

Male Participation in Family Planning: Human Behaviour Perspective

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ABSTRACT

Background: Family planning (FP) is one of the major components of reproductive health and its goal is to prevent unwanted pregnancies and regulate wanted pregnancies, thereby ensuring the health of mothers and children. It also aims at regulating the population in order to maintain the vital balance between development and the environment. Ideally, FP depends on the efforts of a couple where the man and woman are equally responsible and accountable. In reality, however, this is not the case. It is in this background that the present study aims at examining the nature and level of male participation in preventing unwanted pregnancies and the factors that influence male participation in FP.

Methods: The data for the study was derived using mixed methods, drawing from both quantitative and qualitative approaches. The research design was cross-sectional, descriptive and observational.

Results: Despite the high level of knowledge and awareness about FP among the respondents, it was found that male participation in FP continues to remain very low. The multidimensional factors influencing their participation include education of the couple (the unadjusted odds ratio of higher education level of respondents is 2.182 and the adjusted OR is 1.972; and the unadjusted OR of higher education level of the spouse is 2.030, and the adjusted OR is 1.570), and economic condition (the unadjusted OR of higher income is 2.272 and the adjusted OR is 2.436) of family. Male participation in FP was found to be higher in rural areas (69.8 %) and among Dalits (72.5%). Other factors include social stigma and religious practice, patriarchal notions, gender roles and individual characteristics.

Conclusions: Male participation plays a crucial role in population management, but patriarchal notions, socio-culturally defined gender roles, combined with the inefficiency of the current FP programme, and biological factors contribute towards keeping male participation very low.

Keywords: Family planning; male participation; masculinity; human behaviour.

INTRODUCTION

Family planning is a part of the lifestyle of couples that pertains to planning their family size, the time and frequency of childbirth and prevention of unwanted pregnancies. FP is the primary component of reproductive health (RH). It is necessary not only for preventing unwanted pregnancies but also to protect reproductive rights,¹ and this requires both men and women to be equal participants sharing equal responsibility. FP methods include natural, short and long-acting ways of birth spacing (BS), Voluntary Surgical Contraception (VSC), emergency contraceptives and safe abortions, which help protect the reproductive rights of women through the regulation of fertility. FP plays

an important role in maintaining a balance between population, development and the environment. The stages of demographic transition are high stationery, early expanding, late expanding and low stationary and these determine the population growth and population size.¹⁻³ In Nepal, the Seventh Five-Year Plan (1986-1990) introduced the concept of unmet need and population programmes were integrated with other development activities.² In India, the FP programme was initiated by the government in 1951.³ In Nepal, it was launched in 1959 in the NGO sector, and the Family Planning and Maternal Child Health (FPMCH) Project, in 1968 by the public sector.^{2, 4-8}

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Male participation is closely related to perceptions and beliefs of individuals and the communities to which they belong. The health-seeking behaviour of individuals and communities is, in turn, influenced by human health psychology, socio-cultural and environmental conditions,⁹ genetic factors,¹⁰⁻¹² gender roles and the structure of society.^{9,13-15} All these elements have been considered in the present study the objectives of which were to examine the nature of male participation in preventing unwanted pregnancies and identifying the factors related to male participation in FP.

METHODS

The research design followed a mixed approach, using both quantitative and qualitative methods and drawing from cross-sectional, descriptive and observational data. The sample size was calculated using statistical scientific tools for the survey and purposely selected for qualitative data. The sample size was 304 respondents for the survey, 21 respondents for in-depth interviews (IDI) and seven focus group discussions (FGDs). Kailali district in Nepal was selected as the research area, considering its multicultural character, ecological and socio-economic diversity, overlap between rural and urban features and the fact that it is highly populated. The district is also known as an educational and commercial centre and a gateway to the far western development region. The tools of data collection were pre-tested semi-structured questionnaires and an observation checklist, IDI schedule and FGD guidelines. The study setting was a community and health institution. The participants included reproductive health services clients, i.e., safe motherhood period mothers, FP current users, health service providers and health volunteers for quantitative data; and couples who had adopted permanent FP methods, informal community leaders, teachers, and volunteers for qualitative research. In the process of data collection the rights, privacy, dignity and confidentiality of the respondents were maintained. Informed consent was compulsory for all respondents. Inclusion and exclusion criteria were set. Ethical approval was taken from the Nepal Health Research Council (NHRC), Nepal, and the Institutional Ethics Review Board (IERB), Jawaharlal Nehru University (JNU), New Delhi, India. The study used dependent and independent/control variables. Quantitative data was analysed using Microsoft Excel and SPSS software to conduct univariate, bivariate and multivariate analysis, whereas qualitative data was categorised thematically using qualitative data analysis software 'Atlas.ti' and then analysed.

