



Analysis of Active Participation of Men in Family Planning Program in Central Java

Rohmayanti Rohmayanti^{1,2}(✉), Soetrisno Soetrisno², Agung Wibowo², and Haryani Saptaningtyas²

¹Universitas Muhammadiyah Magelang, Magelang, Indonesia

²Universitas Sebelas Maret, Surakarta, Indonesia

rohmayanti@unimma.ac.id

Abstract. This study investigated the percentage of men actively involved in family planning programs across Central Java from 2018 to 2020. It relied on secondary data obtained from the Central Java Provincial Statistics Agency for those years. The data, including the number of male family planning participants (condoms and vasectomy) and the number of fertile-aged couples actively participating. The results revealed a decrease in male participation at the provincial level, dropping from 3.4% in 2018 to 3.1% in 2020. Looking at individual districts and cities within Central Java, the data showed significant variations. In 2018, Surakarta City had the highest participation rate (13.34%), whereas Brebes Regency had the lowest (0.60%). This pattern continued in subsequent years, with Surakarta City maintaining the highest rate (5.97% in 2019) and Brebes Regency consistently having the lowest (0.33% in 2019). Interestingly, in 2020, Magelang City took the lead with the highest participation rate (15.54%), while Brebes District remained the lowest (0.90%). In conclusion, male participation in family planning programs across Central Java remains significantly below the national average. Districts and cities with participation rates below 5% require targeted interventions to improve engagement.

Keywords: Active Participation, Men Family Planning, Condoms, Vasectomy.

1 Introduction

The population of Indonesia in 2023 was 278,696,200 people with a growth rate of 1.06% per year, so the population in 2024 will increase to around 279,965,200 people [1]. The number of women of childbearing age will increase from 72,138,600 in 2020 to 73,512,600 in 2024 [2]. The increase in population is realized by the government to prepare a quality generation as the main capital in accelerating development which will ultimately realize community welfare. The government conducts various Human Resources (HR) development programs, one of which is the implementation of the family planning program. [3]. One of the first indicators of a healthy family is family planning, because with family planning, the Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR), and Toddler Mortality Rate (TMR) in Indonesia can be reduced and achieve the targets set in the Sustainable Development Goals (SDGs) [4].

© The Author(s) 2024

Z. B. Pambuko et al. (eds.), *Proceedings of 5th Borobudur International Symposium on Humanities and Social Science (BISHSS 2023)*, Advances in Social Science, Education and Humanities Research 856,

https://doi.org/10.2991/978-2-38476-273-6_109

Increased male participation can improve the health status of mothers, infants and children, reduce maternal and infant mortality, prevent and overcome reproductive tract infections and sexually transmitted diseases [5]. In addition, the conditions of the Covid-19 pandemic have an impact on the unmet need for family planning. This is expected to increase the number of unwanted pregnancies if it continues [6]. The availability of male contraception could have an important impact on reducing unintended pregnancy rates globally and would be a step towards reproductive justice and greater equity in family planning [7].

The rate of contraceptive use of all methods among couples of reproductive age 15-49 years who have ever married in Indonesia is 55.36%, while Central Java Province is 57.28% in 2022 [8]. Based on Indonesian Demographic Health Survey (IDHS) data in 2017, the percentage achievement of male family planning participation (Vasectomy and Condom) was 4.73% while in 2012 it was 3.50%. Based on the IDHS data in 2012-2017, it can be seen that for 5 years the achievement of male family planning increased by 1.23% or experienced an average increase of $\pm 0.2\%$ per year. Considering these data, it is expected that by 2024, the percentage of male family planning participation will reach 5.73% [9].

Based on Central Statistics Agency (SCA data) (2020) in Central Java, there are 35 cities/districts with 6 cities and the rest in the form of districts. The number of couples of childbearing age in Central Java is 6,525,048 with the number of family planning participants totaling 4,757,722 (70.13%). Among the family planning methods used, the following is the order of users from the highest: injections with 2,747,053 (57.7%), implants with 659,332 (13.9%), pills with 511,948 (10.8%), Intrauterine devices with 447,567 (9.4%), tubectomy with 232,244 (4.9%), condoms with 133,920 (2.8%) and vasectomy with 25,658 (0.54%). According to these data, it is known that male family planning acceptors are very low, only reaching 3.34% [10]. This figure still does not reach the expected male family planning participation target.

