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REVIEW

Adult men's beliefs, values, attitudes and experiences regarding contraceptives: a systematic review of qualitative studies

Luiza AK Hoga, Juliana RC Rodolpho, Priscila M Sato, Michelly CM Nunes and Ana LV Borges

Aims and objectives. To explore the men's beliefs, values, attitudes and experiences towards contraceptives.

Background. The promotion of male participation in contraceptive practices requires the knowledge and consideration of the beliefs, values, attitudes and experiences involved. The systematic review of the literature focusing on these themes can be useful for the evidence-based health care.

Design. A systematic review of qualitative studies.

Methods. Studies published between 1994 until 2011 (inclusive) were included. The participants included men from all cultures, ethnic backgrounds and religions who have expressed their beliefs, values, attitudes and experiences regarding male contraceptives. The databases CINAHL, PubMed, PsycINFO, SciELO, LILACS and MedCarib were explored. The appraisal of primary studies, carried out through the JBI-QARI (Qualitative Assessment and Review Instrument) resulted in the inclusion of 16 studies in this systematic review.

Results. The set of statements of beliefs, values, attitudes and experiences regarding contraceptives resulted in five synthesis: (1) contraceptive behaviour is influenced by religious, family and social backgrounds; (2) gendered, male-centred values predominate in contraceptive behaviours; (3) the sense of invulnerability influences contraceptive behaviours; (4) strong obstacles should be overcome to use contraceptives; (5) behaviours, decision-making and experiences regarding male contraceptives.

Conclusions. The male beliefs and values regarding contraceptives are strongly influenced by religious, family and social backgrounds, and their attitudes in this scope are male centred.

Relevance to clinical practice. A deeper male consciousness regarding contraceptive responsibility should be promoted. It requires the knowledge of the men's personal backgrounds regarding contraceptives because they can be diverse according to family, social and cultural contexts. The consideration of the men's personal perspective is essential in the planning and implementation of reproductive health care. These aspects are essential for the concretisation of the evidence-based health care, a current challenge worldwide.

Key words: contraception, family planning, men, meta-synthesis, reproductive health

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Background

The IV International Conference on Population and Development held at Cairo in 1994 recommended implementing policies aimed at increasing men's involvement in reproductive health and studies focusing on men's perceptions of contraceptive practices. To adhere to this recommendation, the Brazilian federal government implemented the National Policy for Comprehensive Care in Men's Health in 2008. The main prerogatives of this policy were increasing men's involvement and effective participation in contraception in conscious and responsible ways (Brazil 2008).

Male involvement in contraception is considered a defining fact of men's lives. Effective participation in contraception can trigger significant individual, family, social and cultural changes. Increased accessibility to scientific knowledge, especially for those confronting difficulties with access, is considered fundamental to effective contraceptive use (Santos & Vieira 2008).

Health promotion assumptions are important when addressing contraception issues. Health promotion requires considering the social and cultural issues that affect health and illness. Factors such as social class, ethnic and religious backgrounds and cultural traditions exert strong influences on attitudes towards masculinity and paternity, and such factors should not be considered in isolation. In the current environment, healthcare providers must have a deep knowledge of social and cultural diversity and consider the role of these factors in health care. When reproductive issues are involved, an appropriate approach to the patients' backgrounds is crucially important (Santos & Vieira 2008).

A systematic review of men's beliefs, values, attitudes and experiences regarding contraceptives may improve healthcare providers' access to this information. A deep, comprehensive and systematic understanding of these interrelated phenomena can contribute to evidence-based health care (EBH), the implementation of which is being encouraged worldwide (Pearson *et al.* 2005). EBH implementation requires evidence derived from research, clinical expertise and the consideration of context and the patients' own preferences (Noyes *et al.* 2008).

Therefore, the approaching of patient's sociocultural backgrounds and personal preferences, one of the most important steps of the nursing care systematisation, assumes vital importance, especially in the provision of sexual and reproductive health care. This comprehensive approach of nursing care contributes for improving the patient's satisfaction, a significant indicator of the quality of care (Johansson *et al.* 2002).

The Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) checklist and flow diagram were used to guide manuscript development.

This study considered several aspects related to contraceptive behaviours, such as physical, emotional, social and cultural perspectives. This systematic review intended to answer the following questions:

- What are men's beliefs and values regarding contraceptives?
- What are men's attitudes towards contraceptives?
- What are men's experiences with contraceptives?

Aim

The aim of this systematic review was to explore men's beliefs, values, attitudes and experiences regarding contraceptives.

Methods

Search strategy

Studies published between 1994–2011 (inclusive) were included. The year 1994 was chosen as the start of the revision period because that was the year that the Cairo conference first recommended including the male perspective on reproductive health. Since that conference, many researchers have approached the themes addressed in this systematic review.

The CINAHL, PubMed, PsycINFO, SciELO, LILACS and MedCarib databases were explored for this study. The reference lists and bibliographies of retrieved articles were also hand-searched to identify studies that were not found in the databases. The selected articles should be written in English, Spanish or Portuguese languages.

