

International Journal of Biomedical and Advance Research

ISSN: 2229-3809 (Online); 2455-0558 (Print)

Journal DOI: <https://doi.org/10.7439/ijbar>

CODEN: IJBABN

Original Research Article

Perceptions and adoption of male contraceptives among men in Indonesia

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Bandar Lampung, Indonesia***Article History:****Received:** 15/07/2017**Revised:** 31/07/2017**Accepted:** 01/08/2017**DOI:** <https://doi.org/10.7439/ijbar.v8i7.4290>**Abstract**

Introduction: The Family Planning program implemented in Indonesia in the 1970s successfully increases the prevalence of contraception, and on the other hand, lowers fertility. Nevertheless, this success is marred by gender inequality. The majority of family planning acceptors are women.

Method: The study (1) explores male narratives on male contraceptives and male perceptions of their risks and benefits; (2) identifies the factors affecting male decisions about contraception; and (3) shows how men negotiate and discuss contraception with women – if at all – before making decisions. The study was conducted in Bandar Lampung (Lampung) and Kulon Progo (Special Region of Yogyakarta). A total of 30 participants, consisting of married men who received a vasectomy, married men who used condoms, sexually active unmarried men who used condoms, and married men who did not use contraceptives were interviewed in depth. In addition, focus group discussions (FGD) were conducted involving stakeholders in each region.

Results: That men who use contraceptives experienced positive changes after receiving information and support from their peer group. Men who use contraceptives start off with views (myths) similar to those of the surrounding communities. Gender equality perspective was a key factor affecting contraceptive decision-making among men.

Discussion: that male perception of male contraceptives, especially vasectomy, is in flux. Negative prior to use, it gradually transforms into positive after men experience the benefits. Male decisions to use contraceptives are determined by their perceptions

Keywords: Male contraceptives, gender equality perspective, perceptions of contraceptives, masculinity, Indonesia.

1. Introduction

The Family Planning program implemented in Indonesia in the 1970s successfully, on the one hand, increases the prevalence of contraception, and on the other hand, lowers fertility [1]. Nevertheless, this success is marred by gender inequality. The majority of family planning acceptors are women. The level of male participation in family planning programs in Indonesia remains low. In 2012, 2.7% of men use contraceptives, of whom 0.2% received a vasectomy and 2.5% use condoms. The low use of contraceptives by Indonesian men is due to several factors, such as lack of knowledge, male attitudes

towards family planning, and socio-cultural attitudes of the community. Men lacking family planning knowledge are not motivated to use contraceptives [2].

Globally, men do not share equally with women the responsibility for fertility regulation. While family planning efforts almost exclusively target women, the lack of male involvement may also reflect the limited options available to men [3]. There are still many cultural barriers to the use of contraceptives among men. A number of studies show that males do not accept family planning [4-7], surely ironic given that the global trend of family planning

programs is toward gender equality in reproductive health rights. The idea that men should play an active role in family planning is increasingly widely accepted [8]. In a community with strict gender stratification, men have a crucial role in all decision making. Men with high gender sensitivity tend to have a more gender-equal attitude as well, and do not restrict their wives autonomy [9].

A number of studies demonstrate the dominance of men in all reproductive health decisions, including the use of contraceptives [10]. The dominance does not imply any real knowledge of reproductive health. Studies by Sychareun *et al* [11] show men's low knowledge of contraceptive methods. Thus, programs or interventions which encourage equal responsibility for decisions about contraception [12,13], which change norms and gender roles in the family[14], and which improve knowledge, attitudes, discussion, and intentions are crucial[15].

The need for improvement in both the research and in such programs is clear [12,13,18]. With regard to future research, [12] emphasize the importance of in-depth information on men as contraceptive users. Hence, our study aims to (1) explore male perceptions of the risks and benefits of male contraception; (2) identify the factors affecting contraceptive decision-making by men; and (3) describe how gender relations affect male decisions.

1.1 Literature Review

The low male involvement in contraceptive use and, generally, in reproductive health is caused by mistaken perceptions of male contraception. According to Kirkkola *et al* [16], sterilization for both men and women has been available since 1970, but men's striking unwillingness to undergo surgery explains the low use of such a method among men. A common belief is that sterilization is "bad for health" [3,4,17].