One of the indicators of success in family planning is the low unmet need rate. The unmet need rate in Central Java in 2022 was 8.28 [11]. The high unmet need data can occur because not all women are suitable for using contraceptives. Meanwhile, reducing the unmet need rate is one of the efforts to reduce the maternal mortality rate (MMR) seen from the high correlation between MMR and the incidence of unmet need [12]. The unmet need target is expected to reach 5%, therefore men must take a role in the family planning program by participating actively or passively.

The form of male participation in family planning can be done directly (active) or indirectly (passive), among others: active participation is as a participant in family planning by using one of the methods or methods of preventing pregnancy, such as: condoms, vasectomy, interrupted copulation method and periodic abstinence method/ calendar system. Passive male participation is supporting the family planning program [13]. The high rate of female family planning participation has another side to consider, namely the side effects on some users, such as hormonal contraceptives reported that women experience higher rates of depression, decreased sexual function, and decreased sexual desire [14]. The risk of myocardial infarction or ischemic stroke increases 1.6-fold in women who use combined oral contraceptives [15]. This condition can affect a woman's general health.

Since 1999, the family planning program has paid great attention to the participation of men. Previously, the attention and implementation of family planning programs tended to focus more on women [16]. Increase the role of the central NPFPA and regional NPFPA to conduct socialization both through mass media, print media, electronic media, and outdoor media containing messages for male family planning participation in vasectomy, providing rewards for the best male family planning motivators [9]. However, the percentage of male participation in the family planning program is still low.

Family planning and reproductive health issues are still seen as the responsibility of women. The knowledge and awareness of men and families regarding family planning is still relatively low. In addition, there is also limited acceptance and accessibility of male contraceptive services [5]. Moreover, male contraceptive options are limited to condoms and vasectomy [17]. Other studies have shown that men's education and attitudes, knowledge and awareness, socio-cultural factors, psychological factors, health system factors, and policies are determinants in men's participation [18]. Similarly, lack of privacy and space for counseling, myths and misconceptions about contraception, social norms related to the expectation of pregnancy early in marriage, and preference for sons were also related [19]. Ultimately, a man's decision to use contraception is determined by his own perceptions [20].

Recent research articles show that involving men in family planning can improve health outcomes for men, women, and children [21]. However, men's engagement in reproductive health care is low, and researchers have identified different barriers to men's participation in various aspects of reproductive health care [22]. A systematic review and meta-analysis protocol on male involvement in family planning use in Ethiopia aims to provide synthesis research findings on the pooled prevalence of male involvement in family planning [23]. Another study conducted in a rural area of India assessed the male participation in family planning among married males and found that not much attention has been given to the male partners in the usage of contraceptives [24]. Integrating male engagement activities into family planning programs can achieve gender-related outcomes, such as increased male responsibility for family planning and more open communication between partners about family planning [5]. In general, this study was conducted to analyze how men's active participation in family planning programs to get a picture of the percentage of family planning participation in men both as condom and vasectomy family planning acceptors in Central Java and provide reviews related to this.

2 Methods

This study employed a quantitative descriptive approach to investigate the participation of men in family planning programs across Central Java. Specifically, it focused on the percentage of men using condoms and undergoing vasectomy procedures. The research relied on secondary data obtained from the Central Java Provincial Statistics Agency for the years 2018-2020. The data source titled "Contraceptive Usage Rate (CPR) in Fertile Age Couples aged 15-49 years 2021" provided information on the number of

fertile-aged couples (FAC), the number of FAC actively participating in family planning programs, and the total number of contraceptive users (both male and female) [8]. Microsoft Excel software was used to calculate the percentage of male participation using the following formula: (Number of male family planning participants (condoms & vasectomy)) / (Number of FAC participating in family planning programs)*100%.

The analysis yielded data on the percentage of male participation in condom and vasectomy use for the years 2018, 2019, and 2020, covering both Central Java as a whole and individual districts/city within the province. These results were then presented visually using charts for better comprehension of overall trends. Finally, a qualitative analysis of the percentage data was conducted.

