

FACTORS INFLUENCING MALE RELUCTANCE TO USE CONTRACEPTION

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ABSTRACT

Male participation in Indonesian family planning remains critically low, perpetuating a unilateral reproductive burden on women. In rural communities such as Wonocatur Village, Kediri, male contraceptive uptake is below 1%, yet empirical evidence capturing the multifaceted psychosocial drivers of this resistance remains scarce. This study aimed to determine the critical factors influencing contraceptive reluctance among married men of reproductive-aged couples. Employing an observational cross-sectional design with multiple binary logistic regression ($n = 70$), this research utilized a confidential hybrid survey model (combining private digital and paper-based instruments). Unlike conventional studies that rely predominantly on general sociodemographic or cognitive metrics, this approach uniquely captures informal peer pressure and rural masculinity dynamics while mitigating social desirability bias in sensitive health disclosures. The results revealed an alarming 68.6% reluctance rate. Multivariate modeling established feelings of shame and peer stigma as the single most dominant predictor ($AOR = 11.59$; 95% *THEORETICAL*: 2.36 – 56.88; $p = 0.003$), followed by medical myth perceptions regarding physical and sexual stamina decline ($AOR = 6.31$; 95% *THEORETICAL*: 1.49 – 26.65; $p = 0.012$). In conclusion, male contraceptive resistance is predominantly governed by peer-driven stigma and physiological misconceptions rather than mere knowledge deficits. As a strategic contribution, this study proposes an actionable intervention combining confidential digital tele-counseling and couple-centered care, providing healthcare authorities with an evidence-based roadmap to destigmatize male family planning and advance gender equity in reproductive health.

Keywords : Contraceptive Reluctance, Couple-Centered Care, Male Family Planning, Medical Myths, Peer Stigma.

1. INTRODUCTION

Men's involvement in the Family Planning (FP) program is a key element in achieving gender equality and sharing reproductive health responsibilities within the family. However, the facts in Indonesia show a stark disparity; contraceptive use remains a unilateral burden for women (93.66%), while male participation only reaches 6.34%, a figure still far below the BKKBN national target as set out in the 2020–2024 BKKBN Strategic Plan (Sari & Hadi, 2023). This disparity stems from systemic barriers, including the focus on women in family planning promotion, limited access to male-friendly health facilities, and a limited choice of male contraceptive methods (Sardi & Werdani, 2025). As a result, men are positioned as passive participants, while the responsibility for pregnancy prevention and the risk of contraceptive side effects falls entirely on their wives (Aba et al., 2026). This condition is reinforced by a patriarchal cultural construct that stigmatizes family planning as the exclusive domain of women (Agustina et al., 2025).

Men's reluctance to use family planning is influenced by low reproductive health literacy and the prevalence of misperceptions about medical myths, which in rural contexts can also be intertwined with religious interpretations of contraception law and acceptability, including debates surrounding fatwas (religious edicts). Most men still believe the unfounded belief that male contraceptive methods—particularly the Male Method of Surgery (MOP/Vasectomy)—can impair sexual function, diminish virility, and reduce physical stamina for work (Irawaty & Rafani, 2021).

The lack of educational channels specifically designed for men has led to these concerns persisting without adequate medical clarification. Various literature confirms that knowledge level, risk perception, education level, and quality of health services are fundamental determinants in shaping men's

attitudes toward contraception (Lope et al., 2025).

In addition to medical and cognitive factors, psychosocial barriers such as shame and peer stigma are crucial barriers in society. Within rural masculine norms, men who use contraception are often stigmatized, considered "weak," or ridiculed as men who "submit to their wives' control." These psychosocial barriers need to be examined alongside conventional knowledge-based indicators to determine whether reluctance to use family planning is more influenced by limited information or by stigma and pressure from social norms.

Therefore, this study aims to identify predictors of male reluctance to use family planning by comparing the contribution of sociocultural factors—specifically shame, peer stigma, and masculinity norms—with knowledge and perceptions of medical myths, in an effort to fill a gap in research that has previously emphasized cognitive determinants. This peer pressure creates feelings of awkwardness, inferiority, and shame when consulting openly with health professionals in public facilities. These psychological barriers work synergistically with traditional patriarchal norms, leading men to withdraw and reject family planning programs to maintain their social standing within their social circles (Irawaty & Rafani, 2021).