RESULTS

The quantitative and qualitative data were analysed to understand the nature and level of male participation in FP, which is a major step towards the protection of reproductive rights. Table 1 shows that all the respondents knew about FP; of these, 39 percent knew about methods to prevent unwanted pregnancies, followed by those who were aware of both methods of preventing unwanted pregnancies and regulating wanted pregnancies (35%); 15 percent were aware of the government FP programme and 11 percent wished to regulate wanted pregnancies. As for current male participation, 35 percent men participated in all areas, 22 percent provided support in FP choices and use of FP methods, 18 percent interacted with their partners about FP choices, and 3 percent had no knowledge regarding FP. Table 2 shows the correlation between the decision-maker in the case of BS methods—in 52 percent of the cases, it was the women herself; in 22 percent cases, the decision was based on interaction between the couple; in 19 percent cases, the decision was made solely by the husband; in 7 percent cases, it was friends, and in the least it was the mother-in-law—where male participation in FP was 70 percent. Perceptions about male participation in FP were explored through the awareness level of couples about the availability of health services. Perceptions and experiences of informants were assessed both in terms of methods of FP as well as level of sharing the problems of women. A clear preference was found in favour of FP methods provided by public health services. Female community health volunteers (FCHVs) were the most common source of information, and women had had regular contact with them since 1988. Men argued that women have several FP choices whereas male methods are tedious and difficult to use, store and dispose of. They felt that women prefer to interact among themselves about FP BS methods rather than with their spouses. Similarly, special interviews were conducted among 10 respondents out of 120 current users of FP methods who had opted for voluntary surgical contraceptive. Table 3 shows that the decision making power with respect to sterilisation belongs to the husband in 73 percent cases, and in 12 percent cases it is a joint decision. Among those who opted for sterilisation, 70 percent felt better and 30 percent were neutral after the operation. As for negative perceptions about permanent FP methods, 60 percent complained of weakness, 30 percent cited restrictions to religious rituals and 10 percent reported loss of libido. In terms of physical activity after the operation, 70 percent resumed activity as usual, 20 percent reported an increase in physical activity and 10 percent reported a decline.

Table 1. Distribution of respondents in terms of knowledge of FP and area of male participation (MP) in FP

Knowledge of FP	Number	Percentage	Area of MP in FP	Number	Percentage
Preventing unwanted pregnancies	118	38.81	Interaction for choice of FP methods	56	18.4
Regulating wanted pregnancies	34	11.18	Use of FP methods	67	22.05
Both	106	34.87	Support in FP choices	68	22.37
Government FP programme	46	15.13	All of the above	105	34.54
Total	304	100	Do not know	8	2.64
			Total	304	100

The qualitative data was analysed to study gender roles and human behaviour, mostly among couples who had adopted FP, with a family size of two to four. According to the government policy on FP surgeries for women, the husband's informed consent is necessary, but women's consent is not deemed necessary for male sterilisation. Men's health is perceived as being more important than that of women and men's familial and social role is also considered superior. Female respondents argued that men want more children without taking any responsibility. There is a perception that sterilisation leads to physical weakening, as a result of which those who undergo it cannot take on heavy workload; moreover, they are not allowed to participate in religious rituals. As per Hindu religious traditions, men have the sole right and responsibility to participate in funerals and their presence is considered an essential condition to securing a place in heaven for the deceased family member. Such factors contribute to the general perception that it is women who should adopt permanent FP methods.