3 Results

The results of this study are depicted in the form of diagrams, namely the percentage of male family planning participation in Central Java. The percentage of male family planning participation in all districts and cities in Central Java in 2018, 2019 and 2020. Fig. 1 shows that from in 2018 there was a significant decrease in percentage from 3.4% to 3.1% for condom and vasectomy family planning participation. In general, the percentage of active male family planning participation in Central Java is low, below 5%.

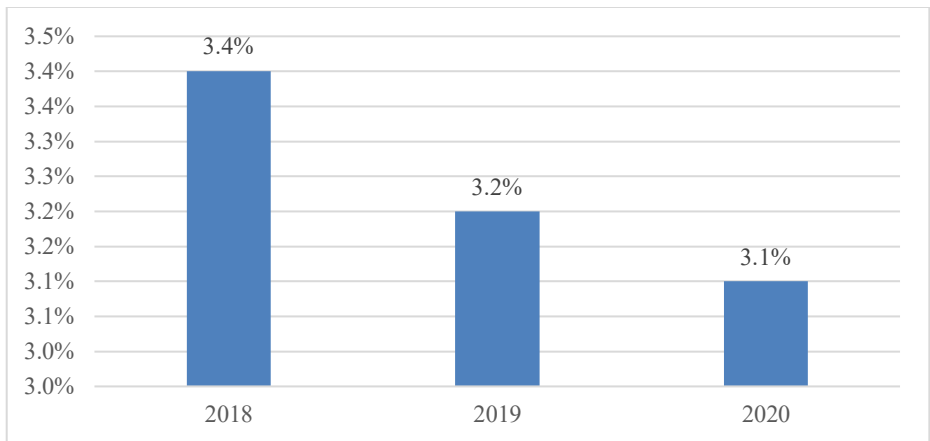


Fig. 1. Active Male Family Planning Participation in Central Java

The following is an overview of the percentage of male family planning in districts/cities in Central Java in 2018. According to Fig. 2, in 2018 the highest percentage of Surakarta City was 13.34% and the lowest was Brebes Regency 0.60% with a difference of 12.74%. This percentage shows that there is an imbalance in the data because of the 35 districts / cities in Central Java, most of the numbers are below 5%.

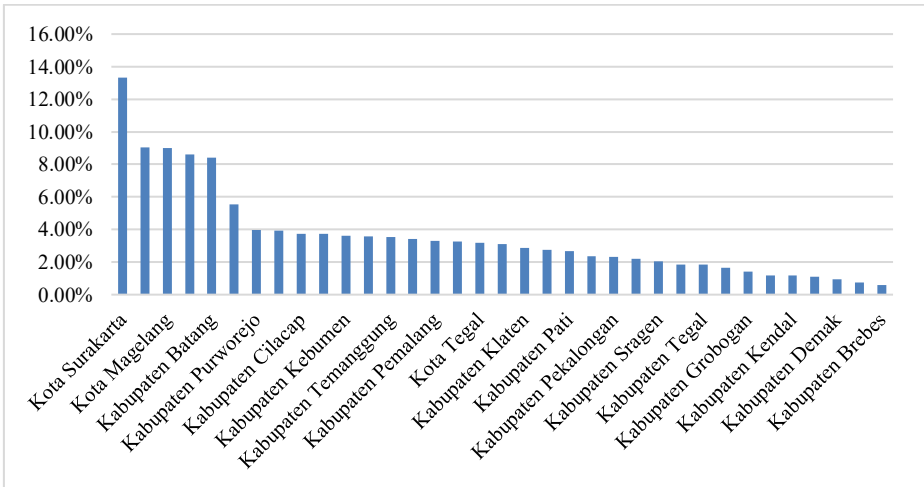


Fig. 2. Male Family Planning in Central Java (2018)

According to Fig. 3, in 2019 the highest percentage of Surakarta City was 5.97% and the lowest was Brebes Regency 0.33% with a difference of 5.64. In this data, it can be seen that there has been a significant decrease in numbers because the numbers have decreased by more than 50% from 2018. Please note that in 2019 the Covid-19 pandemic has begun to occur in Indonesia.