Two independent groups of reviewers assessed all abstracts that appeared to meet the inclusion criteria. Full reports were retrieved for all studies that appeared to meet the inclusion criteria.

The Patient, Intervention, Control and outcome (PICo) strategy was used to explore the databases. 'P' refers to all men from all cultures, ethnicities and religious backgrounds; 'I' refers to male beliefs, values, attitudes and experiences regarding contraceptives; and 'Co' refers to the period between 1994–2011. The findings pertaining to beliefs, values, attitudes and experiences regarding contraceptives and the researchers' recommendations were explored.

The keywords used for Boolean search strategy were 'men' or 'male' or 'human male' and 'adult' and 'behavior' and 'contraception' or 'contraception behavior' or 'birth control'

or 'family planning' or 'family planning services' and 'health knowledge, attitudes, practice'. Various combinations of these words and phrases were used with the search engines.

Inclusion/exclusion criteria

This review considered men from a variety of cultures, ethnicities and religious backgrounds who have expressed beliefs, values, attitudes and experiences regarding contraceptives. We included qualitative primary research studies that embraced, but were not limited to, phenomenology, grounded theory, ethnography, action research and feminist research and were published in indexed scientific journals. It is also considered interpretive studies that drew on beliefs, values, attitudes and experiences regarding contraceptives. We did not consider reports that focused on the beliefs, values, attitudes and experiences regarding contraceptives from the perspectives of women or healthcare providers.

Assessment of methodological quality

Studies that met the inclusion criteria were appraised by two independent groups of reviewers for methodological quality. This appraisal was based on the Joanna Briggs Institute (JBI) 'Critical Appraisal Tool for Qualitative Studies'. Any disagreements that emerged between the two groups of reviewers were resolved through discussions in which all of the reviewers participated. No strong disagreements between the two groups emerged.

Findings

Database search results

The database searches resulted in 1464 studies. Of them, 1437 were removed because of duplicates and after evaluation of abstracts. Therefore, 27 potentially relevant studies were retrieved after an analysis of the remaining abstracts. Six studies were excluded for a more detailed appraisal of full text. After that, a critical appraisal of the methodological quality of the 21 remaining studies resulted in the exclusion of five studies. The PRISMA flow diagram is presented in Fig. 1.

The studies were conducted in 10 countries: the United States of America (n = 4), Brazil (n = 4), Australia (n = 1), Finland (n = 1), Jordan (n = 1), Lebanon (n = 1), Nepal

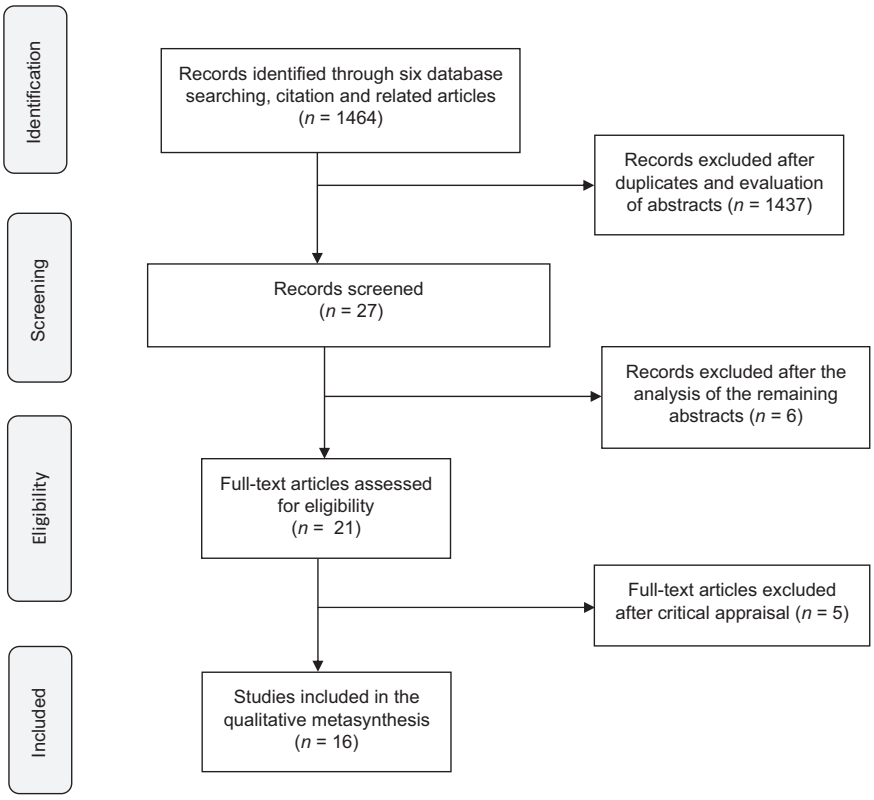

Figure 1 Literature search process for inclusion/exclusion in the meta-synthesis, adapted from PRISMA 2009 flow diagram (Moher *et al.* 2009).