Men's active involvement depends heavily on the quality of communication between partners and mutual support within the household. Open and equal communication allows husbands and wives to rationally discuss the benefits and risks of each contraceptive method to protect the health of the mother and family. However, this decision-making process does not always occur free from external pressures. Religious norms, patriarchal traditions, and social views on men's roles and masculinity can limit contraceptive method choices, influence how couples communicate, or even make reproductive decisions more dependent on

social circumstances than on marital agreement.

Therefore, a couple-centered service approach needs to consider these cultural and social contexts, in addition to strengthening communication and shared decision-making (Ramayani & Agustia, 2026; Roudsari et al., 2023). Support and encouragement from wives have also been shown to increase husbands' confidence to actively participate in family planning (Sawitri & Wahyuni, 2024). Therefore, men must be positioned as sovereign reproductive subjects with unique emotional and psychological needs, not simply complementing their wives' opinions (Irawaty & Gayatri, 2021), especially since husbands' involvement has been shown to be positively correlated with long-term continued contraceptive use (Qudratullah & Fitrianti, 2023).

This reluctance to use family planning is clearly reflected at the community level in Wonocatur Village, Kediri Regency. This area has a population of 1,418 people divided into 592 heads of families (KK) and 237 couples of childbearing age (PUS) spread across 12 neighborhood associations (RT). Ironically, based on initial investigations into records of male contraceptive use in Wonocatur Village, the proportion is still below 1%. This figure is an initial finding at the village level, not official government data. The results of a preliminary survey of 12 male PUS in 3 neighborhood associations confirmed this high level of resistance; the majority of men refused to use family planning due to embarrassment in front of health workers, fear of being ridiculed by their peers in the neighborhood, concerns about becoming weak and lacking energy, and ignorance about male contraceptive methods.

1. METHODS

This research was a quantitative, observational, and analytical study with a cross-sectional design. Observations of the independent variables (feelings of shame/peer stigma, perceptions of medical myths, and reproductive health knowledge) and the dependent variable (men's reluctance to use contraception) were conducted simultaneously within a single observation

period. The study was conducted in Wonocatur Village, Kediri Regency, East Java, from July to August 2026.

The study population was all men/husbands of fertile couples (PUS) who permanently resided in Wonocatur Village, namely $N = 237$ fertile couples (PUS) spread across 12 neighborhood associations (RT). The sample size was calculated using the Slovin formula ($e = 0.10$). The results of this calculation, obtained a sample of $n = 70$ respondents. Sampling was conducted using the Stratified Purposive Sampling technique in 12 RTs.

The number of samples in each RT was determined proportionally based on the allocation formula and the results obtained were proportional distribution: RT 01, 03, 04, 05, 09, 10 (6 respondents each); RT 02, 06, 08, 12 (5 respondents each); and RT 07 and 11 (7 respondents each). Sample selection was based on inclusion criteria: legal husband of PUS (wife's age 18–49 years), permanent domicile in Wonocatur Village, able to communicate verbally/in writing, signed informed consent. Exclusion criteria: having a history of infertility or permanent medical sterilization (MOP/MOW), wife is pregnant, seriously ill/cannot be found after 2 data collection.

The dependent variable for male reluctance to use contraception (dependent) examines the refusal of male reproductive health partners (PUS) husbands to use male contraceptive methods (condoms/MOP). Measured using a Likert scale (1–4), it is categorized as Reluctant (score $\geq$ median) and Not Reluctant/Accepting (score $<$ median). The reproductive health knowledge variable examines understanding of anatomy, types of male contraception, effectiveness, and service procedures. Measured using the Guttman Scale (True = 1, False = 0), it is categorized as Less ($< 56\%$) and Good/Sufficient ($\geq 56\%$).

The medical myth perception variable examines misconceptions about the effects of male contraception on sexual/erectile function and physical stamina. Measured on a Likert scale, it is categorized as high (belief in myths) and low (medical understanding). The feelings of shame and peer stigma variable examines psychosocial pressures such as embarrassment about consulting a healthcare professional, fear of being ridiculed by peers, and feelings of inferiority related to

masculinity. Measured on a Likert scale, it is categorized as high (experienced stigma) and low (not affected).