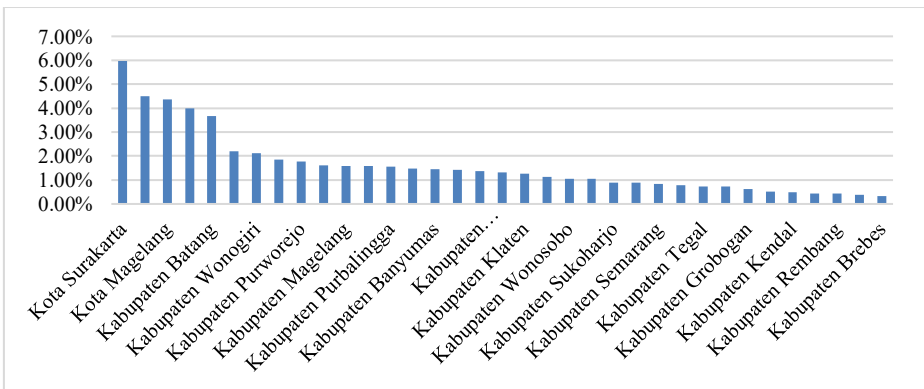


Fig. 3. Male Family Planning in Central Java (2019)

Based on Fig. 4, in 2020 the highest percentage of Magelang City was 15.54% and the lowest was Brebes Regency 0.90%. The percentage difference is 14.64%, which is very far away or inequality. Overall, all districts/cities have experienced an increase, but most of them still have not reached the 5% mark.

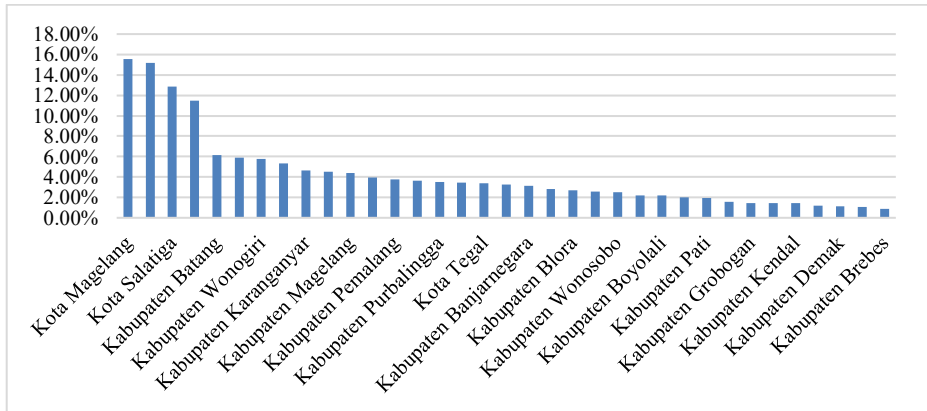


Fig. 4. Male Family Planning in Central Java (2020)

4 Discussion

4.1 Factors Affecting Male Participation in the Family Planning Program

The study revealed that male participation in family planning programs across Central Java remains below 5%. This trend is consistent with national and global data, where male involvement generally lags behind female participation. Several factors contribute to this disparity. Studies have shown that a woman's prior use of family planning, open discussions about sexual and reproductive health within couples, and a husband's approval of family planning methods all have a positive influence on male involvement [25]. Conversely, barriers like limited access to quality services, financial constraints, a partner's preferences, and cultural norms can hinder male participation [22]. Low overall family planning coverage can also stem from various factors, including a desire for larger families, limited knowledge about options, lack of male education, negative perceptions of family planning methods, and of course, low male involvement [23].

Encouragingly, research suggests that including men in family planning efforts can lead to better health outcomes for both partners and challenge the misconception that family planning is solely a woman's concern [26]. However, challenges persist. Studies have identified lack of information, affordability issues, and the desire for more children as reasons for men's low engagement [27]. Additionally, socio-cultural factors like traditional beliefs that promote large families, reliance on outdated practices, and misconceptions about modern contraceptives create further barriers [28]. Knowledge about available methods, number of desired children, and access to family planning services are all critical factors influencing male participation [29]. Some cultural norms even discourage male involvement due to fear of side effects or a belief that family planning is a woman's responsibility [3]. Social pressures, including gender roles associated with childbearing and religious considerations, also play a role [30]. Attitudes towards contraceptive use and risk-taking behavior are heavily influenced by gender norms.