(n = 1), Swaziland (n = 1), Tanzania (n = 1) and Zimbabwe (n = 1). A total of 487 men participated in the studies. The men's ethnicity, when noted, included Asian Americans, Caucasians, immigrant or native Hispanics, and native Africans or Swazis. The characteristics of the studies are shown in Table 1.

Data extraction/collection, analysis and qualitative evidence

The analysis of the studies' findings involved aggregation and synthesis. The JBI-Quari Degrees of Credibility Scale was used to classify the credibility of primary studies' findings. This scale is based on three levels of credibility: unequivocal, credible or unsupported. In this systematic review, only the unequivocal evidence was included. The JBI-Quari considers studies unequivocal and beyond reasonable doubt when they include findings that are matter of fact, directly reported/observed and not open to challenge (Pearson *et al*. 2007).

The men's statements and their respective contents contributed to the synthesis of the findings, as shown in Fig. 2. In this figure, the statements are presented, and studies that found similar results are identified by their respective numbers. Some quotes were extracted from the primary studies to exemplify the main findings. The original content of these quotes was preserved, and the corresponding study and page are cited at the end of each quote. The recommendations given by the authors of the primary studies are shown in Table 2.

Discussion

Strong influence of personal backgrounds on contraceptive behaviours

The primary studies' findings reflected the strong influence of religious, family and social backgrounds on contraceptive behaviours.

The influences of religion on contraceptive behaviours were explored by Grady *et al.* (1996). The men who were affiliated with a Christian denomination were more likely to use contraception than nonChristians. The authors suggested that this behaviour derived from the Christian men's proscriptive attitudes towards abortion, which lead such men to take greater responsibility for contraception.

The Protestant male-dominant attitude towards contraceptives and the adoption of contraceptive responsibilities (Lottes & Kuriloff 1992) can be attributed to Protestant men's sense of responsibility for financial support and the preservation of male hegemony in the family. In traditional Islamism (Kridli & Libbus 2001), the idea of family planning is accepted under certain conditions. The spacing of births can be influenced by contraceptive use, but the final size of the family cannot be limited. Therefore, sterilisation is forbidden to preserve the possibility of future births. The use of behavioural methods, such as the rhythm method and extended breastfeeding, is freely permitted, but modern birth control methods such as pills, intrauterine devices and diaphragms can be used only when natural methods have failed. Among Muslims (Ghazal-Aswad *et al*. 2002), couples are expected to be fruitful and are pressured to have children. The basis for attitude is the belief that God will take care of the children and provide for their survival needs regardless of the family's economic situation.

The evidence demonstrating the strong influence of religious, family and social backgrounds on contraceptive behaviours indicates the importance of the systematisation of nursing care. It implies the listening of sociocultural backgrounds, in an attentive and nonjudgmental way, and the identification of men's needs regarding reproductive health and family planning. In this way to provide nursing care, a culturally meaningful health care and a meaning-centred model in reproductive healthcare facilities can be improved and implemented.

Challenges to increase the male involvement with contraception

The studies referred to a low use of male contraceptives. This finding demonstrates that greater male responsibility for contraception and autonomy in the use of contraceptives present considerable challenges. In this sense, the complex, interconnected biological and social factors should be considered when approaching contraception issues (Dudgeon & Inhorn 2004). Unmet contraceptive needs are conditioned by a combination of social opposition, lack of knowledge about contraceptives, method-related problems and side effects (Casterline & Sinding 2000, Westoff & Marshall 2010).

The men confronted difficulties related to the conditions under which they would or would not use contraceptives and the cultural patterns related to the use of contraceptives (Dudgeon & Inhorn 2004). These difficulties can emerge from the sociocultural construction of masculinity and the male deference to gender norms that exclude them from the reproductive health issues (Mullany *et al*. 2007, Mumtaz & Salway 2009). Furthermore, the male perspective of reproductive health, particularly the range of meanings of reproductive behaviours and beliefs within particular social and