Data collection using a structured questionnaire. Construct validity testing on 30 male PUS outside the research area using the Pearson Product Moment correlation test (all items are valid) $r_{count} > 0,361$). The reliability test using Cronbach's Alpha showed an alpha value of more than $\alpha > 0.70$ for all variables.

Data collection procedures were implemented using a hybrid approach (a combination of offline and online) to optimize response rates and ensure respondent privacy. Offline data collection: Researchers, accompanied by village health cadres, conducted door-to-door visits to identify potential respondents who met the inclusion criteria. Online data collection: For respondents who had time constraints (working outside the home) or desired more privacy, an electronic version of the structured questionnaire (Google Forms) was distributed via private WhatsApp messages after respondents completed electronic informed consent.

Given that the questionnaire contained sensitive questions about sexual function, masculinity, stigma, and contraceptive use, participants were given the opportunity to complete the questionnaire independently in a private setting, without their partners, cadres, or family members present. Participants could also choose to complete the questionnaire online if they desired greater privacy. Participants were not required to provide verbal answers to researchers or cadres and were free to skip any questions they felt uncomfortable with.

Data confidentiality was maintained by not including names, telephone numbers, complete addresses, or other direct identification on the questionnaire or in the analysis database. Each respondent was assigned a research code, and a list of links between the code and identification, if needed for follow-up, was stored separately and accessible only to the principal investigator. When filling out the questionnaire via Google Forms, the settings for collecting email addresses, usernames, and other identifying information were automatically disabled. The questionnaire link was sent via private WhatsApp messages, not through a group

chat, and the researcher did not copy the contents of the conversation into the research database.

Digital data were stored on password-protected devices and storage accounts with two-factor authentication, with access restricted to the principal investigator. Files downloaded from Google Forms were coded, stored in encrypted storage, and not shared with unauthorized parties. Conversation histories, phone numbers, email addresses, and other digital metadata not required for analysis were not included in the research dataset and were deleted after the data verification process was completed, in accordance with established retention policies. Research results were reported in aggregate so that individual responses could not be identified. The entire research protocol was approved by the Health Research Ethics Committee of Strada Indonesia University prior to implementation, to ensure the protection of human rights and minimize potential psychosocial risks for research subjects.

2. RESULTS

A hybrid data collection approach in Wonocatur Village resulted in the recruitment of 70 male respondents of childbearing age. Sampling was conducted using stratified purposive sampling with proportional allocation based on residential area, the application of predetermined inclusion and exclusion criteria, and the use of both offline and online approaches to expand respondent access. However, purposive respondent selection still has the potential to introduce selection bias because not every member of the population has an equal chance of being selected; therefore, the representativeness of the sample to all male couples of childbearing age in Wonocatur Village needs to be interpreted with caution. The sample size was determined using the Slovin formula, not through formal power analysis. Therefore, the adequacy of statistical power for binary logistic regression analysis, particularly when estimating multiple predictors simultaneously, cannot be ascertained and may increase the risk of unstable estimates or overfitting. Future research should employ a priori analysis that specifically considers the proportion of events, the number of predictors, the expected effect size, and the

established level of significance and statistical power.

Sociodemographic Characteristics of Respondents

The distribution of respondents' sociodemographic characteristics is presented in the following table.

Table 1. Distribution of Respondents' Sociodemographic Characteristics (n = 70)

Character clover	Category	Freku next (n)	Percent level (%)
Age Group	20 - 35 years (Early Adulthood)	26	37,1
	36 - 50 years (Late Adulthood)	44	62,9
Level of education	Elementary Education (Elementary/Mid dle School)	29	41,4
	Secondary Education (SMA/SMK)	33	47,1
	Higher Education (Diploma/Master' s)	8	11,5
Main Job	Farmers / Farm Laborers	31	44,3
	Self-employed / Trader	24	34,3
	Private Employees / Civil Servants	15	21,4
Number of Living Children	≤ 2 child	39	55,7
	> 2 child	31	44,3
Questionnai re Filling Method	Luring (Paper- based / Door-to- door)	42	60,0
	Daring (Google Forms via WhatsApp)	28	40,0
Total		70	100,0

Based on Table 1, the majority of respondents were in the 36–50 years age range (62.9%), had secondary education of high school/vocational school (47.1%), and worked in the agricultural sector as farmers/farm laborers (44.3%).

Univariate Analysis of Research Variables

Univariate analysis was used to describe the frequency distribution of independent variables (reproductive health knowledge, perception of medical myths, and

peer stigma) and dependent variables (male reluctance to use family planning).