Several studies have identified key reasons behind the low involvement of men in Indonesian family planning programs. One major factor is lack of information. A review found a scarcity of resources specifically addressing the issue of low male participation [31]. This is concerning, considering the national data showing a very low rate of male family planning use, hovering around 1.3%. Education also plays a significant role. Research suggests that higher education levels are strongly linked with men's utilization of family planning services in Indonesia [32]. Men with higher education or secondary education, along with those who possess knowledge about contraceptive methods, are more likely to use family planning compared to those with lower education levels. Perceptions and knowledge deficiencies further exacerbate the problem. Qualitative studies using focus groups revealed that many men view family planning as a woman's responsibility, and their overall knowledge about contraception remains low [33]. This lack of information is compounded by the absence of targeted counseling services for men. Additionally, some men feel uncomfortable or embarrassed to participate in family planning programs. Cultural norms and program focus also contribute to the issue. Community and religious leaders have emphasized the need for improved information and counseling specifically designed to engage men in family planning efforts [33].

4.2 Causes of Data Inequality Between Central and Regional Data

According to the results of this study, it is known that there are data imbalances, when the percentage of national data at the Central Java Province level only reaches 3.4%, while at the city/district level the highest percentage can even reach above 15%, but the distribution of data is uneven because most of them are in the range of 5%. Family planning data at the central level is often smaller than data at the local level due to various factors. A study highlighted that large disparities in the demand for family planning satisfied by modern methods between countries still exist, and socio-economic disparities within countries in terms of access to modern contraception still exist [34]. In addition, a report on puskesmas and family planning noted that puskesmas make far fewer referrals to stand-alone family planning clinics than in the past, which may impact the data available at the central level [35]. Factors contributing to low family planning coverage, such as lack of knowledge, lack of husband education, and negative perceptions towards family planning use, which could lead to inaccurate data reporting at the central level [23].

4.3 Causes of the Decline in Family Planning Acceptors

Based on the results of the study, it is known that in 2019 there was a decrease in the active participation rate of male family planning from above 13.34% in 2018 to 5.97% in 2019. As it is known that in 2019 the world and Indonesia began the Covid-19 pandemic. A comprehensive review of studies in low and middle income countries found decreased access to contraceptive services during the pandemic [36]. This decline can be attributed to the fact that methods such as short-acting and long-acting reversible contraceptives require a visit with a medical practitioner to initiate use, and their use is

restricted during the pandemic [37]. The pandemic also disrupted access to birth control in some states of the United States, with as many as half of family planning patients facing delays in obtaining birth control or related care [38].

4.4 Strategies to Increase Men's Active Participation in the Family Planning Program

Family planning cadres, including health workers and community outreach specialists, play a vital role in promoting male involvement. Their training equips them to provide counseling and certain family planning methods [39]. However, challenges persist. Many family planning services are perceived as unfriendly to men, and there's a lack of infrastructure specifically designed to cater to them, including flexible service hours and policies that acknowledge men's needs [40]. Additionally, healthcare providers often lack the training and support needed to effectively counsel men on contraception [41]. There's an opportunity to improve the situation. Existing facilities could be better utilized by extending service hours or allocating dedicated times for men and their partners [40]. Given their influential role in society, engaging men and securing their support for family planning is crucial. Their involvement can significantly improve reproductive health outcomes and promote gender equity [33].

Policy also plays a part. A review identified a gap between policy intentions and actual implementation, suggesting shortcomings in planning and managing sexual and reproductive health programs [22]. Furthermore, an analysis of national policies revealed that family planning is often framed as a women's issue, with minimal focus on men and boys [42]. This oversight translates into limited access to male-focused services and a lack of consideration for men's needs within reproductive health policies. Consequently, low male participation persists [43].