Table 1 Studies included and correspondent characteristics

Study	Author (year)	Method	Country/ethnic focus/setting	Purpose	Data collection	*n*	Data analysis
1	Degni *et al.* (2008)	Qualitative	Finland Somali men	To explore perceptions of contraceptive use by women	In-depth interview	98	Construction of headings and sub headings
2	Manhoso and Hoga (2005)	Thematic oral history	Brazil Public hospital	To describe the experiences of men who underwent vasectomy	In-depth interview	20	Thematic analysis
3	Petro-Nustas and Al-Qutob (2002)	Ethnography	Jordan	To identify attitudes and practices regarding contraceptives	Focus group	37	Content analysis
4	Raine *et al.* (2010)	Qualitative	USA Low-income communities	To examine social norms about sexual relationships and its impacts on contraceptive use	Focus group	64	Content analysis
5	Hoga *et al.* (2001)	Ethnonursing	Brazil Low-income community	To explore the involvement in reproductive health	In-depth interview	15	Thematic analysis
6	Simkhad *et al.* (2010)	Qualitative	Nepal Trekking guides working in mountains	To explore how trekking guides use condom	In-depth interview	21	Thematic analysis
7	Johnson and Williams (2005)	Mixed method	USA Caucasian/ Asian American	To explore contraceptive practices	In-depth interview	20	Thematic analysis
8	Bunce *et al.* (2007)	Focus group	Tanzania Kigoma, Kibondo and Kasulu Districts	To explore emergent themes related to vasectomy	In-depth interview	22	Content analysis Thematic analysis
9	Sable *et al.* (2006)	Focus group	USA Hispanic immigrants	To understand the attitudes towards family planning	Focus group	33	Content analysis
10	Marchi *et al.* (2008)	Qualitative	Brazil Public hospital	To assess the perspectives towards contraceptive methods	Semi-structured interview	20	Thematic analysis
11	Ziyane and Ehlers (2007)	Descriptive	Swaziland Swazi	To investigate contraceptive knowledge, attitudes and practices	Focus group	15	Thematic analysis
12	Chikovore *et al.* (2002)	Grounded theory Ethnography	Zimbabwe Rural zone	To understand the perceptions related to contraceptive use	Focus group	29	Content analysis
13	Marchi *et al.* (2003)	Oral history	Brazil Public clinic	To investigate the process that leads to decide for vasectomy	Semi-structured interview	20	Content analysis
14	Myntti *et al.* (2002)	Exploratory	Lebanon	To understand the role in reproductive health	In-depth interview	11	Content analysis
15	Smith *et al.* (2011)	Qualitative	Australia	To explore the relationship between young males' perspectives on pregnancy and fatherhood and their attitudes, beliefs and practices related to condom and birth control	Semi-structured interview	42	Thematic analysis
16	Jackson *et al.* (2011)	Exploratory	USA Low-income community	To document the importance of partners in women's contraception, familiar planning and decision-making towards unplanned pregnancy	In-depth interview	20	Content analysis

cultural settings, represents important issues to be explored within the healthcare setting (Dudgeon & Inhorn 2004).

Many primary studies found a predominance of male-centred values in contraceptive behaviours. These values run deep and are continuously incorporated by men through primary and secondary socialisation. In early infanthood, children begin to learn how to behave in a gender-specific way within their family and society (Berger & Luckmann