Table 2. Frequency Distribution of Research Variables (n = 70)

Variables	Category	Frequen cy (n)	Percenta ge (%)
Reproductive Health Knowledge	Not enough (< 56%) Pretty good (≥ 56%)	42 28	60,0 40,0
Perception of Medical Myths	High (Believe Myth) Low (Understanding of Medical Facts)	45 25	64,3 35,7
Feelings of Shame & Peer Stigma	High (Experiencing Stigma) Low (Not Affected)	44 26	62,9 37,1
Men's Reluctance to Use Family Planning (Dependent)	Refuse Not Refuse (Accept)	48 22	68,6 31,4
Total		70	100,0

The data in Table 2 shows that the majority of male couples (PUS) in Wonocatur Village have a high level of reluctance to use family planning (68.6%). Furthermore, the majority of respondents have limited reproductive health knowledge (60.0%), a high level of perception of medical myths (64.3%), and experience high levels of peer stigma/shame (62.9%).

Bivariate Analysis (Chi-Square Test)

Bivariate analysis was conducted to test the relationship between each independent

variable and men's reluctance to use contraception.

Table 3. Bivariate Analysis of the Relationship between Independent Variables and Men's Reluctance to Use Family Planning.

Independent Variables	Men's Reluctance to Use Birth Control		Total	p-value	Odds Ratio / OR (95% CI)
	Refuse (n, %)	Not Reluctant (n, %)	N (%)		
Reproductive Knowledge					
Not enough	34 (81,0%)	8 (19,0%)	42 (100%)	0,006	4,25 (1,48 – 12,18)
Pretty good	14 (50,0%)	14 (50,0%)	28 (100%)		(Reference)
Perception of Medical Myths					
High (Believe Myth)	39 (86,7%)	6 (13,3%)	45 (100%)	< 0,001	11,56 (3,65 – 36,60)
Low (Medical Understanding)	9 (36,0%)	16 (64,0%)	25 (100%)		(Reference)
Peer Stigma					
High (Experiencing Stigma)	40 (90,9%)	4 (9,1%)	44 (100%)	< 0,001	22,50 (6,09 – 83,15)
Low (Not Affected)	8 (30,8%)	18 (69,2%)	26 (100%)		(Reference)

Based on Table 3, the statistical test results indicate a significant relationship between reproductive health knowledge and reluctance to use family planning, as well as a highly significant relationship between perceptions of medical myths and feelings of shame or peer stigma with reluctance to use family planning. However, the effect estimates in the bivariate analysis need to be interpreted with caution because the confidence intervals are relatively wide, especially for the peer stigma variable (6.09–83.15).

With a relatively small sample size ($n = 70$), the width of the interval indicates that the precision of the odds ratio estimates is still limited and the effect sizes obtained may be unstable, as well as a highly significant association between perceptions of medical myths and feelings of shame or peer stigma with reluctance to use family planning. However, interpretation of these findings requires caution because the study did not include the influence of local religious leaders or regional religious norms as structural factors. In the Indonesian context, patriarchal norms, the assumption that contraception is associated with the loss of masculinity, and various misconceptions about contraception can be barriers to men's involvement in family planning programs (Rahayu et al., 2023).

Therefore, these factors have the potential to influence men's involvement in reproductive health and act as confounding variables in the relationship between peer

stigma, perceived medical myths, and men's reluctance to use family planning. These factors may also act as confounding variables in the relationship between peer stigma, perceived medical myths, and men's reluctance to use family planning.

Multivariate Analysis (Binary Logistic Regression)

All independent variables met the bivariate selection criteria ($p < 0.25$) and were therefore included in the multivariate Binary Logistic Regression (Multiple Logistic Regression) modeling using the Enter method. The analysis results are presented in the following table:

Table 4. Final Modeling of Multivariate Binary Logistic Regression Analysis

Variable	B	S.E.	Forest	df	Mr. (p)	Adjusted OR (AOR)	95% CI for AOR
Lack of Knowledge	0,985	0,680	2,100	1	0,147	2,68	0,71 – 10,15
High Medical Myths	1,842	0,735	6,281	1	0,012	6,31	1,49 – 26,65
High Peer Stigma	2,450	0,812	9,098	1	0,003	11,59	2,36 – 56,88
Permanent	-2,715	0,915	8,795	1	0,003	0,066	-

Notes:

Nagelkerk $R^2 = 0,584$; Hosmer and Lemeshow test $\chi^2 = 5,142$ ($p = 0,742$); Overall percentage = 82,9%.

