Contraceptive Conversations: Exploring Awareness, Beliefs, and Stigma around Contraception in Urban India

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ABSTRACT

Background: Despite improved access to contraceptive methods in urban India, widespread misinformation, social stigma, and limited education continue to restrict their effective use. Critically, poor contraceptive knowledge has direct implications beyond reproductive health - This study aimed to evaluate current knowledge, attitudes, and practices around contraception to identify persisting gap sand barriers.

Objectives: To assess awareness, knowledge, attitudes, beliefs, and acceptance around contraceptive practices among urban Indians, focusing on generational, educational & gender, societal influences that shape contraceptive choices

Methods: A cross-sectional online awareness survey of 240 participants (140 females and 100 males) aged 18 to 50 years was conducted between September and October 2025.

Results: Females showed notably greater openness in discussing contraception than males. The male condom was the most recognised and used method, yet awareness of its role in HPV and cancer prevention was absent. Awareness of IUDs and implants was poor. Over 50% lacked knowledge on the correct use of oral contraceptive pills, including unawareness of associated cancer risk profiles. 30% believed contraceptives adversely affect fertility or sexual function. 75% equated emergency contraception with abortion. 80% found sex education inadequate and 70% had not received contraceptive counselling from a healthcare professional. Over 50% expressed a need for a dedicated contraceptive helpline.

Conclusion: Knowledge gaps, societal myths, and stigma continue to hinder the widespread acceptance and correct use of contraceptives in urban India. Addressing misinformation through comprehensive sex education, proactive healthcare counselling, and community-based awareness initiatives is crucial to promoting informed, appropriate, and stigma-free practices.

Keywords: *Contraception, Awareness, Urban India, Stigma, HPV, Emergency contraception, Oral Contraceptive Pill, Condom Use, Knowledge Gaps, Sexual Health, Family Planning*

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1. INTRODUCTION

Contraception is a fundamental component of reproductive healthcare, enabling individuals and couples to exercise agency over family planning decisions and reduce rates of unintended pregnancy of unintended pregnancy, whilst protecting themselves from sexually transmitted infections & diseases. Despite significant advances in contraceptive technology and their increased availability across India, the uptake and consistent, correct use of modern contraceptive methods remain suboptimal, particularly in urban populations where access is expected to be less restricted.

India, as one of the world's most populous nations, has long engaged with family planning programmes at a policy level. However, translating policy into practice has been hampered by persistent misinformation, deeply ingrained social stigma, inadequate sex education, and limited counselling by healthcare providers. These challenges are not confined to rural or economically disadvantaged populations; urban Indians continue to demonstrate significant gaps in contraceptive literacy,

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influenced by generational attitudes, gender norms, and cultural taboos surrounding sexuality and reproductive health.

Emergency contraception in particular remains one of the least understood domains of reproductive health, with a substantial proportion of the population conflating it with abortion. Such misconceptions discourage timely use and may contribute to unintended pregnancies and their associated morbidities. Furthermore, myths around the effect of contraceptives on fertility and sexual function continue to deter uptake, even among educated urban cohorts.

This study was designed to systematically evaluate current levels of contraceptive awareness, knowledge, attitudes, beliefs, and practices among urban Indians aged 18 to 50 years, while exploring the generational, educational, gender-based, and societal factors that shape contraceptive choices. The findings aim to inform targeted educational interventions and policy recommendations to improve contraceptive counselling and practice in the urban Indian context.

2. OBJECTIVES AND METHODOLOGY:

Study Objectives: The primary objective of this study was to assess the level of awareness, knowledge, attitudes, beliefs, and acceptance around contraceptive practices among urban Indians. Secondary objectives included:

- To explore generational, educational, gender-based, and societal influences on contraceptive choices.
- To identify the most prevalent myths and misconceptions surrounding contraception and emergency contraception.
- To determine the adequacy of sex education received and contraceptive counselling by healthcare professionals.
- To understand social and partner-related barriers to independent contraceptive decision-making.

Study Design: A cross-sectional, descriptive online awareness survey was conducted between September and October 2025. The survey was administered online using a structured, self-administered questionnaire to ensure anonymity and encourage honest reporting, particularly on sensitive topics related to sexual and reproductive health.

Participants: A total of 240 participants were enrolled, comprising 140 females (58.3%) and 100 males (41.7%). The age range was 18 to 50 years. Participants were urban-dwelling individuals recruited through digital outreach methods. Inclusion criteria required participants to be residing in an urban Indian setting at the time of the survey. Participants below 18 years or residing in rural areas were excluded.

Survey Instrument: The questionnaire was developed by the study team based on existing validated tools on contraceptive knowledge, attitudes, and practices (KAP), adapted for the Indian urban context. It covered the following domains:

- Demographic information (age, gender, educational qualification, marital status)
- Awareness and knowledge of contraceptive methods
- Attitudes and beliefs regarding contraception and its effects on fertility and sexual function
- Perceptions and knowledge of emergency contraception
- Adequacy of sex education received
- Contraceptive counselling received from healthcare professionals
- Social, partner, and family influences on contraceptive decision-making
- Need for dedicated contraceptive support services

Ethical Considerations: Participation was entirely voluntary and anonymous. Informed consent was obtained prior to the commencement of the survey. No personally identifiable information was collected.

3. RESULTS:

Gender Differences in Contraceptive Discussions

Females demonstrated notably greater openness and willingness to discuss contraception compared to males. This finding is consistent with the societal expectation that contraception is predominantly the domain of women, placing a disproportionate burden of contraceptive responsibility on female participants.

Awareness and Use of Contraceptive Methods

The male condom was identified as the most widely recognised and most commonly used contraceptive method among both genders. Awareness of long-acting reversible contraceptive (LARC) methods, specifically intrauterine devices (IUDs) and subdermal implants, was found to be poor across the surveyed population. This gap in awareness of highly effective, long-acting methods represents a significant missed opportunity in contraceptive uptake.