Limited male responsibility for contraceptive use cannot be separated from unequal gender relations within a community. In a patriarchal culture, the issues of contraception and birth spacing are considered as "women's affairs". According to Mitra *et al* [5], men would balance their manhood, which wants more children, against a decision to use contraceptives. A study by Weinstein *et al* [7] reported that men who tended to place family planning obligations solely on women had negative attitudes themselves towards the use of male contraceptives. Education and marital status were significantly associated with these attitudes.

Theoretically, the use of a male contraceptive is influenced by three factors: technical, economical and cultural. Other considerations are religious affiliation, the partner's approval, the nature and cost of any medical procedure, side-effects, accessibility to the service or product, and whether existing methods are sustainable,

including their cost and reversibility [5]. Religion has an important role in the decision to use contraceptives. The great majority of Islamic jurists believe that family planning is permissible in Islam. The silence of the Quran on the issue of contraception, these jurists have argued, is not a matter of omission by God, as he is "All-Knowing" and Islam is understood to be timeless.

The "characteristics theory" argues that fertility differences among religious groups are not caused by religious doctrines. Rather, demographic and socioeconomic differences affect fertility [18]. Birth control is misconstrued by Muslims as an innovation developed to satisfy western understanding [25]. Several studies among Muslims show that low use of contraceptives is associated with misconceptions and lack of adequate knowledge about the services [19]. The most of their Muslim participants feel that family planning is against the tenets of Islam [20]. Earlier Tober *et al* [21] find that Muslim communities believe contraceptives are capable of reducing the Muslim population. In Thailand, most Muslims believe that their religion opposes contraception [22].

A study by Dynes *et al* [23] in Kenya shows that acceptance of family planning by a society brings about individual acceptance of the program itself. The public perception of ideal fertility is thus very important. Identification of contraceptive users in areas with pronatalist norms is highly useful for future interventions. In theory, Islam facilitates contraceptive use but, in fact, there is inconsistency. A number of authors find that socio-demographic characteristics and other non-religious factors are more decisive than religion is [6,24]. On the other hand, in contrast, a number of other authors show a major role for religion in the decision to use contraceptives [20, 22, 25, 26].

The urgent need for male involvement in family planning programs is based on the fact that in various cultures such male involvement still faces many obstacles. A study by Kabagenyi *et al* [4] in Uganda, for example, identify: lack of time and lack of awareness of the importance of their involvement as affecting men's roles in fertility regulation. Another study that conducted in India finds several factors inhibiting the use of condoms: the cost, especially for poor families, moral values, ethnic and religious factors, the gender gap, lack of dialogue between partners, and condom-related stigma, all of which cause risky sexual behaviour without contraception. As well, personal factors such as the rejection of condoms, consumption of alcohol or drugs before sex, alienation, and depression also reduce condom use [27].

Efforts to involve men encounter many obstacles. According to Kamal *et al* [28] males more likely to participate are those whose wives are educated, those

engaged in skilled work, those with knowledge of contraceptive methods, those secure in their social network and getting consistently favourable messages about family planning from it, and those having supportive spouses, especially where both the husband and wife have reached an age of maturity. Regrettably, according to Smerecnik *et al* [29], current approaches to sex education of Muslim youth in the Netherlands are likely to be unsuccessful given the rigidity of sexual norms in Muslim society in general. In addition Smerecnik *et al* [29], identify new barriers to sex education among Muslim youth, for example, “lack of respect for an Imam who opposes a youth’s views on sexuality”.

2. Methods

Our study uses a qualitative approach to obtain in-depth information on various matters related to the use of contraceptives among men. It is conducted in regency and a city in Indonesia –that is, Kulon Progo Regency of Special Region of Yogyakarta, and Kota Bandar Lampung of Lampung Province. Thirty participants are interviewed in depth, consisting of married men who received a vasectomy, married men who use condoms, sexually active unmarried men who use condoms and married men who do not use contraceptives. Focus group discussions (FGD) involve married men and stakeholders in each area of study. A total of 22 people are involved in the FGD. Semi-structured interviews with key respondents, and FGD, are conducted between June and August 2016. Participants are selected on recommendations from the National Population and Family Planning Coordination Boards (BKKBNs) responsible for family planning programs in the regions.