Based on Table 4:

- The results of the model goodness of fit test using the Hosmer-Lemeshow Test showed a p value = 0.742 ($p > 0,05$), which means that the logistic regression model is able to predict the observation value well (fit). The Nagelkerke R Square value is 0,584 show that 58,4% the variability in men's reluctance to use contraception can be explained by the variables in the model, whereas 41,6% the remainder is explained by other variables outside the study.
- The most dominant factors influencing men's reluctance to use family planning were feelings of shame and peer stigma (peer stigma) with a p-value of 0.003 and an AOR of 11.59 (95% CI: 2.36 – 56.88). This means that men of childbearing age who experience stigma and shame from their social environment are 11.59 times more likely to be reluctant to use family planning

after being controlled for medical myths and knowledge.

- c. The second dominant factor was Perception of Medical Myths with a p-value of 0.012 and AOR of 6.31 (95% CI: 1.49 – 26.65). Men who believed medical myths were 6.31 times more likely to refuse male contraception.

3. DISCUSSION

The results of the study in Wonocatur Village, Kediri Regency revealed that the level of reluctance of men of reproductive age (PUS) in using contraception is still very high, reaching 68.6%. Based on the final binary logistic regression modeling, the most dominant factors influencing the reluctance to use contraception are feelings of shame and peer stigma (AOR = 11.59; $p = 0.003$), followed by the perception of medical myths (AOR = 6.31; $p = 0.012$). Meanwhile, the variable of knowledge level has a significant relationship in the bivariate analysis, but its direct effect is reduced after being controlled by the variables of social stigma and medical myths in the multivariate analysis. This interpretation also needs to consider the structural influence of religious norms and local religious figures that have not been measured in this study.

In rural East Java, religious authorities can shape men's understanding, acceptance, and decisions regarding contraceptive use (Khairunida et al., 2025). Therefore, future research should include respondents' level of religiosity, perceptions of religious leaders' views, and the role of religious leaders in male family planning education and decision-making. These factors have the potential to interact with peer stigma and perceptions of medical myths to influence men's reluctance to use family planning.

The findings of this study empirically demonstrate that peer stigma is the strongest predictor of male reluctance to use family planning in rural areas, with an 11.59-fold increase in the risk of reluctance. In Wonocatur Village, traditional masculinity social norms remain strongly embedded in men's informal social structures and are thought to be intertwined with religious understandings shaped, among other things, by the authority of local religious leaders. In informal social structures (such as cangkrukan groups or neighborhood associations) for men, control over reproductive decisions is often viewed as

a core component of a husband's authority (Mollet & Mollet, 2024). Within this framework of "masculine sovereignty," men's participation in family planning programs is often misperceived as a form of "submission to their wives" or a loss of the husband's authority as head of the family (Rahayu et al., 2023).

This social pressure from peer groups creates a deep sense of awkwardness, inferiority, and shame for men to consult openly with health workers in public facilities. (Nyalela & Dlungwane, 2023). Integrated health posts (Posyandu) and community health centers (Puskesmas) have long been portrayed as "women's spaces," so the presence of men seeking family planning information triggers discomfort and anxiety, which becomes the subject of gossip in social circles.

This finding is in line with research (Roudsari et al., 2023) which confirms that for rural men, maintaining social reputation and a masculine image in the eyes of their peer group is often valued more than rational reproductive health considerations. However, interpretation of these findings requires considering the study's sample size, 70 respondents, compared to the number of variables in the model. This increases the risk of overfitting, which can cause effect size estimates, including the AOR, to appear larger than they actually are. Therefore, these findings are more appropriately viewed as a strong indication of factors contributing to men's reluctance to use family planning, rather than as a definitive estimate of effect size.