Over 50% of respondents reported lacking adequate knowledge regarding the correct use of oral contraceptive pills, including appropriate timing, missed dose management, and drug interactions. This finding suggests that even for methods that are widely known, correct-use knowledge remains deficient.

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Beliefs and Misconceptions

Approximately 30% of participants expressed the belief that contraceptive use adversely affects fertility or sexual function. This misconception, if left unaddressed, constitutes a significant barrier to contraceptive adoption, particularly among individuals in their reproductive years who are concerned about future fertility.

A striking 75% of respondents equated emergency contraception (EC) with surgical or medical abortion. This widespread conflation reflects a critical gap in public understanding of the mechanism of action of EC, which functions primarily by preventing or delaying ovulation rather than by terminating an established pregnancy. Such misinformation likely discourages timely use of EC following unprotected intercourse, potentially contributing to higher rates of unintended pregnancy.

Sex Education and Healthcare Counselling

80% of participants rated the sex education they had received as inadequate. This perception of deficiency in formal reproductive and sexual health education underscores the need for reform in not only school curriculum but also in community health programmes to provide evidence based, age-appropriate information on contraception benefitting adolescents and adults alike.

70% of respondents reported never having received contraceptive counselling from a healthcare professional. The absence of proactive counselling in clinical settings highlights a systemic gap in reproductive health delivery, where contraception is frequently overlooked as a topic of discussion during family gatherings or health professional consultations

Access to Information and Support Services

Over 50% of participants expressed a clear need for a dedicated contraceptive helpline or support service. This finding indicates an unmet demand for accessible, confidential, and non-judgmental sources of contraceptive information and guidance beyond formal healthcare settings.

Influence of Social Factors on Contraceptive Decision-Making

A majority of female participants reported feeling pressured and unable to make independent decisions regarding contraceptive use. The primary sources of this pressure included fear of social judgment, partner disapproval, and family influence. This highlights the extent to which individual reproductive autonomy remains constrained by interpersonal and societal dynamics, even in an urban setting

4. DISCUSSION

The findings of this study reveal persistent and multifaceted gaps in contraceptive knowledge, attitudes, and practices among urban Indians, despite the relatively higher levels of education and healthcare access associated with urban residence. These results are consistent with existing literature on reproductive health literacy in South Asian contexts, including emergency contraception misconceptions, inadequate sex education, and poor health care counselling, that require targeted intervention.

The disproportionate burden of contraceptive responsibility on women, reflected in their greater engagement with the topic, mirrors findings from regional and global studies. While this engagement is positive in terms of knowledge-seeking behaviour, it simultaneously reflects inequitable gender norms that may limit shared reproductive decision-making between partners.

The dominance of the male condom as the most recognised and used method, coupled with poor awareness of LARCs such as IUDs and implants, suggests that contraceptive education efforts have been narrowly focused. LARCs are among the most effective available methods and are particularly beneficial for individuals seeking long-term contraception without the requirement for daily adherence. Expanding awareness and counselling regarding these methods should be a priority for both healthcare providers and public health campaigns.

The finding that 75% of respondents equated emergency contraception with abortion is particularly concerning. EC pills, such as levonorgestrel-based products, work by inhibiting or delaying ovulation and do not interrupt an established pregnancy. This misconception likely has a direct bearing on the underutilisation of EC following unprotected intercourse. Educational campaigns specifically addressing the mechanism of EC are warranted.

The finding that only 30% of participants had received contraceptive counselling from a healthcare professional, combined with the near-universal perception of inadequate sex education, suggests that neither the health system nor the education sector is adequately meeting the reproductive health information needs of urban Indians. Integrating structured contraceptive counselling into routine primary care and health care professional consultations, alongside revised school-level sex education, could substantially address these gaps.

Social and interpersonal barriers to contraceptive decision-making, particularly among women, underscore the need for couple-based and community-level interventions that address partner communication, gender equity, and the destigmatisation of contraception. Reproductive autonomy cannot be achieved through individual knowledge alone; it requires supportive social environments and equitable relationships.

The requirement for daily adherence. Expanding awareness and counselling regarding these methods should be a priority for both healthcare providers and public health campaigns.

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5. CONCLUSION

This cross-sectional survey demonstrates that knowledge gaps, societal myths, and stigma continue to significantly hinder the widespread acceptance and correct use of contraceptives among urban Indians. Emergency contraception remains one of the least understood aspects of reproductive health, with the majority of respondents holding incorrect beliefs about its mechanism of action. Furthermore, the majority of participants had not received contraceptive counselling from a healthcare professional and perceived their sex education as inadequate.

Addressing these challenges requires a multi-pronged approach: comprehensive, evidence-based sex education beginning at the school level; proactive and non-judgmental contraceptive counselling by healthcare providers; community-based awareness initiatives targeting stigma and misinformation; and the establishment of accessible, dedicated contraceptive support services such as helplines. Additionally, interventions must address the structural gender inequities that limit women's reproductive autonomy and reinforce the need for shared contraceptive responsibility.

These findings have important implications for reproductive health policy and practice in India and contribute to the growing evidence base highlighting the need for renewed investment in contraceptive literacy and counselling in urban settings.

6. LIMITATION

This study has several limitations that should be acknowledged. First, the use of a self-administered online questionnaire may introduce selection bias, as participation was limited to individuals with internet access and digital literacy, potentially overrepresenting more educated urban populations. Second, the cross-sectional design precludes causal inference. Third, social desirability bias may have influenced responses to sensitive questions regarding sexual behaviour and contraceptive practices, despite the anonymous format.

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