Table 2. Correlation between decision making power in FP choices and male participation in FP

Decision-making power holder in FP choices	MP in FP		Total
	Yes	No	
Individual (the woman herself)	42	20	62 (51.67%)
Husband	19	4	23 (19.17%)
After mutual discussion	21	5	26 (21.67%)
Mother-in-Law	1	0	1 (1%)
Friend	1	7	8 (6.67%)
Total	84 (70%)	36 (30%)	120 (100%)
P Value = 0.001			

Note: Respondents who were current users of modern family planning methods.

The factors related to male participation in FP were studied using multivariate logistic regression. Table 4 shows that the correlation between male participation in FP with caste is less positive among Tharus (unadjusted OR: 0.816), and positive among Brahmans/Kshetris (1.767), where the reference category is Dalit. After adjustment to other factors, there is a less positive

relation (0.451) among Tharus and a positive relation (1.177) among Brahmans/Kshetris. Similarly, the correlation of male participation in FP with place of residence is less positive (i.e.; unadjusted OR: 0.650) in urban areas, where the reference category is rural areas, and after adjustment to other factors, there is a less positive relation (0.534) in urban areas. When it comes to education, there is a positive correlation (unadjusted OR: 2.329 in the case of middle level education and 2.030 in the case of higher education), where the reference category is no education; after adjustment to other factors, it remains positive (2.421 for middle education and 1.570 for higher education). The correlation between male participation in FP and the education of the spouse is positive (unadjusted OR: 2.667 for middle education and 2.182 for higher education), where the reference category is no education; after adjustment to other factors it stays positive (2.620 for mid-level education and 1.972 for higher level education). Its correlation with occupation is less positive (unadjusted OR: 0.407 for physical work and 0.621 for housewife), where the reference category is table work; after adjustment to other factors it remains less positive (0.770 for physical work and 0.668 for housewife). The correlation of male participation in FP with the monthly income of the family is positive (unadjusted OR: 1.746 for middle income and 2.717 for higher income), where the reference category is low income; after adjustment to other factors, it remains positive (1.557 for middle income and 2.436 for higher income). Its correlation with the number of children is positive (unadjusted OR: 1.378 in the case of one to two children, and 1.198 for three or more than three children), where the reference category is no child; after adjustment to other factors, it remains positive (1.539 for one to two children and 1.252 for three or more than three children) association. Male participation in FP is highest among Dalits, at 73 percent, followed by Brahmans/Kshetris at 68 percent, and lowest among Tharus at 55 percent. The education levels of the respondents are as follows: higher

education (75%), followed by middle education (60%), and no education (57%). The education levels of the spouses are as follows: higher education (74%), followed by no education (59%), and middle education (58%). The place of residence was rural areas in 70 percent of the cases and urban among 60 percent. Male participation in FP was 72 percent among families with higher income, followed by 60 percent in lower income families, and 56 percent in mid-level income families. Similarly, in terms of the occupation of respondents, male participation among those involved in table work was 68.5 per cent, physical work: 67 percent, and housewives: 52 percent. In terms of the number of children, no child: 58.6 percent, one or two children: 58.7 percent, and three or more children: 67.8 percent.

Table 3. Correlation between decision making power regarding sterilisation and male participation in family planning.

Decision-making power holder for adopting VSC	Male Participation in Family Planning		Total
	Yes	No	
Husband	57	31	88 (73.3%)
Mother-in-law	8	2	10 (8.3%)
Woman herself	3	2	5 (4.2%)
Health workers/FCHV	2	1	3 (2.5%)
Couple	14	0	14 (11.7%)
Total	84 (70%)	36 (30%)	120 (100%)

Note: This data pertains to respondents who were current users of modern family planning methods.

Table 4. Association between male participation in family planning and different factors