Preliminary interviews with the key respondents ensure that they have adequate knowledge and are committed to developing family planning programs. The number of interviews in each city is 15 (fifteen). The interviews are conducted by experienced staff from the Lampung and Yogyakarta chapters of the International Planned Parenthood Federation (IPPF), a London-based NGO chosen by the Indonesian Government. Repeated interviews allow for cross-checking and data validation. Upon completion, the transcripts and field notes are analyzed and coded with regard to whether or not each case reflects a socio-cultural structure. The questions identify barriers to male use of family planning and participation in it. The researcher asks participants how they assess their situation, make decisions, and take action. An open-ended approach ensures that participants are independent and free from pre-constructed responses or social contexts. Specific questions, rather than general questions, gain a greater insight into experience and into common knowledge usually taken-for-granted. We seek to understand the inner world of

male contraceptive users. The FGDs are conducted in Bandar Lampung and Yogyakarta. A member of the local research team is present to observe, take notes, and transcribe the FGDs. The transcripts of the interviews and FGDs become the coding framework.

3. Results

3.1 Description of Participants

A total of 30 participants are interviewed in-depth for information. They consist of seven condom users, 16 vasectomy recipients, five sexually active unmarried men, and two married men who do not use contraceptives. The average age of the participants is 38.0 years with an age range of 21 years to 64 years. Their educational backgrounds range from elementary to post-graduate degrees. The participants’ occupation is also varied, including workers, fishermen, police officers, civil servants, self-employed, wage workers, and students. Meanwhile, 22 participants are involved in the FGD, consisting of male contraceptive users.

3.2 Male Perceptions of Contraceptives

In the in-depth interviews and FGD, men have fairly positive views towards contraceptives, especially those participants who received a vasectomy and use condoms. Men who received a vasectomy have views quite different from the stereotyped view of contraception as a women’s affair. They generally hold that contraception is the responsibility of both the husband and wife. Moreover, for several men, contraceptive use is a reflection of their love for their wife and their wish to spare her from side-effects.

“... Female contraceptives have many counter-indications; if it does not fit, it will affect her physical condition. But, it is not one of the main factors to me ... because I have already had a son and daughter and I do not want more children; so, I underwent a vasectomy to enhance affection and harmony” (H, vasectomy recipient, Kulon Progo).

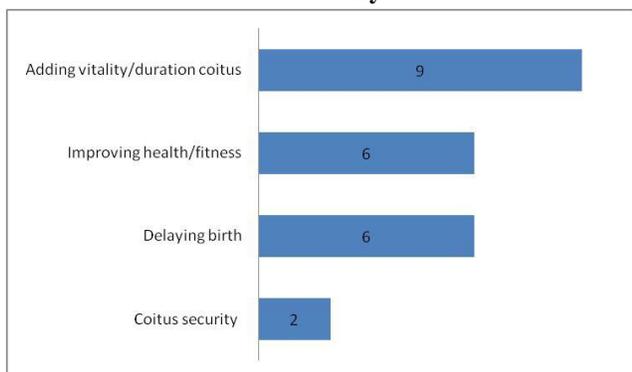
Vasectomized men present themselves not only as a marital partner, but also to their friends as agents of positive change. Their personal experience with vasectomy encourages others to be interested in undergoing a vasectomy.

“After my vasectomy, I told my story to my friends, relatives and neighbours ... it turned out that there were among them who followed suit. I’m the first who underwent a vasectomy in this village and then there were relatives, neighbours and close friends who did so. There were also women who then underwent tubectomy. In total, there are 5 people who underwent a vasectomy” (MS, vasectomy recipient, Kulon Progo).

The level of male participation in contraception remains low in Indonesia, one of the main factors being men’s (and the public’s) mistaken perceptions of male contraception, especially of vasectomy. There are many among the general public who perceive vasectomy as castration, or even as mutilation of the male genitals. Even among the participants, some initially had a similar notion, later eroded by counselling prior to the trivial procedure. Indonesia requires couples intending a vasectomy to undertake such counselling.