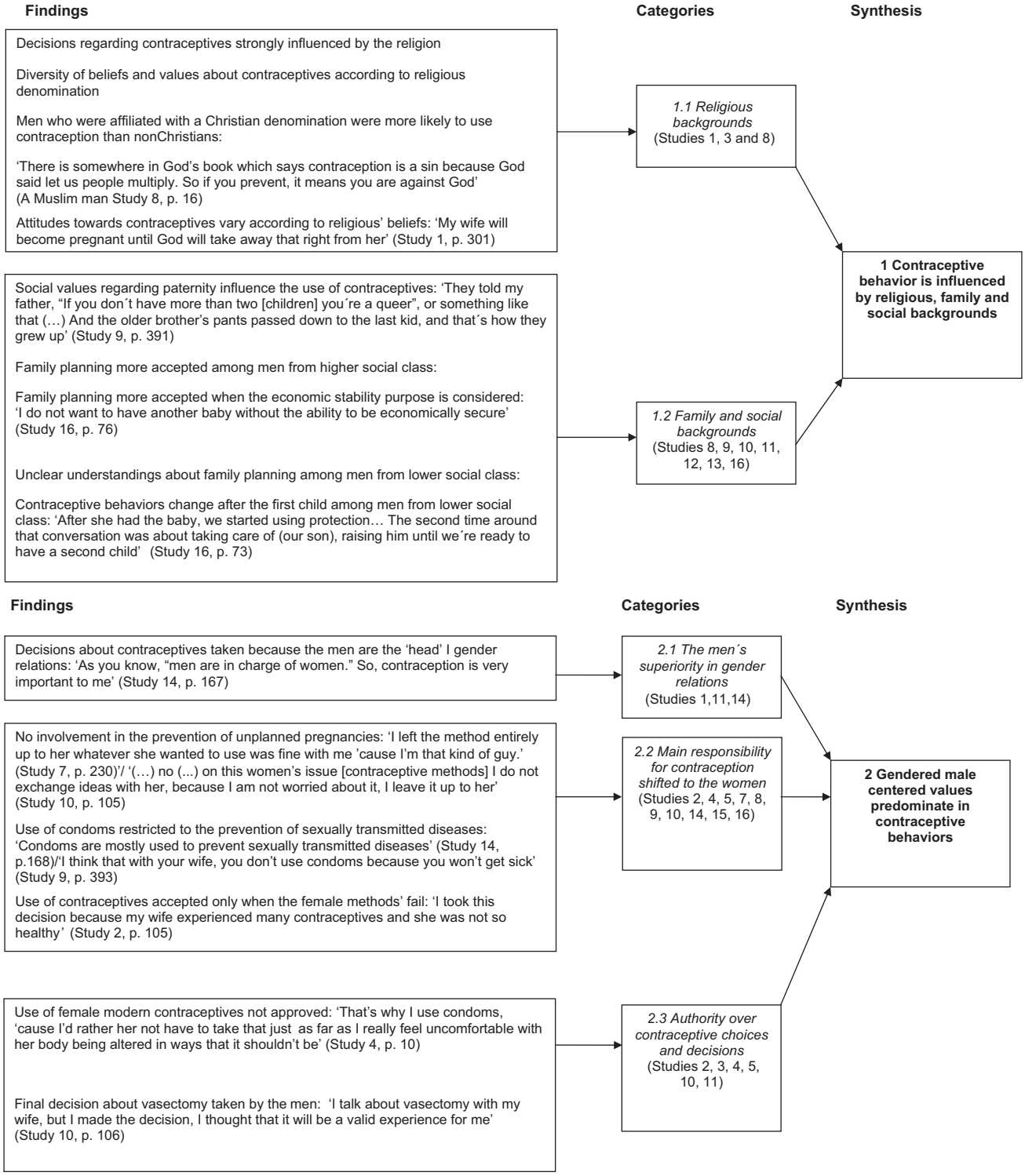

Figure 2 Set of statements of beliefs, values, attitudes and experiences regarding contraceptives and the synthesis of findings.

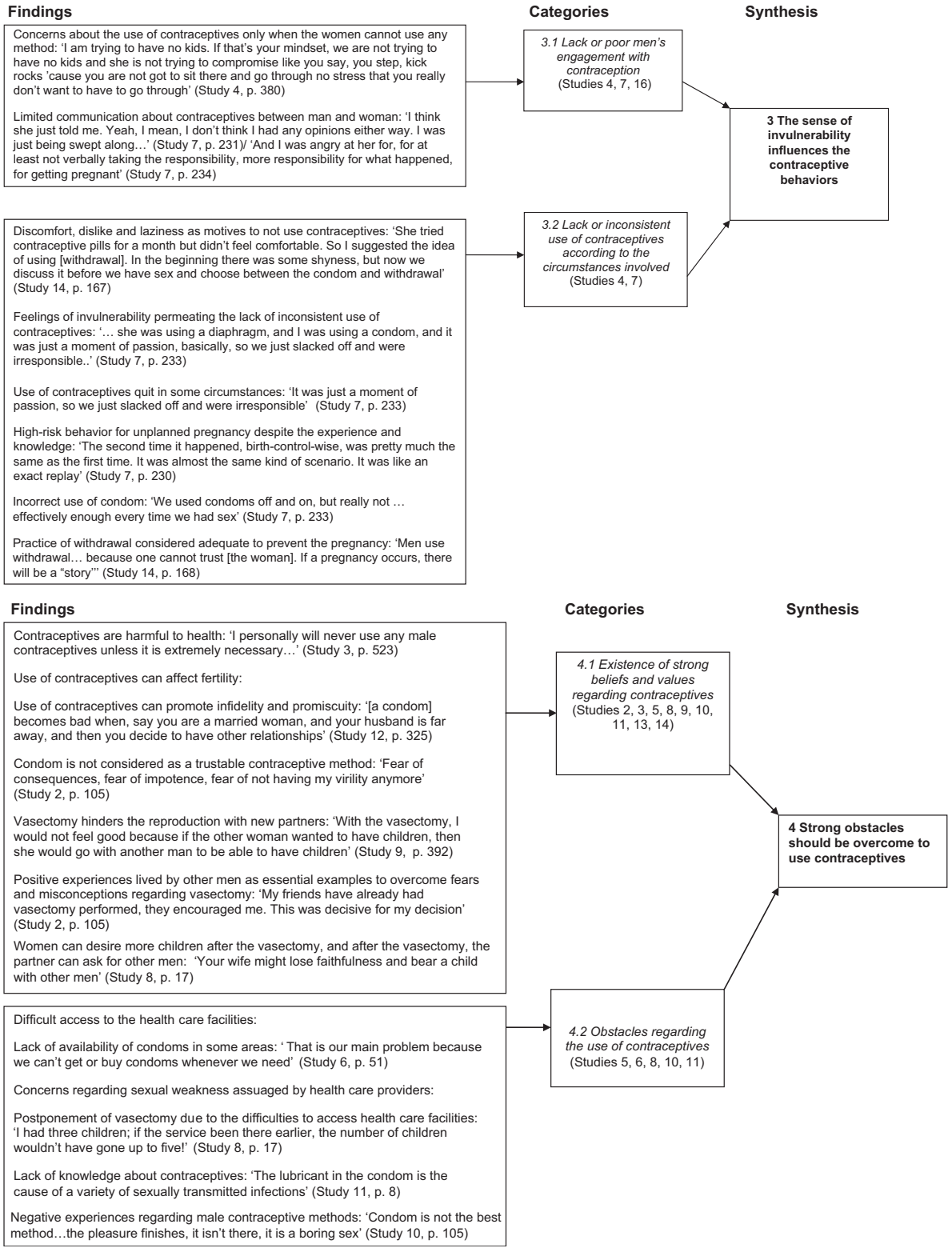

Figure 2 (Continued)