Characteristic	Male Participation in Family Planning							
	Present		Absent		Unadjusted		Adjusted	
	No.	%	No.	%	OR	P value	OR	P value
Ethnicity:								
Dalit	37	72.5	14	27.5	1.000	0.036**	1.000	0.098
Tharu	61	55.0	50	45.0	0.816	0.537	0.451	0.091
Brahman/Kshetri	97	68.0	45	32.0	1.767	0.030**	1.177	0.597
Address:								
Rural	90	69.8	39	30.23	1.000		1.000	
Urban	105	60.0	70	40.0	0.650	0.080	0.534	0.077
Education level:								
Illiterate	17	56.5	13	43.5	1.000	0.034**	1.000	0.418
Below 10 years	111	60.0	74	40.0	2.329	0.056*	2.421	0.197
More than 10 years	67	75.0	22	25.0	2.030	0.014***	1.570	0.301
Education level of spouse:								
Illiterate	10	58.8	7	41.18	1.000	0.008***	1.000	0.179
Below 10 years	99	57.9	72	42.11	2.667	0.065*	2.620	0.182
More than 10 years	86	74.1	30	25.86	2.182	0.003***	1.972	0.077
Occupation:								
Table work	52	68.5	21	31.5	1.000	0.031**	1.000	0.511
Physical work	100	67.0	49	33.0	0.407	0.010***	0.770	0.522
Housewife	43	52.0	39	48.0	0.621	0.089	0.668	0.284
Income:								
Low income	62	59.6	42	40.4	1.000	0.005***	1.000	0.055*
Normal income	40	56.3	31	43.7	1.746	0.050**	1.557	0.231
High income	93	72.1	36	27.91	2.717	0.001***	2.436	0.016
Number of children:								
No child	17	58.6	12	41.4	1.000	0.643	1.000	0.639
1-2 children	54	58.7	38	41.3	1.378	0.432	1.539	0.382
More than 3 children	124	67.8	59	32.2	1.198	0.496	1.252	0.513

The results of qualitative data revealed the following inhibiting factors: patriarchal society, hegemony of masculinity in remarriage and bigamy or polygamy, traditional religious views on male sterilisation, suspicions around women's sexual behaviour, son preference, and poor education and awareness about reproductive health. The FP programme initiated by the government, from the very beginning, followed a target-based and motivational approach where the sole focus was on FP was on information and awareness; side-effects and socio-cultural stigma and taboo were not addressed. Provisions under the FP programme mainly include the organising of an FP camp base near the client area once a year to provide daily services at the hospital base, free recanalization services and introducing more long-acting birth spacing methods, providing motivation to counselling, and target based approach to needs-based approach. Similarly, women are given a range of choices; moreover, priority is accorded to women's FP methods, which are also more easily accessible. Gender roles are strictly followed in society and they are perceived as natural and God-given. Many women argued that despite the awareness about male sterilisation being easy, inexpensive and having few side effects, there is a stigma associated with it, and therefore, it is still mostly

women who undergo sterilisation—men opt for it only if the service is not available for women.

The health and well-being of the family appear to have a correlation with the adoption of FP methods and male participation. Table 5 shows the perception of respondents about the change in the well-being of the family after adopting FP methods: 40 percent reported an improvement, 50 percent as usual and 10 percent reported a decrease. Similarly, the effect on the health of men after adopting FP methods was reported as very good by 59 percent, good by 37 percent and as usual by 4 percent. Largely, respondents reported better or normal health while a few experienced back pain, weakness, and loss of libido. The general perception was that male participation in FP leads to better health and well-being of the family, and proper education of children.

It was observed that in nuclear families, there is a greater interaction and support around the choice of FP methods, whereas in a joint family, women tend to play a vital role in the choice of FP methods. Moreover, women were found to be more sincere in performing their roles, both physically and emotionally. The facial expressions and housing conditions of users of FP methods were closely observed and the results were quite favourable.

Table 5. Distribution of respondents according to the perceived changes in the well-being and health of the family due to male participation in family planning.

Well-being of family after adopting FP method	Number	Percentage	Effect on health in case of male participation	Number	Percentage
Increasing trend	120	39.5	Very good health	179	58.9
As usual	154	50.7	Good health	112	36.8
Decreasing trend	30	9.9	As usual	13	4.3
Total	304	100	Total	304	100