Here are some key strategies to increase male participation in family planning. First, involving men in policy, including men's perspectives when developing policies and guidelines can enhance their participation in family planning programs. Second, scaling up successful programs, expanding programs that have demonstrably succeeded in engaging men can lead to wider participation [40]. Third, implementation research and monitoring, conducting research to identify and address gaps in program implementation can improve male participation rates. Fourth, expanding contraceptive options, developing a broader range of male contraceptive methods can increase their appeal and encourage participation [43]. Fifth, male outreach, engaging male motivators, peer educators, and mentors can effectively reach men with family planning information and services. Sixth, targeted communication, implementing communication programs specifically designed for men can raise awareness and encourage their involvement in family planning [44]. Lastly, comprehensive sexuality education, providing comprehensive sexuality education to men can improve their understanding of family planning and reproductive health matters [42].

5 Conclusions

The results of this study show that the percentage of active male family planning in Central Java is in the low category because it has not met the national target, even in 2019 it has decreased due to the Covid-19 pandemic. However, the percentage by district / city looks much higher at the highest percentage, while at the lowest percentage many are less than 1%. The implication for practice from this study is that the results of this study can be used as basic data to make policies on men's participation in family planning. Future researchers can conduct a literature review to determine the factors that influence low male participation in family planning and then design interventions to increase it.

Reference

1. Badan Pusat Statistik *Jumlah Penduduk Pertengahan Tahun (Ribu Jiwa)*; 2023;
2. Kemenkes Laporan Kinerja Kementerian Kesehatan Tahun 2020. *Kemenkes* **2021**, 1–209.
3. Amraeni, Y. The Impact Of Demography And Perception On Male Contraceptive Use In Indosenia. *Indones. J. Heal. Sci. Res. Dev.* **2020**, *2*, 32–38, doi:10.36566/ijhsrd/Vol2.Iss3/50.
4. Labola, Y.A. Peran Keluarga Berencana Dalam Menurunkan Kematian Ibu Dan Bayi Baru Lahir Di Indonesia. *J. Univ. Kristen Satya Wacana* **2018**, 1–6.
5. Sutinah, S. Partisipasi Laki-Laki Dalam Program Keluarga Berencana Di Era Masyarakat Postmodern. *Masyarakat, Kebud. dan Polit.* **2017**, *30*, 290, doi:10.20473/mkp.v30i32017.290-299.
6. UNFPA Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-Based Violence, Female Genital Mutilation and Child Marriage. *Interim Tech. Note* **2020**, *7*.
7. Carmen R. Abbe, Stephanie T. Page, A.T. Male Contraception. *YALE J. Biol. Med.* **2020**, *93*, 603-613., doi:10.1016/B978-0-12-801238-3.64620-2.
8. Statistik, B.P. *Persentase Wanita Berumur 15-49 Tahun Dan Berstatus Kawin Yang Sedang Menggunakan/Memakai Alat KB (Persen)*; Jakarta, 2022;
9. BKKBN *Rencana Strategis Direktorat Bina Kesertaan Kb Jalur Wilayah Dan Sasaran Khusus Tahun 2020 - 2024*; 2020;
10. BPS Jawa Tengah *Profil Kesehatan Provinsi Jawa Tengah 2020*; 2021; Vol. 1.;
11. Badan Pusat Statistik Provinsi Jawa Tengah *Jumlah Pasangan Usia Subur (PUS) Dan Peserta KB Aktif Menurut Kabupaten/Kota Di Provinsi Jawa Tengah*; Jawa Tengah, 2021;
12. Ilma Widyatami, A.; Sri Natungga, G.; Damayanti, R.; Eria Dewi, S.; Hadumaon Siagian, T. Determinan Unmet Need Pada Pasangan Usia Subur Di Kawasan Indonesia Timur. *J. Kel. Berencana* **2021**, *6*, 31–41.
13. Taufiq, L.D. Partisipasi Pria Dalam Program Keluarga Berencana (Kb). 2020.
14. Welling, L.L.M. Psychobehavioral Effects of Hormonal Contraceptive Use. *Evol. Psychol.* **2013**, *11*, 718–742, doi:10.1177/147470491301100315.
15. Roach, R.E.J.; Helmerhorst, F.M.; Lijfering, W.M.; Algra, A.; Dekkers, O.M. Combined Oral Contraceptives: The Risk of Myocardial Infarction and Ischemic Stroke. *Cochrane Database Syst. Rev.* **2014**, *2014*, doi:10.1002/14651858.CD011054.