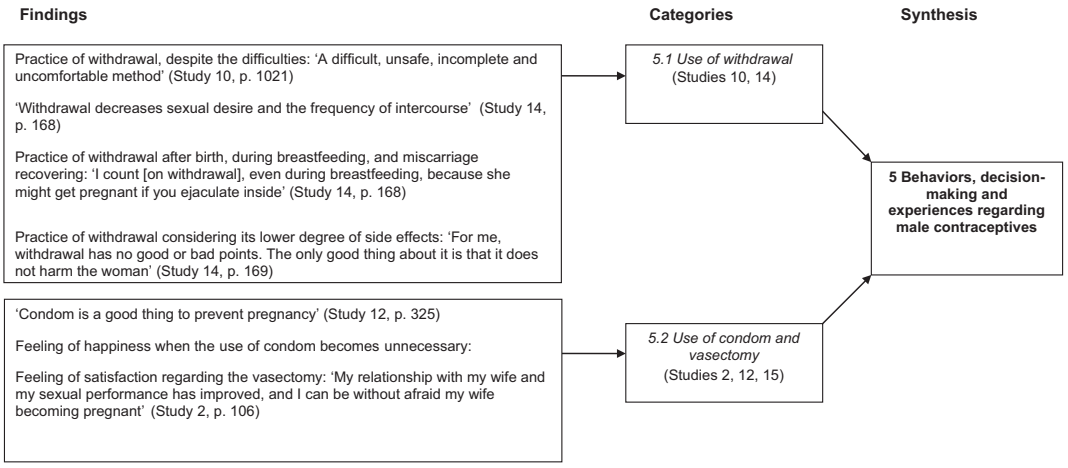

Figure 2 (Continued)

1974). In this sense, an ethnographic study stated that the men's attitudes are based on what their cultures consider masculine or associated with 'machismo'. The masculinity must be proven to others, unlike femininity, which is considered inherent to the female condition (Hoga *et al.* 2001).

The men's sense of invulnerability to unplanned pregnancies was reported in the primary studies. Consequently, special attention should be focused on low-income people and those from racial/ethnic minority groups. Among these groups, the preconception care service rates were lower, and the burden of unintended pregnancies was higher (Dunlop *et al.* 2010). Primary care providers do not routinely perform sexual risk assessments or provide contraceptive counselling (Ewing *et al.* 1999, Chandra *et al.* 2005). Some researchers have supported the utility and importance of assessing female and male patients' reproductive intentions and sexual and contraceptive practices as part of the primary health encounter. From the patients' perspective, the dissemination of family planning knowledge and the use of strategies to prevent unintended pregnancies and provide opportunities for preconception health care may be critically important (Dunlop *et al.* 2010).

The existence of social inequalities must be considered in the provision of reproductive health care. The distribution of health care and educational resources and their accessibility or deliberate denial to different groups may either address or heighten existing social inequalities. Equity and inclusiveness are critical issues and are indicators for those seeking to ensure service delivery (Vaux & Visman 2005). Thus, this argument assumes inequity and inequality as the main drivers of conflict.

The full context and the variety of causes of conflicts should be considered because inequality is only one of the many possible causes of conflict (Whaites 2008). When conflicting issues, such as inequity and inequality, affect the provision of healthcare services, they may be alleviated by such strategies as strengthening pro-equity policies and planning, improving providers' capacity to provide health services and reducing access and participation barriers for excluded groups (Bornemisza *et al.* 2010). These recommendations are important because promoting communication about family planning can allow couples to make informed decisions together. In one study, couples who were encouraged to discuss their fertility intentions in the early stages of marriage had greater control over their fertility and could achieve their intended family size (Kamran *et al.* 2011).

As the primary studies demonstrated, the men who used contraceptives overcame strong obstacles. The main obstacles were beliefs regarding some contraceptive methods, a lack of knowledge about and negative experiences with contraceptives, and difficulties related to healthcare access and providers. Mistik *et al.* (2003) also reported a variety of reasons the men cited for not using contraceptives. Their main reasons were fear that contraceptive use would undermine their authority as head of the family or would encourage their wives to be unfaithful; that their religious beliefs opposed contraceptive use; a fear of harmful side effects from contraceptives; and the desire for a large number of children. These findings demonstrate that men's concerns about contraceptives should be identified and approached when delivering family planning services. For example, when healthcare providers discuss condom use, they should discuss the patients' deeply incorporated beliefs, as recommended by Ali (2002). One of the reasons Egyptian men did not use condoms was their belief that they could not

Table 2 Recommendations given by the primary researchers for practice, professional staff and further studies

Recommendations for clinical practice

To listen the sociocultural backgrounds in an attentive and nonjudgmental way and to identify their needs regarding reproductive health and family planning (studies 2, 4, 5 and 16)