DISCUSSION

FP is a lifestyle choice made by a couple, which entails the practice of adopting external objects and activities to fulfil certain needs and regulating family size, without interfering in the course of normal life, and which results in the protection of reproductive rights,¹⁶ without any physical, social and psychological^{17,18} burden. It is one of the major pillars of RH and is closely related to human behaviour and attitude, which, in turn, are influenced by an individual's socio-cultural environment. Birth control and women's health have always been primarily viewed as issues of politics, and not technology.^{3, 19, 20} There is a complex mutual and causal relationship between birth control and women's power at large. Contraception provides women with a valuable tool for birth control.²⁰ Accordingly, FP is a broad concept

encompassing individual characteristics, socio-culture practices, policies and availability of health services.²¹ The findings of the quantitative, qualitative and observational data are similar and interconnected. All respondents knew about FP and FP methods, but method-specific knowledge and men's participation were found to be low. In terms of perceptions of individuals and the community regarding male participation in FP, almost everyone felt it was necessary. Men had access to VSC methods, whereas women lacked access to such services and complained of side effects. Condoms were viewed as safe and as having no side effects but there was some trouble faced with usage, storage and disposal. These findings are consistent with other studies that have been conducted in Indonesia.^{22, 23} In 52 percent of the cases, women alone made an informed choice about

birth spacing FP methods; only in one-fifth of the cases was it the couple's decision. In the case of undergoing VSC, husbands held the decision-making power in 73.3 percent of the cases, followed by the mother-in-law in 8.3 percent cases. These learnings were consistent with those drawn from other studies conducted in India.²⁴ Male sterilisation was perceived as easy and cost effective but men only opted for it when the service was unavailable for women. Both society and technology seem to favour women's methods, and they use both methods. The perception of respondents towards FP sterilisation was that it is easy, has no side effects and involves little pain with lifelong benefits. Eighty percent of the respondents had a discussion with their spouses before undergoing sterilisation surgery. The relationship between spouses was found to be more harmonious among those who had adopted FP methods, than among those who had not. The community under study was characterised by prevailing gender discrimination, hegemonic masculinity and prescribed gender roles in sexuality and reproduction.

The correlation between male participation in FP and different variables was studied in terms of unadjusted (using the first variable in the category as reference) and adjusted OR (adjustment of others variables). A positive correlation was found between male participation in FP and caste, education level of respondents and spouses, family income and the number of children. No correlation was found with the occupation of the respondents since the reference category had the highest male participation. Men's participation was highest among Dalits (73%), followed by Brahmins/Kshetris (69%). It was also high among respondents with higher education (75%), those with well-educated spouses (74%), those with higher family income (72%), those occupied in table work (68.5%), those with three or more children (67.8%) and those residing in rural areas (70%). The findings were also influenced by existing FP programmes in the community. These learnings were similar to those of various studies conducted in Nepal, India and Kenya.²⁵⁻²⁷ Similarly, perceptions of individuals and the community were not defined by any single consideration; rather they were shaped by several factors—mainly, the prevalence of patriarchy, son preference, hegemony of masculinity, traditional religious beliefs, low education levels, and lack of proper education about reproductive health. Moreover, given that the programme started out with a target-based and motivational approach and focussed on FP operations—with priority given to women adopting FP methods—the underlying socio-culturally defined assumptions about gender roles as 'natural' or 'God-given' were not tackled. These were reinforced by the role of rumours, misinformation, religious taboos and

stigma around men adopting permanent FP methods, combined with misinformation and distrust of women's sexuality, the predominance of female staff in service delivery, and the long-standing presence of the FCHV programme, where health workers also give priority to women. Similar results have been found by other studies conducted in Nepal, India and other developing countries.^{21, 26, 28}

With respect to knowledge and experience of male participation in FP, it was found that better health and financial conditions helped improve the overall well-being of the family. More than 90 per cent of the respondents believed that male participation in FP ensures better health for all. It was observed that men who undergo sterilisation tend to be better educated and work in the formal sector.

CONCLUSIONS

In overall, this study suggests that men's participations in FP was poor but the knowledge level regarding FP was high. Male participation was closely linked to the FP programmes in place. It was higher among lower castes and in rural areas. The rumours, social and religious stigma and taboos associated with FP methods, and gender roles, superiority of males and patriarchal notions continue to influence in the community. It was mostly women who adopted FP methods. Educated men and working men in the formal sectors showed greater level of participation. Various factors were important in influencing in male participation in FP that include education of the couples, occupation, effectiveness of existing policies and programmes, income level of the family, individual behaviour, and socio-cultural practices. A strong correlation was found between male participation in FP and the health and well-being of the family.

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