16. BKKBN Survei Demografi Dan Kesehatan : Kesehatan Reproduksi Remaja 2017. *Badan Kependud. dan Kel. Berencana Nas.* **2017**, 1–606.
17. Muttreja, P.S.S. Family Planning in India: The Way Forward. *Indian J. Med. Res.* **2018**, 76, 1–9, doi:10.4103/ijmr.IJMR.
18. Sharma, S.; Bhuvan, K.C.; Khatri, A. Factors Influencing Male Participation in Reproductive Health: A Qualitative Study. *J. Multidiscip. Healthc.* **2018**, 11, 601–608, doi:10.2147/JMDH.S176267.
19. Nair, S.; Dixit, A.; Ghule, M.; Battala, M.; Gajanan, V.; Dasgupta, A.; Begum, S.; Averbach, S.; Donta, B.; Silverman, J.; et al. Health Care Providers' Perspectives on Delivering Gender Equity Focused Family Planning Program for Young Married Couples in a Cluster Randomized Controlled Trial in Rural Maharashtra, India. *Gates Open Res.* **2019**, 3, doi:10.12688/gatesopenres.13026.1.
20. Haryanto, S. Perceptions and Adoption of Male Contraceptives among Men in Indonesia. *Int. J. Biomed. Adv. Res.* **2017**, 8, 292–299.
21. UNFPA *Impact of COVID-19 on Family Planning : What We Know One Year into the Pandemic*; 2021;
22. Roudsari, R.L.; sharifi, F.; Goudarzi, F. *Barriers to the Participation of Men in Reproductive Health Care: A Systematic Review and Meta-Synthesis*; BioMed Central, 2023; Vol. 23; ISBN 1288902315692.
23. Anbesu, E.W. Male Involvement in Family Planning Use and Its Determinants in Ethiopia: A Systematic Review and Meta-Analysis Protocol. *Syst. Rev.* **2022**, 11.
24. Pragyan P. Parija, A.P.; Panigrahi, S.K.; Thakur, P.; Pal, R. Male Involvement in Family Planning in a Rural Area of India. *J. Fam. Med. Prim. Care* **2022**, 11, 1943–1948, doi:10.4103/jfmpe.jfmpe.
25. Teshale Mulatu, Yitagesu Sintayehu, Yadeta Dessi, M.D. Male Involvement in Family Planning Use and Associated Factors among Currently Married Men in Rural Eastern Ethiopia. *SAGE Open Med.* **2022**, 10, 1–7, doi:10.1177/20503121221094178.
26. Gage, A.J. Association of Male Partners' Gender-Equitable Attitudes and Behaviors with Young Mothers' Postpartum Family Planning and Maternal Health Outcomes in Kinshasa, DRC. *Int. J. Environ. Res. Public Health* **2022**, 19, doi:10.3390/ijerph191912182.
27. Kassa, M.; Abajobir, A.A.; Gedefaw, M. Level of Male Involvement and Associated Factors in Family Planning Services Utilization among Married Men in Debremarkos Town, Northwest Ethiopia. *BMC Int. Health Hum. Rights* **2014**, 14, 1–8, doi:10.1186/s12914-014-0033-8.
28. Kabagenyi, A.; Reid, A.; Ntozi, J.; Atuyambe, L. Socio-Cultural Inhibitors to Use of Modern Contraceptive Techniques in Rural Uganda: A Qualitative Study. *Pan Afr. Med. J.* **2016**, 25, 78, doi:10.11604/pamj.2016.25.78.6613.
29. Msovela, J.; Tengia-Kessy, A.; Rumisha, S.F.; Simba, D.O.; Urassa, D.P.; Msamanga, G. Male Partner Approval on the Use of Modern Contraceptive Methods: Factors Determining Usage among Couples in Kibaha District, Tanzania. *Contracept. Reprod. Med.* **2020**, 5, 1–7, doi:10.1186/s40834-020-00107-8.
30. Capurchande, R.; Coene, G.; Roelens, K.; Meulemans, H. "If I Have Only Two Children and They Die. Who Will Take Care of Me?" -a Qualitative Study Exploring Knowledge, Attitudes and Practices about Family Planning among Mozambican Female and Male Adults. *BMC Womens. Health* **2017**, 17, 1–15, doi:10.1186/s12905-017-0419-6.