To implement culturally meaningful health care and a meaning -centred model in reproductive healthcare facilities (studies 2 and 5)

To deliver a broaden family planning and sexual and reproductive issues in education for males, both during and beyond the school years, within existing training programmes within community health agencies (studies 4, 5, 7, 8 and 13)

To develop contraceptive counselling for young men in primary health settings (especially those men who have not yet fathered children) (study 16)

To height the interest in use of contraception postbirth for men with children (study 16)

To include issues related to gender relations and to attribute equal responsibility to men and women in questions regarding reproductive health and in the decision-making regarding contraception (studies 5, 8, 13 and 16)

To include both men and women in family planning services and education programmes (study 8)

To involve males in teaching other men about sex education through the lifespan (study 5)

To offer separate spaces to men in family planning services (study 8)

To address careful planned communication in family planning services (studies 7 and 8)

To deconstruct stereotypes regarding family planning (studies 9 and 13)

To consider the full context in which family planning decisions to design successful service interventions (study 9)

To increase the availability and access of family planning facilities in every localities and the direct contact between men and caregivers in such services (studies 5, 6, 8 and 16)

To incorporate discussion of family planning into all types of healthcare interventions, involving the multi-professional healthcare team (study 16)

Specific to contraceptive methods

Condom

To promote the pleasurable aspects in the use of condom (study 4)

To associate condom with other aspects of popular culture (i.e. music or fashion trends) to increase the use (study 4)

To improve partner communication around attitudes, and intentions may challenge unrealistic or idealised beliefs and strengthen males' role in pregnancy prevention (study 15)

Focus should be directed towards men taking responsibility for initiating and continuing condom use in a relationship rather than only in response to partner requests or then concerned about STIs (study 15)

To increase the use of this method through the males' greater awareness of the limitations of hormonal contraception, the potential challenges in maintaining effective use and to explicitly and mutually agree on contraceptive method choice (study 15)

To encourage greater ownership over birth control among men, educators and clinicians should redirect messages about condoms functioning only as a means to prevent disease, to one that equally prioritises the role of condoms in pregnancy prevention (study 15)

Vasectomy

To disseminate the positive experiences lived by other men to improve confidence in this method (study 2)

To offer regular schedule to ensure consistent levels of vasectomy service provision (study 8)

To establish links between vasectomy services and community outreach and mobilisation (study 8)

To provide adequacy in equipment and supplies stock in vasectomy facilities (study 8)

To offer systematic and clear instructions regarding the method (study 8)

To create mass media campaigns using physicians and satisfied clients to address myths and misinformation regarding vasectomy (study 8)

To promote attractiveness to the method through highlighting the economic benefits of smaller family size (study 8)

To increase the reputation and credibility of the provider and the hospital/clinic (study 8)

To provide an effective and less painful vasectomy to the users (study 8)

To include details about schedules, procedures and what to expect during and after the procedure (study 8)

To include the community in the process and long-term effects of vasectomy to avoid persistent rumours about the method (study 8)

Recommendations for professional staff

To adopt an reflexive attitude regarding the own beliefs and values about sexual and reproductive issues (study 5)

To avoid ethnocentric attitudes in delivering care and education (study 5)

To be prepared to moderate discussion about contraceptives (study 4)

To be trained to address the men's reproductive health needs (study 8)

Recommendations for further studies

To explore the links between attitudes inspired by faith and contraceptive practices among Muslim immigrants and refugees in other Western countries (study 1)

To explore the effects of religion on family planning practices (study 3)

To test ways to strengthen and support pregnancy prevention desires (study 4)

To elaborate and validate ways to increase the acceptance and use of condoms in the context of long-term relationships and more intimate relationships (study 4)

To explore the associations between relationship dynamics and contraceptive use (study 4)

To identify risks of sexual behaviour among tourists and trekking guides, and understand the power relationship between them (study 6)

To explore relevant themes from varied racial and ethnic groups and from varied geographic and socio-economic backgrounds related to men's role in contraception (study 7)

receive or give sexual pleasure when using one. These men believed that women received greater sexual pleasure when they felt the ejaculate passing into their bodies (Dudgeon & Inhorn 2004).

Regarding experiences with contraceptives, we observed that withdrawal, a method that has no scientific evidence to support its effectiveness as a contraceptive method, is being used by many men. Data collected in developing countries show that more than half of women between 15–49 years of age, or approximately 705 million women, are at risk of unintended pregnancy, and many of them were using withdrawal as a contraceptive method. The same study showed that 29% of women have unmet contraception needs. Consequently, an estimated 76 million unplanned pregnancies occur every year around the world. Ten million unplanned pregnancies occur among the 64 million women who rely on traditional contraceptive methods (United Nations Population Fund 2008). A study from Turkey also showed that 31·2% of women used withdrawal because it was their husband's preference (Yanikkerem *et al.* 2006). Yet, men are still not an important target group in most contraceptive programmes. This finding demonstrates that problems related to inadequate attention to men's roles in and their perspectives on birth control issues should be considered and addressed to increase their visits to health centres for birth control.