Men’s self-assurance generally grew stronger after a vasectomy. In general, vasectomy is a contraceptive method that does not have negative side effects; on the contrary, it even increases men’s vitality. Surrounding communities continue to label vasectomised men as bizarre. This view stems partly from a religious misunderstanding that certain methods “kill” offspring. The 1995 fatwa (or formal religious opinion) from the MUI (Indonesian Council of Scholars of Islam) that vasectomy is entirely *halal* (allowed by Islamic law) does not immediately change public opinion. Men who accept the method tend to have views different from their communities.

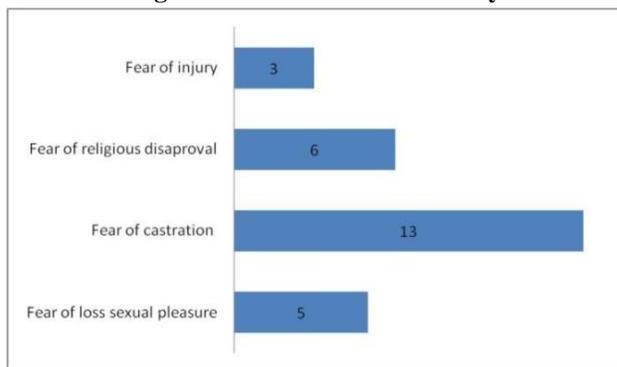
Figure 1: Participants’ Views of the Impacts of Vasectomy



FGDs identify various myths persisting within communities with regard to male contraceptives, particularly vasectomies. These myths include that a vasectomy is synonymous with castration. As a result, men would behave effeminately, says the myth. Vasectomy is simply interrupting the vas deferens so as to prevent sperm from entering into the seminal stream. Sperm, semen and male hormones continue in full production. Equally nonsense is these myths: that (2) a vasectomy requires major surgery; (3) a vasectomy decreases libido (sexual desire); (4) a vasectomy lowers male “virility”; (5) a vasectomy increases infidelity. Any initial belief in these myths fades away with counselling. Men who used condoms also hesitated initially; but, later, their doubts went away.

Interviews reveal barriers or concerns prior to using contraceptives. Doubts among participants prior to vasectomy show a previous lack of understanding. Such concerns are due to a lack of reliable information. The perceived synonymy of castration with vasectomy lingers on in public opinion. In general, the public understands little and knows less about either vasectomy or condoms. Most men obtain initial information, or myths, from their peer group. They get reliable information from medical personnel only after they have opted to use a contraceptive. It is a strong belief in gender equity, we find, that leads them to use contraceptives. The strong belief overcomes their hesitancy, and reliable information ends their fears.

Figure 2: Barriers to Vasectomy



Medical technical information about contraceptives for men remains a rare commodity. This lack correlates highly with poor education and poor access to Information, Education and Communication (IEC) media. To increase men’s participation in using contraceptives, we must improve men’s knowledge of contraceptives.

3.3 Men’s Motivation to Use Contraceptives

Men who used contraceptives have personality types different to those of men in general. We identify six conditions affecting contraceptive use among men: the perceived adequacy of the number of children; the wife’s health; economic pressures; perceived religious norms; social networks, and perceived gender equality.

People differ about the ideal number of children. Several participants with only two children feel that two is enough. Other participants prefer four, five, or six children. Generally, this perception stems from economic factors. Participants perceiving two children as “enough” say that they would have financial difficulty in having more children. A wife’s health not allowing hormonal contraceptives or IUDs motivates men to find alternatives. However, this factor does not stand alone. Other prerequisites are the number of children and the man’s view of gender equality.

Twelve respondents use contraceptives themselves even though their wife is in good health. In fact, five of them have taken that responsibility ever since the beginning of their marriage. In general, as above, men who use contraceptives agree that contraception and other reproductive health issues are, at least, shared responsibilities of husband and wife, and that the use of male contraceptives is an expression of love to the wife.

Gender equality in the present study affects contraceptive use among men. All the participants who used contraceptives had a similar view of gender equality. This is seen from their attitudes to, for example, sharing domestic tasks. In general, domestic chores are assigned fairly to the husband and wife and those children who are able to help. At the same time, family strategic decisions are made jointly by the husband and wife in consensus.

