07	25.88
Secondary above	72.49	11.28	16.23
		Caste	
Sc	67.58	14.37	18.04
ST	68.47	15.45	16.07
Obc	68.92	12.25	18.83
General	70.37	10.69	18.94
		Ethnicity	
Tribal	69.64	16.31	14.05
Non-tribal	68.59	12.69	18.72

3, which shows the distribution of men's usage of modern contraception in Odisha by district. Malkangiri (24%), Subarnapur (24%), Koraput (25%), and Baleshwar (27%), which have adopted contemporary techniques more successfully, have the greatest utilization rates. The lowest rates of usage, however, are seen in Nuapada (10%), Jagatsinghapur (13%), and Dhenkanal (12%), indicating a conspicuous lack of knowledge or access to contemporary

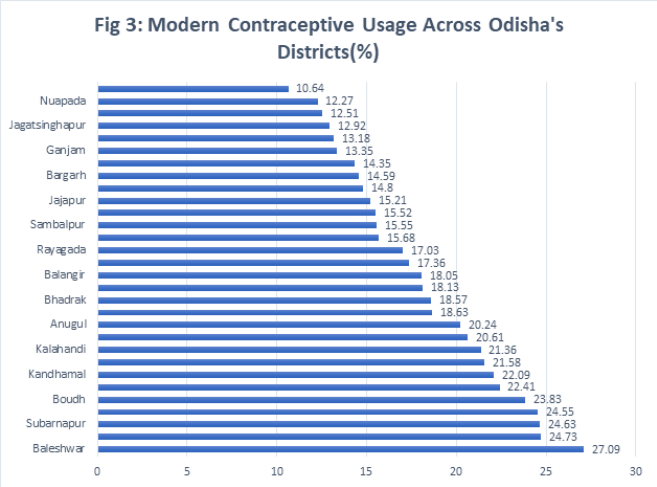

Figure : 3 Modern Contraceptive Usage Acrass Odisha's Districts (%)

contraception. Due to the influence of specific government efforts or community-based programs, certain tribal and interior districts, such as Kalahandi (21%) and Kandhamal (22%), may do better than some more urbanized or coastal areas. However, as areas in the south and west, such as Ganjam (13%) and Bargarh (14%), continue to fall short of the state's developing average, more outreach and education are required. Overall, the graph shows that although the usage of modern contraceptives has improved in several districts, a sizable section of the state still lags. To ensure equitable reproductive health outcomes throughout Odisha, regional discrepancies must be addressed via localized legislation, enhanced service delivery, and greater male engagement in family planning.

Use of Traditional Birth Control Methods in Odisha's Districts (%)

The distribution of traditional birth control techniques in Odisha by district is shown in Figure 4, with significant regional variation. The districts with the greatest rates of traditional birth control use are Anugul (27%) and Nayagarh (26%). Cuttack (15%), Debagarh (18%), and Kendujhar (16%) are other districts with high frequency; this may be due to cultural preference or limited availability to contemporary contraceptive services. The lowest percentages of traditional methods reported in Nabarangpur (5%), Jharsuguda (8%), and Ganjapati (7%),

Table 2: Awareness of Contraceptive Access Points Among Tribal and Non-Tribal Men

Awareness among men of accessing contraceptives by place	*Nontribal (%)*	*Tribal (%)*
mun/govt hospital	85.91	14.09
AYUSH	89.07	10.93
Government Dispensary	83.05	16.95
UHC//UHP/UF	79.3	20.7
CHC/Rural Hospital/Block PHC	82.56	17.44
Public PHC/Additional PHC	79.13	20.87
Sub-Centre/ANM	75.59	24.41
Govt. Mobile Clinic	91.7	8.3
Public Camp	68.86	31.14
Anganwadi/ICDS Centre	85.35	14.65
ASHA	83.91	16.09
Other Community-Based Worker	26.8	73.2
Public Health	86.82	13.18
NGO Or Trust Hospital/Clinic	61.17	38.83
Private Hospital	82.76	17.24
Private Doctor/Clinic	91.29	8.71
Private MOBILE Clinic	96.88	3.12
Pharmacy/Drugstore	91.49	8.51
Other Private Health	98.16	1.84
Shop	86.06	13.94
Friend/Relative	89.81	10.19
OTHER	96.24	3.76

on the other hand, can be the result of a general lack of usage of contraceptives or a move toward contemporary methods. In many tribal and southern regions, traditional practices are less prevalent due to differing fertility requirements or ignorance. The findings show that although some districts

