

**ATTITUDES AND PERCEPTIONS OF MALES TOWARDS CONTRACEPTIVE
SERVICES IN ENGELA DISTRICT OF OHANGWENA REGION, NAMIBIA**

By

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(ALGALE001)

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List of Abbreviations and Acronyms

CDC	Centers for Disease Control and Prevention
DCC	District Coordinating Committee
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
FGD & KII	Focus Group Discussion and Key Informant Interview
MCH	Maternal and Child Health
MGECW	Ministry of Gender Equality and Child Welfare
MoHSS	Ministry of Health and Social Services
NAPPA	Namibia Association of Planned Parenthood
NDHS	Namibia Demographic and Health Survey
NPC	National Planning Commission
REPC	Research, Ethics and Publication Committee
STIs	Sexually Transmitted Infections
SSA	sub- Saharan Africa
UCT	University of Cape Town
UN	United Nations
UNFPA	United Nations Population Funds
WHO	World Health Organisation

Definition of Key terms

Family Planning: the practice of controlling the number of children one has and the intervals between their births, particularly by means of contraception or voluntary sterilization.

It allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. (World Health Organisation [WHO], Family planning /contraception, 2017).

- Contraception/Contraceptive: They are methods or devices used to prevent pregnancy; also called birth control (Difference between birth control and contraception, 2010).
- Knowledge: Facts, information and skills acquired through experience or education; the theoretical or practical understanding of a subject (Merriam-Webster Dictionary, 2017).
- Attitude: Manner, disposition, feeling, position regarding a person or thing; tendency or orientation especially of mind (Merriam-Webster Dictionary, 2017).
- Perceptions: The act or faculty of perceiving, or apprehending by means of the senses or of the mind, and cognition (Merriam-Webster Dictionary, 2017).
- Practice: Repeated performance or systematic exercise for the purpose of acquiring skill or proficiency (Merriam-Webster Dictionary, 2017).

Declaration

I, ALEXANDER ADEDOTUN ALAGBA hereby declare that this dissertation for the M.Phil.(MCH) degree at the University of Cape Town hereby submitted by me has not been previously submitted for any degree by any other student, known or unknown to me at this or any other university to the best of my knowledge.

I also declare that this dissertation is my original work in design and execution and that all materials and references contained herein have been duly acknowledged.

The University of Cape Town is empowered to reproduce either part or the whole work for the purpose of research and training in any manner deemed fit.

Signed by candidate

.....

SIGNATURE

17th February 2018

DATE

DEDICATION

This work is dedicated to the Almighty God without whom it would not have been possible. I dedicate this work to the Alagba Family—past, present and yet to be born.

For those that have gone, I appreciate your efforts to make me who I am today.

For those present, thank you for your support and assistance in helping me to achieve my goal.

For those ones yet to be born, welcome to the Royal family. Ours is a family of achievers and let this be imbibed by you that you are victors.

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Abstract

Introduction

In sub-Saharan Africa the unmet need for contraception for married couples is estimated to be 24%, with rural, uneducated, poor women generally experiencing a greater risk for unplanned, unwanted pregnancies compared to their urban, educated, well informed counterparts. Recommendations for addressing unmet contraceptive need are inclined to emphasise family planning programmatic efforts. The role of men in contraceptive decisions tends to receive less attention, the perception being that men are often uninvolved and unsupportive of the contraceptive needs of their female partners. This study reviewed the attitudes and perceptions of men about contraceptive services in Engela District of the Ohangwena Region, Namibia.

Methods

A qualitative study was conducted using Focus Group Discussions (FGD) and Key Informant Interviews (KII) with men and women aged between 18-60 years residing in the Engela district of the Ohangwena Region. Men and women were purposively selected and participated in four and two focus group discussions respectively to explore the subject. Interviews with six influential and respected key informants, including government officials and community leaders were conducted. Data generated from the interviews were transcribed, coded, and content analysis conducted. Based on the research domain, themes and subthemes were generated.

Purposive sampling was done. Many people were contacted to participate as participants in the research, some declined from participating due to lack of interest, and it was only those that were

keen on participating that were enlisted by the research assistants. Influential leaders, respected in the community were also selected as KII.

Results

The findings revealed that specific reproductive health issues are common in the community, with a high level of awareness of family planning and contraceptives among men and women, many women having access to contraceptives Yet men held negative views about women's decision to use contraceptives without their consideration and approval by them. The results indicated that community-level information was not ideal, and should be improved.

Conclusion

The study showed that most of the men who participated in the study are well informed about family planning and available contraceptive options for both men and women. **It also revealed the attitudes and perceptions of men to FP and contraception use of women.** However, there is little male involvement in contraceptive decisions.