Table 1: Conditions Motivating Participants' Contraceptive Use

| Informant's ID code and original contraceptive methods | Conditions Motivating Contraceptive Use | | | | | |
|--------------------------------------------------------|-----------------------------------------|-------------------------|------------------|---------------------------|----------------|---------------------------|
| | Adequate number of children | Wife's health condition | Economic factors | Perceived religious norms | Social Support | Perceived gender equality |
| Bandar Lampung | | | | | | |
| D (condoms) | No | No | No | + | + | + |
| M (condoms) | No | Yes | No | + | - | + |
| Y (condoms) | Yes | Yes | No | + | + | + |
| H (vasectomy) | Yes | No | Yes | + | - | + |
| HM vasectomy) | No | No | Yes | + | + | + |
| M (vasectomy) | Yes | Yes | Yes | + | + | + |
| P (vasectomy) | Yes | Yes | Yes | + | + | + |
| R (vasectomy) | Yes | No | Yes | + | + | + |
| S (vasectomy) | Yes | No | Yes | + | + | + |
| SY (vasectomy) | Yes | No | Yes | + | + | + |
| Z (vasectomy) | Yes | Yes | Yes | +/- | +/- | + |
| Kulon Progo | | | | | | |
| S (condoms) | No | Yes | Yes | + | + | + |
| W (condoms) | Yes | Yes | Yes | - | + | + |
| Y (condoms) | No | Yes | Yes | - | + | + |
| A (vasectomy) | Yes | Yes | No | - | + | + |
| H (vasectomy) | Yes | No | No | + | + | + |
| K (vasectomy) | Yes | No | Yes | + | + | + |
| M (vasectomy) | Yes | Yes | No | + | + | + |
| MS (vasectomy) | Yes | No | No | + | + | + |
| R (vasectomy) | Yes | No | Yes | - | + | + |
| S (vasectomy) | Yes | No | No | +/- | +/- | + |
| T (vasectomy) | Yes | No | Yes | + | + | + |

3.4 Gender Relations and the Correlations with Male Contraceptive Decision-Making

Men's participation in family planning remains a sensitive issue in Indonesia. Various cultural and structural obstacles still hinder efforts to improve men's participation in family planning programs, particularly in vasectomy. Families adopting a vasectomy as their reproductive health option manage to overcome these obstacles, and they have closer gender equality. In the present study, we examine gender equality from three aspects: (1) strategic decision-making, (2) characteristics of the ideal man, and (3) division of domestic chores.

Firstly, in a patriarchal culture, all important decisions are made by men, who act as the head of the family. Women or wives do no more than follow the decisions made by males. In some cases, tactical decision-making involves women by way of joint deliberation, but strategic decisions and final dispositions generally remain in male hands.

Patriarchal ideology manifests itself in all cultures; however, there are variations in its application. Those variations include the domestic duties acceptable to men, the public activities permitted to women, male and female autonomy in household decisions, values relating to gender

relations, and so on. In fact, variations occur even among households within the same culture. Such variations need to be understood, for they affect Government policy.

Our interviews show that gender relations vary among households of nominally the same culture. Our findings contrast with the accepted picture of a monolithic culture based on male domination. The families with the husband using either condoms or vasectomy show a pattern of joint family strategic decision-making. Indeed, decisions concerning daily needs, such as menus, are generally made by the wife, and financial management is also handled by the wife.

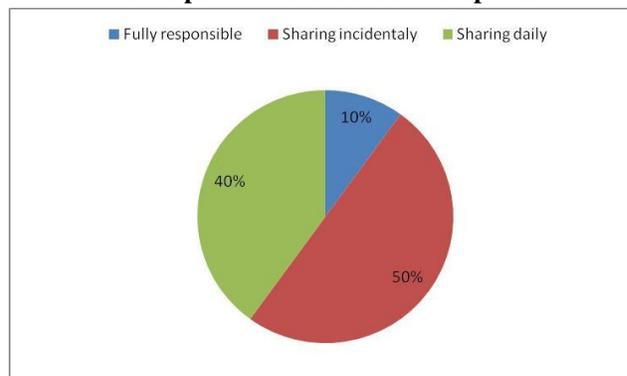
Secondly, among male contraceptive users, the ideal man is he who takes great responsibility for his family. Ideal men provide for the daily needs of the family. In fact, several participants say that men should not only meet the daily needs of the family, but also make sacrifices for their families, beyond just providing a living.