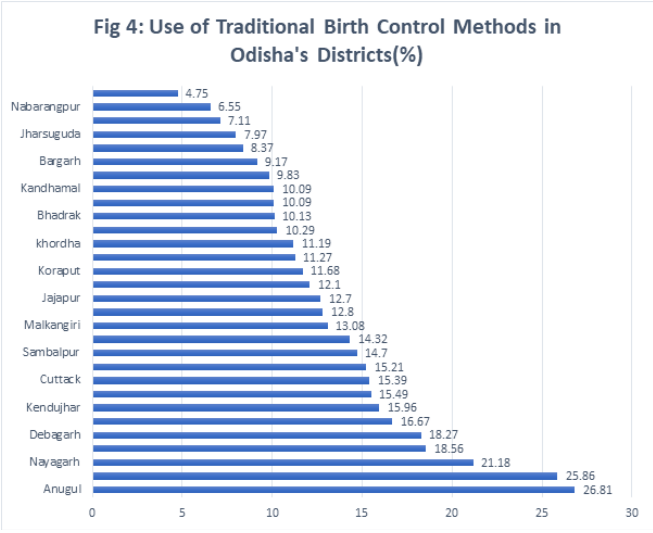

Figure : 4 Use of Traditional Birth Control Methods in Odisha's Districts (%)

are steadfastly sticking to conventional techniques, perhaps because of societal norms, others are abandoning them, probably because modern birth control is simpler to obtain. The significance of region-specific initiatives to improve reproductive health care throughout Odisha and encourage knowledgeable contraception choices is highlighted by these variances.

Awareness of Contraceptive Access Points Among Tribal and Non-Tribal Men in Odisha

The substantial disparities in reproductive health knowledge and service accessibility between tribal and non-tribal males in Odisha are illustrated in Table 2, which shows glaring disparities in awareness of contraceptive access sites. Non-tribal men are significantly more knowledgeable than their tribal counterparts in almost all clinical and institutional settings. For example, just 14% of non-tribal males know that there are municipal or government hospitals, but 86% of tribal men do. Similar patterns may be observed at government dispensaries (83% vs. 17%), AYUSH institutions (89% vs. 11%), and public health clinics (87% vs. 13%). Despite being essential elements of community-level contraceptive outreach, even frontline health workers like ASHAs and ANMs have limited access among tribal populations (16% and 24%,

respectively). The most significant difference is between mobile and private health services. In contrast to 97% of non-tribal males, just 3% of tribal men are aware of private mobile clinics. This pattern is also seen in private hospitals (83% vs. 17%) and pharmacies/drugstores (91% vs. 9%), suggesting that infrastructure or geographic location severely restricts access to private healthcare in tribal communities. Interestingly, only at NGO/trust hospitals (39%) and other community-based staff (73%) do tribal males show higher awareness, suggesting that community-driven and NGO-led efforts are more successful in reaching tribal communities. Furthermore, 31% of tribal males exhibit somewhat higher awareness through public camps, indicating that community-based outreach that is conducted over a shorter period of time is more effective than institutional outreach that is conducted over an extended period of time. These results highlight the urgent need for treatments tailored to indigenous communities. The awareness gap may be overcome by expanding outreach that is sensitive to cultural differences, bolstering the presence of grassroots workers, and enhancing communication and infrastructure. Recognizing that cultural and informational hurdles, in addition to geographic limitations, make it difficult for tribal populations to receive contraceptives, policies should place a high priority on equitable access to health care. Informed decision-making, population health equity, and reproductive autonomy are all significantly impacted by this discrepancy in Odisha.