The second significant determinant factor was the high level of perception of medical myths (AOR = 6.31). The majority of respondents (64.3%) believed the myth that male contraception—particularly the Male Operation Method (MOP/Vasectomy)—can castrate the reproductive organs, cause erectile dysfunction (impotence), and drain physical energy. Given that 44.3% of respondents in Wonocatur Village work in the agricultural sector (farmers and farm laborers) who rely on daily physical strength, the fear of physical weakness after the birth control procedure is a very real economic-psychological barrier. This misconception persists due to the lack of medical education channels specifically designed to address concerns about male anatomy and physiology, and because it is

intertwined with religious interpretations in rural Javanese communities, including perceptions regarding the status of fatwas and the permissibility of vasectomy. Without clarification from trusted medical sources and religious figures, this understanding can reinforce the notion that male contraception is contrary to religious norms, making it even more difficult to dispel medical myths. These findings support the study.(Murti et al., 2023)which states that male resistance to birth control stems from fear of loss of sexual performance and work capacity due to a lack of medical clarification from trusted sources.

Although bivariate analysis showed a significant association between lack of knowledge and reluctance to use contraception ($p = 0.006$; $OR = 4.25$), multivariate analysis did not show independent significance ($p = 0.147$). This indicates that providing cognitive education alone (knowledge-based intervention) is insufficient to change men's behavior if psychosocial barriers (stigma) and myths remain unaddressed. Men may have basic knowledge about condoms or vasectomies, but their decision to use them remains hampered by clashing social norms and feelings of shame (Sardi & Werdani, 2025).

The findings of this study provide strategic implications for Village Midwives, Community Health Centers, and DP2KBP3A of Kediri Regency in reformulating intervention strategies: 1) Provision of Digital-Based Private Counseling Channels: Opening private consultation services (e.g., tele-counseling via WhatsApp Village Midwives) to ensure confidentiality and reduce the embarrassment of men who are reluctant to come directly to public service facilities; 2) Couple-Centered Care Approach: Involving husbands and wives in an integrated manner in family planning counseling sessions to build equal communication and mutual support in the division of reproductive responsibilities (Ramayani & Agustia, 2026); 3) Empowerment of Male Peer Educators (Male Role Models): Involving male figures or male family planning acceptors at the village level to provide real testimonials regarding the medical safety of male family planning to break down myths and stigmas of masculinity in peer groups (Jain et al., 2021).

This study used a cross-sectional design, thus only being able to demonstrate

correlational relationships between factors and unable to conclude dynamic, long-term causal relationships. Furthermore, the study focused on a single rural area in Kediri Regency with a sample size of 70 respondents. Therefore, generalizing the findings to populations with different sociocultural characteristics requires caution. The use of stratified purposive sampling allows researchers to obtain representation of certain subgroups according to predetermined characteristics, but does not provide an equal opportunity for each member of the population to be selected as in random sampling.

Therefore, selection bias is likely, particularly if the characteristics of respondents willing to participate differ from those of male couples who were not reached or declined to participate. This could result in the distribution of stigma, perceptions of medical myths, knowledge, and reluctance to use family planning in the sample not fully reflecting the conditions of the male couple population in Wonocatur Village or other rural areas.

Furthermore, the relatively small sample size of 70 respondents needs to be considered when assessing the robustness of a multivariate model that includes multiple predictors. The limited number of observations and the potential imbalance between the number of contraceptive reluctance cases and the number of predictors can increase the risk of overfitting, resulting in unstable coefficient estimates and adjusted odds ratios, and widening confidence intervals.(Pavlou et al., 2024).

Thus, the results of multivariate analyses should be understood as indicating a relationship that needs to be confirmed through research with larger sample sizes, probability sampling methods, and models that consider a greater proportion of predictors. Generalization of the results should also be limited to populations with similar demographic and sociocultural characteristics to the study site.

4. CONCLUSION

The level of reluctance of men of reproductive age (PUS) to use contraception in Wonocatur Village, Kediri Regency is relatively high (68.6%). Feelings of shame and peer stigma were proven to be the most

dominant determinants (AOR = 11.59), followed by the perception of medical myths (AOR = 6.31). Men who experienced peer stigma pressure were 11.59 times more likely to refuse family planning, while men who believed medical myths were 6.31 times more likely to be reluctant to use family planning. These findings emphasize the need for policies that not only focus on providing information, but also directly target stigma and misconceptions through digital-based private counseling, male-friendly health education, and the involvement of religious leaders, community leaders, and male family planning acceptors as peer educators. These strategies are expected to increase men's access to reliable information, build social acceptance, and strengthen men's participation in contraceptive decision-making at the family and community levels.

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