31. Mardiya, R.; Rahmita, H.; Fitria, N. Lack of Sources of Information on the Low Participation of Men Using Family Planning: A Scoping Review. *Sci. Midwifery* **2022**, *10*, 4259–4264, doi:10.35335/midwifery.v10i5.1011.
32. Idris, H.; Idris, H.; Syafriyanti, W. Trends and Determinants of Family Planning Utilization Among Men in Indonesia. *Makara J. Heal. Res.* **2021**, *25*, doi:10.7454/msk.v25i3.1271.
33. Rahayu, S.; Romadlona, N.A.; Utomo, B.; Aryanty, R.I.; Liyanto, E.; Hidayat, M.; Magnani, R.J. Reassessing the Level and Implications of Male Involvement in Family Planning in Indonesia. *BMC Womens. Health* **2023**, *23*, 1–14, doi:10.1186/s12905-023-02354-8.
34. Ewerling, F.; Victora, C.G.; Raj, A.; Coll, C.V.N.; Hellwig, F.; Barros, A.J.D. Demand for Family Planning Satisfied with Modern Methods among Sexually Active Women in Low- and Middle-Income Countries: Who Is Lagging Behind? *Reprod. Health* **2018**, *15*, 1–10, doi:10.1186/s12978-018-0483-x.
35. Rana, M.J.; Goli, S. Tracing Long-Term Trajectories of Contraceptive Practice across 185 Countries. *PLoS One* **2018**, *13*, 1–16, doi:10.1371/journal.pone.0205927.
36. Polis, C.B.; Biddlecom, A.; Singh, S.; Ushie, B.A.; Rosman, L.; Saad, A. Impacts of COVID-19 on Contraceptive and Abortion Services in Low- and Middle-Income Countries: A Scoping Review. *Sex. Reprod. Heal. Matters* **2022**, *30*, doi:10.1080/26410397.2022.2098557.
37. Aly, J.; Haeger, K.O.; Christy, A.Y.; Johnson, A.M. Contraception Access during the COVID-19 Pandemic. *Contracept. Reprod. Med.* **2020**, *5*, 1–9, doi:10.1186/s40834-020-00114-9.
38. Caruso, S.; Rapisarda, A.M.C.; Minona, P. Sexual Activity and Contraceptive Use during Social Distancing and Self-Isolation in the COVID-19 Pandemic. *Eur. J. Contracept. Reprod. Heal. Care* **2020**, *25*, 445–448, doi:10.1080/13625187.2020.1830965.
39. Boydell, V.; Nulu, N.; Hardee, K.; Gay, J. Implementing Social Accountability for Contraceptive Services: Lessons from Uganda. *BMC Womens. Health* **2020**, *20*, 1–12, doi:10.1186/s12905-020-01072-9.
40. Hardee, K.; Croce-Galis, M.; Gay, J. Are Men Well Served by Family Planning Programs? *Reprod. Health* **2017**, *14*, 1–12, doi:10.1186/s12978-017-0278-5.
41. Pintye, J.; Gage, A.J.; Eborika, K.; Adamou, B.M.; Dral, A.A.; Bag, N.I.; Osuafor, G.N.; Khowaja, F.; Jungari, S.; Radzuma, N.D.; et al. Examining Males' Perceptions and Concerns about Adopting Modern Family Planning Methods in Delta State, Nigeria. *BMC Womens. Health* **2022**, *20*, 26–42, doi:10.1186/s12905-021-01253-0.
42. DeGraw, E.; Rottach., E. Male Engagement in Family Planning: Understanding Global Policy Barriers and Enablers. *Washington, DC Palladium, Heal. Policy Plus* **2021**.
43. USAID *Increasing Men's Engagement to Improve Family Planning Programs in South Asia*; 2018;
44. George, A.S.; Mehra, V.; Scott, K.; Sriram, V. Community Participation in Health Systems Research: A Systematic Review Assessing the State of Research, the Nature of Interventions Involved and the Features of Engagement with Communities. *PLoS One* **2015**, *10*, 1–25, doi:10.1371/journal.pone.0141091.

Open Access This chapter is licensed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits any noncommercial use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.