Knowledge of Ovulatory Cycle Among Tribal and Non-Tribal Men in Odisha

Odisha's tribal and non-tribal men differ significantly in their awareness of the ovulatory cycle, as seen in Figure 5. Across the board, nontribal males are always more understanding than their tribal counterparts. Just 12% of tribal males are aware of this crucial window for fertility, compared to 88% of non-tribal men who properly grasp that conception is most likely to happen around the middle of the menstrual cycle. Likewise, just 22% of tribal

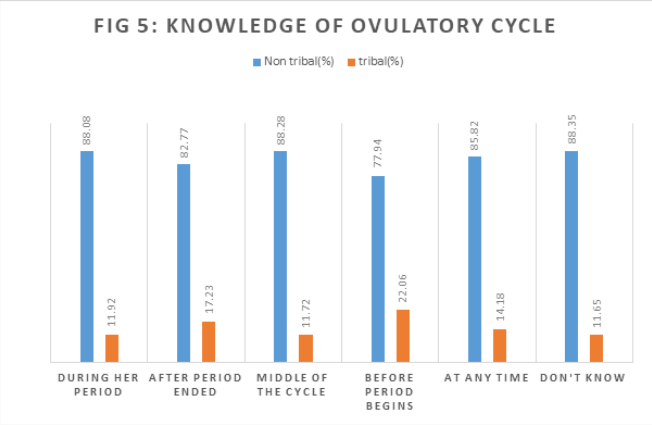

Figure : 5 Knowledge of Ovulatory Cycle

males accurately forecast their likelihood of conception before the onset of menstruation, compared to 78% of non-tribal men. It is alarming that a greater proportion of tribal males gave inaccurate or ambiguous answers. Compared to fewer than 1% of non-tribal males, 14% of tribal men in these groups think pregnancy can occur at any moment, and 12% say they are unsure. A serious issue with reproductive health education, particularly for indigenous groups, is brought to light by this knowledge gap. Tribal men's poor knowledge of reproductive cycles not only hinders them from making educated decisions about contraception, but it also fuels myths and downplays the shared duty of family planning. The results show how urgently indigenous populations require focused, culturally relevant reproductive health education and outreach initiatives. Involving male health educators, ASHA employees, and community leaders might help close this knowledge gap and promote improved family planning and reproductive autonomy among tribal males.

Discussion

This study utilizes data from the NFHS-5 (2019–21) to demonstrate that tribal and non-tribal males in Odisha exhibit substantial differences in reproductive awareness, knowledge, and contraceptive use. The large number of individuals (69%) who do not use contraception is a significant statistic showing that few males utilize family planning. The most reported techniques are condoms (3%), pills (5%), and female sterilization (8%), but their utilization is still very low despite current approaches. Traditional methods such as periodic abstinence (4%) and withdrawal (9%) are still often used, especially in tribal areas, due to cultural norms and limited availability of contemporary alternatives. Younger males (15–24 years old) utilize contraception the least (94% do not use it), while among men 45–54 years old, it progressively increases to 28%. Over time, a stronger desire to control fertility and increasing exposure to reproductive knowledge are probably the causes of this. There are also discernible disparities at the district level: Baleshwar and Boudh have higher rates of modern contraceptive usage than Nuapada and Jagatsinghapur. Anugul and Rayagada had the most dependence on traditional methods, indicating regional differences in acceptance and accessibility. People's socioeconomic position and educational attainment have a big impact on how often they utilize contraception. Tribal and illiterate males are more likely to employ traditional tactics, whereas wealthier and better-educated men are more likely to employ contemporary ones. Long-standing gaps in reproductive health outreach are evident in the fact that Scheduled Tribe males report utilizing traditional techniques the most (15%) and contemporary methods the least (16%). The blatant ignorance regarding access to contraception is one of the main issues. Only 8% of tribal males are aware of private pharmacies and mobile

clinics, whereas non-tribal men are far more familiar with government hospitals, PHCs, and pharmacies. Tribal knowledge is higher than that of non-tribals only in informal sources such as "other community-based workers" (73%), indicating a dependence on unofficial networks and a lack of integration with formal health systems. A particularly worrying finding is that tribal men have a poor understanding of the ovulatory cycle; less than 22% of them are aware of when it is fertile, compared to over 85% of non-tribal men. Unplanned births and unmet contraceptive needs are caused by this lack of reproductive awareness.

Contraceptive education should be provided by community health services, such as ASHA staff, mobile health units, and Anganwadi centres. By participating and communicating ideas in a culturally appropriate manner, tribal leaders may build trust, which will boost acceptability and uptake. To bridge the knowledge and access gaps, family planning programs must shift from a woman-centric approach to one that actively engages males as equal participants in reproductive decision-making. These findings highlight the urgent need for culturally aware, community-driven reproductive health interventions and policies that strongly promote male family planning involvement, particularly in tribal communities.

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