Introduction:

Gender inequity has been closely linked with the vast unmet need for family planning (FP) among women in sub-Saharan Africa (SSA). In this region, male partners have been cited as considerable obstacles to women's FP use due to their disapproval or opposition, and their lack of support for contraceptive use has been found to be shaped by gender and social norms regarding women's reproductive responsibilities and men's decision-making authority. In order to successfully promote gender equity and involve men meaningfully in sexual and reproductive health, it is critical to understand how men respond to changing gender relations, particularly within their sexual relationships. This qualitative study was undertaken to understand men's perspectives of gender roles and cultural norms and how these shape men's responses to FP. Few studies have explored barriers to male involvement in FP in SSA from the perspectives of men themselves.

Methods:

Twelve focus group discussions (FGDs) were held with married men (n=106) in two districts (one rural and one peri-urban) in Nyanza Province, Kenya in May-June 2013. This region of Kenya has the largest percentage of married women with an unmet need for FP in the country (32%) and one of the highest fertility rates in Kenya (5.4). The HIV prevalence in Nyanza is 15.1% among Kenyan adults aged 15-64 years compared to 5.6% nationally. Kenya continues to report high rates of unintended pregnancy and low contraceptive prevalence, despite efforts over the past three decades to improve FP access and provision.

The FGDs were conducted in the local Dholuo language in a private room at a clinic or community center and were led by a trained local male facilitator and a note-taker. The interview guide included sections about individual and community perceptions regarding male approval of FP, barriers to male FP involvement, and potential intervention strategies to address these barriers. Between eight and ten men attended each FGD. About one-half of the sample was recruited from HIV clinics through a convenience sample of male HIV+ patients ages 18 and over who were married. The other one-half of the

sample was recruited from the general community through a convenience sample of eligible men without documentation of HIV status. Recruitment was done to maximize variation of the sample. The mean age of the participants was 36.8 years and their mean number of children was 3.3. Eighty-eight (83.0%) of the participants reported one wife at the time of the study, and 18 (17.0%) reported two or more wives.

Extensive field notes were taken by the note-taker and facilitator during and after each FGD, which were analyzed by the study team using content analysis to uncover major themes and develop a coding scheme. Codes were reviewed by the Kenyan team for confirmation and discrepancies in coding were discussed and resolved amongst the team.

Results:

Many participants felt that gender roles were shifting, making the definitions of manhood and womanhood more tenuous than in the past. Men's previous identities as sole breadwinners gave them significant control over decision-making within their families; however, this authority was being undermined by their wives' increasing labor force participation and subsequent financial contributions to the household. The threat of women's new power at the societal and relationship levels was further accentuated by contextual factors, all of which heightened men's fears of being unable to meet traditional male obligations. Notably, men reported facing high rates of unemployment and the loss of job security, as well as the persistent threat of the inability to work due to HIV-related illness.

The weakening of their household decision-making authority affected men's overall sense of status and worth. Many participants believed that the partner who made the most money also had the most power within the couple. A couple's sharing of financial and household decisions and tasks was not regarded favorably because it reduced men's power. This left men fundamentally unsure about who they were within the household and community. Such uncertainty could provoke fear, anxiety, and anger regarding women's newfound status in society. Importantly, men observed that women were experiencing a heightened position in society at a time when they felt men were facing unemployment and challenges to their male roles, creating a sense that men's authority was clashing with women's rights. Some participants felt they had to compete with women for power within the relationship and household. They

also felt that others in their community believed some men had been "overpowered" by their wives, which they deeply resented.

Shifting gender roles not only threatened men's status in relation to women, but also influenced how they compared to other men in their communities. Men whose wives had more say in household or relationship matters were judged by other men as being controlled by their wives. Some participants also opposed vasectomy due to fears of being unable to fulfill their responsibility of fathering future children, which could encourage a wife to find another man who would.

In this context of shifting gender relations, participants' discussions regarding FP predominantly reflected fears regarding male gender roles. Despite widespread acceptance of FP, participants largely focused on the negative consequences of FP use, particularly the anticipated impact on female sexuality. Prominent fears about women's increased sexual freedom and promiscuity linked to contraceptives' effect on libido may have been amplified by men's perception of eroding decision-making dominance within the household and relationship. Women's FP use could be viewed as another way in which men were being displaced. Thus, while most participants felt that couples should ideally decide on family size together, the majority believed men should ultimately retain control over FP decisions.

Discussion

Our findings underscore the need for healthcare providers and program planners to take into account men's gender-related beliefs and how these relate to FP. Scholars have pointed out that the pressures on masculinity introduced by contextual factors could provide useful entry points for engaging men in gender equity. To better involve men in FP, providers could highlight the positive implications of FP use that would resonate with them, such as the financial benefits of smaller families. Increased FP education for men is also needed to help dispel misconceptions regarding FP use, including potential side effects. Given the significance of gender relations between men, community leaders and male outreach workers could be called upon to serve as role models that actively promote male engagement in FP. In our study, participants generally agreed that family size decisions should be made jointly, particularly because it reduced relationship conflicts. Capitalizing on these beliefs, more male-centered programs could help

shift men's approval of joint decision-making around family size to other reproductive domains, such as FP. It is important to continue to foster that sense of gender equality to garner male support for FP by focusing on ways to successfully engage men rather than blame them for gender inequality or see them exclusively as barriers to women's reproductive rights.