The issue of making a living among the participants is no longer dominated by the husband. A wife has the potential – and the opportunity, respondents say – to make a living, even possibly having a larger income than that of her husband. The levels of education and openness to information of men (and women, we expect) affect this view. Several participants told of their wives' opportunities to work in the public sector.

Thirdly, gender relations control the patterns of division of daily domestic chores among the husband and wife and older children. Some participants have a housemaid in their home, but the husband still took part in the day-to-day chores. This finding is interesting in view of its contrast to the general pattern of the division of domestic labour in patriarchal cultures, that is, that the wife (or maid) is entirely burdened with the domestic workload.

The intensity of men's role in domestic chores varies, of course, and it is influenced by various factors in addition to gender values, such as the wife's employment, familial responsibilities, finances, transport, paid help, and so on. Domestic chores, interestingly, create household harmony. Men's role in domestic chores constitutes an indicator of gender equality. The higher the involvement, the more positive the perception of gender equality. Figure 2 shows that the intensity of the role varies. The minimum level is as a complement to the wife's obligatory labour. The maximum level is as a househusband, the common term for a man who cares for the home and children while his wife is in full-time employment. In general, men actively involved in domestic chores distance themselves from, and challenge, the prevailing social norms.

Figure 2: Pattern of Division of Domestic Chores among Participants who Used Contraceptives



4. Discussion

Our results indicate that male perception of male contraceptives, especially vasectomy, is in flux. Negative prior to use, it gradually transforms into positive after men experience the benefits. Male decisions to use contraceptives are determined by their perceptions. Detailed, accurate information and intensive counselling are prerequisites for changing perception. Negative perceptions flow from many myths and misunderstandings about contraception. Our study confirms the work by Mitra *et al* [5] and Kirkkola *et al* [16], on male fears of sterilization, such as the loss of virility, impairment of libido, and reduced sexual performance. Even to use condoms, some feel, results in sexual dissatisfaction or allergic reactions.

Incomplete and inaccurate information on contraceptives – let alone outright myths and untruths – handicaps men. Despite their initial lack of knowledge and their preliminary concerns, the participants in this study choose to use contraceptives. Their decision is positively influenced by the support of their social network and the process of dialogue and intensive counselling. Men who use contraceptives in this study perceive contraception as not merely a woman's affair.

Moreover, several participants play roles not limited to men as partners, but rather extended to men as agents of positive change. These results contrast with those of Biradar *et al* [30]. Additionally, in this study, another factor affecting contraceptive use is perceived gender equality. As does Mishra *et al* [9], we show that men who use contraceptives generally have a gender-equal perspective, confirmed by their views of the ideal man, family decision-making, and the division of domestic chores.

Cultural factors, such as religion, in the present study have little or no effect on men's decisions to use contraceptives. This supports previous studies of some authors [6,24]. Despite the perception among men that contraceptives are contrary to religion, this is not an obstacle to using them. Any prohibition against the use of contraceptives, especially vasectomy, is at best debatable; in fact, in Indonesia, the *halal* fatwa for vasectomy is official government policy, in this case from the Indonesian Council of Scholars of Islam. It's true that there are different opinions among the communities and among the scholars.

The main condition that motivates men to use contraceptives is their conviction of equal gender relations. Male contraceptive users have independent personality types. They do not accept the mainstream view that family planning is a woman's concern. In such a cultural context, the use of contraceptives, for men, can be seen as a form of sacrifice, an expression of unselfishness, and an act of love. Thus, the decision to use contraceptives is a difficult one for men. This finding confirms that of other studies, such as Mishra *et al* [9] and Sarkar *et al* [27].

5. Conclusion

Male perceptions of contraceptives change. Men who use contraceptives start off with views (myths) similar to those of the surrounding communities. These views change with exposure to information from the media and from health personnel. Direct dialogue and counselling shape better perceptions, and upon using contraceptives and benefitting from them, men develop positive views and act as agents of positive change in others. The key factor affecting men's decision to use contraceptives is a gender-equal perspective.

We recommended more effort to change men's view of contraceptives. The movement should be initiated by the local governments through a variety of innovative policies and development of the community-based socio-cultural IEC. The success of the movement depends on cross-party support. Efforts to improve stakeholders' participation and involvement are crucial. On a wider scale, new policy is required, further to encourage men's involvement and participation in contraceptive use in particular and reproductive health in general.

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