In particular, in traditional societies, it is very difficult to address these issues with the men (Yanikkerem *et al.* 2006, Rahnama *et al.* 2010). Consequently, health policy makers and healthcare providers must overcome this strong challenge. They must consider that withdrawal remains a method of choice for family planning in a number of developing countries, including those where modern methods for family planning are readily available. These findings provide insight into the complexity of the underlying decision-making processes and suggest that multidimensional interventions may be needed to reduce the rate of unintended pregnancy (Rahnama *et al.* 2010).

Many researchers from different cultural backgrounds have described the male-centred nature of gender relations in sexual and reproductive behaviours. A Brazilian study focusing on the cultural development of sexuality showed that male supremacy was symbolised in daily relationships, which sustain the social order and determine male domination regarding sexual behaviour (França & Baptista 2007). Such findings confirm the need for healthcare providers to understand their patients' cultural backgrounds, especially when private issues such as contraceptive practices are involved. Great caution was recommended to avoid applying religious, social and cultural stereotypes to people seeking contraceptive counselling. The possibility of non-correspondence between personal values, religious teachings and social/cultural norms was noted.

This study's findings highlight the male dominance in contraceptive decision-making. The existence of gender disparities has been shown by many researchers. Pirotta (2005) found that men usually use condoms for protection from sexually transmitted diseases (STDs) and AIDS, particularly during casual sexual intercourse. Nevertheless, contraceptive responsibilities typically fell to the women. The men's role in contraception was considered secondary (Rios 1993, Carvalho *et al.* 2001). When men accept contraceptive responsibilities, as in the vasectomy, they usually make their decision about the matter without seeking their partners' opinions. This specific behaviour corroborates with the attitudes of the women, who attribute to their spouses the responsibility for decisions about definitive contraception methods that determine the family size (Landry & Ward 1997).

Many men ignore the use of contraceptive methods or do not use them in a systematic way because they do not feel vulnerable to the consequences of an unplanned pregnancy. The men's numerous deep-rooted beliefs and values regarding different contraceptive methods may contribute to their contraceptive behaviours. Researchers have reported many reasons that men resist using contraception. The main reasons were fear of losing authority within the family context, fear of presumed collateral effects of contraceptive use, an association between vasectomy and the castration, the male condom's influence on sexual pleasure, an association between withdrawal and the reduction in spontaneous sexual intercourse (Ringheim 1993, Carvalho *et al.* 2001), a mistrust of the effectiveness of condoms and a perceived decline in virility and sexual pleasure after vasectomy (Landry & Ward 1997).

Regarding vasectomy, men around the world are not well informed about this method. They have a negative image of vasectomy, even when they had access to consistent information from healthcare providers or an acquaintance who had a vasectomy and was satisfied (Landry & Ward 1997).

Another important finding of this meta-synthesis was related to healthcare delivery. The major concerns were related to the limited availability of healthcare providers and healthcare services' lack of sensitivity to men's demands (Amaro 1988). The time available was considered incompatible with the male routine, and adequate information about male condom and vasectomy was not available. Furthermore, male sexuality was not discussed with adequate complexity or depth (Carvalho *et al.* 2001).

Relevance to clinical practice

This synthesis of qualitative research highlights healthcare providers' key position in meeting men's needs regarding contraception and family planning. The study could contribute to future advances in developing the body of knowledge needed to address this complex issue and broaden the understanding of families' sociocultural backgrounds and the subjective aspects of contraceptive use. This type of description of men's experiences with contraception might also improve health care by influencing clinical practices – particularly nursing interventions – in the reproductive healthcare field. The following recommendations were reported.

Healthcare providers must increase their communication skills to understand families' social and cultural backgrounds in healthcare settings. In doing so, it may be possible to identify the men's needs concerning reproductive health and family planning in an attentive and nonjudgmental way. It is also necessary to broaden family planning and sexual and reproductive education for males, both during and beyond the school years. In this way, the primary healthcare team can equip itself with knowledge about the appropriate framework for managing contraceptive counselling for young men. To this effect, it is also important to increase the interest in postbirth contraception for men with no children. Healthcare providers need to incorporate family planning discussion into all types of healthcare settings and involve the entire health team. The professionals can provide adequate spaces within the healthcare services to unite the family and carefully promote opportunities to discuss family planning methods with both women and men. Such interventions can include issues related to gender relations and discussions about equality in men and women's responsibilities for reproductive health and family planning issues.

We emphasise the need to address these recommendations in a complex and articulate way for public policy making and the development of public health practices focused on sexual and reproductive health.

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Contributions

Study design: LAKH, JRCR, MCMM, ALVB; data collection and analysis: LAKH, PMS, JRCR, MCMM, ALVB and manuscript preparation: LAKH, JRCR, ALVB.

Conflict of interest

The manuscript has been submitted solely to the journal and that it is not published, in press, or submitted elsewhere. We do not have any conflict of interest.

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