CHAPTER 1

INTRODUCTION

1.1 Introduction

Sexual and reproductive health is significant as it influences the wellbeing of women, men and children. Through sexual intercourse, many women become vulnerable to sexually transmitted infections (STIs), and human immunodeficiency virus (HIV). Many women become victims of gender-based violence losing their freedom and rights to men. Sexual intercourse may also lead to unwanted pregnancies and unsafe abortions (International Planned Parenthood Federation, 2015). Reproductive health, if and when discussed openly by both parties, implies behavioral responsibility and a willingness of people to facilitate satisfying and safe sexual experiences, while reducing their risk of contracting STIs or unplanned pregnancies. It also demonstrates the capacity of individuals to freely decide when and how often they want to reproduce (International Planned Parenthood Federation, 2015). Traditionally, family planning services refer to programmes aimed at regulating the number and spacing of children in a family through the practice of contraceptive use or other methods of birth control (American Heritage Dictionary, 2009). In general, family planning services provide a comprehensive package of care that includes the provision of information, screening for STIs and the provision of various contraceptive methods, namely oral contraceptives, injectable contraceptive methods, barrier methods including condoms, and surgical methods including sterilization (World Health Organisation [WHO], 2012). These services are intended to help couples or individuals reach their reproductive goals. However, reproductive health is a broader concept of family well-being, not merely the provision of family planning for the purpose of limiting the number of children the couple will have (Davis et al., 2016). Access to reproductive health and specifically

contraceptive services guide reproductive decisions and choices relating to the prevention of unwanted pregnancies, decreasing high risk pregnancies, taking precautions to prevent STIs, seeking treatment for STIs when necessary, and screening for cervical cancer (United Nations Population Fund [UNFPA], 2015).

The Government of the Republic of Namibia provides no-cost family planning services at all health facilities in the country (Namibian National Health Policy, 2010). There are scheduled outreach services in all the regions to reach areas far from the health facilities and school health program to many of the schools to educate learners about health issues, including contraceptives and family planning. Family planning services and counseling are also available at government-run youth and recreation centers in many towns across the country (Namibian National Health Policy, 2010). The private sector, including civil society organizations such as Namibia Planned Parenthood Association (NAPPA), provides contraceptives and counseling services to the public. Namibia has a mostly youthful, vibrant and sexually active population with 37 percent of the population being under the age of 15 years (World Bank, 2010) and one in six women aged 15-19 years have already started childbearing (Namibia Demographic and Health Survey [NDHS], 2006/07). The Ministry of Health and Social Services (MoHSS), in a survey conducted in 2007, reported that 37 percent of Namibian women had experienced sexual intercourse by the age of 18 years, rising to 61 percent by the age of 20 years. Although knowledge of modern contraceptives among these women was more than 80 percent among female adolescents, contraceptive use was very low. In a study conducted by Zealand in the Erongo region of Namibia in 2008, only 11 percent of sexually active females aged 15 to 19 years reported using modern contraceptives (Zealand, 2008). Research conducted by Gockel-Frank (2009) in Khorixas, in the Kunene

Region of Namibia, showed that the majority of women practiced contraception inconsistently and this leads to unplanned/unwanted pregnancies. (Gokel-Frank Martina., 2009).

Fertility desires and choices are informed by several interactive forces, including socio-economic, biomedical, cultural, and political factors (King et al., 2011). Researchers have explored the knowledge and attitudes about FP, and demographic and sociocultural factors, such as level of education, spousal communication and cultural practices, that influence contraceptive use (Zeyneloghi et al., 2013; Saluja et al., 2011). Although contraceptive decision-making should involve both men and women, there is a tendency for women to take sole responsibility for contraceptive use. Family planning services inadvertently endorse this bias by focusing information and methods on women (Saluja et al., 2011). Men have five birth control choices: abstinence, withdrawal, condom, vasectomy and outer-course (Cullins, 2013). By comparison, women have multiple options: abstinence, natural family planning methods, barrier methods, hormonal methods, and implantable devices such as implanon and nexplanon, permanent methods including sterilisation, emergency contraception and abortion (Cullins, 2013; Centers for Disease Control and Prevention [CDC],1999). It is important to point out that the significant role of men in contraceptive choice and reproductive health decision-making (Mboane & Bhatta., 2015; Nanda et al., 2013). Condom use for contraception, calls for cooperation from both partners. When male partners are involved in decision-making about hormonal contraceptive use, there appears to be lower discontinuation rates (James-Hawkins & Broaddus, 2016). Male involvement in reproductive health helps to expand the range of contraceptive options, supports women's contraceptive use, and prevents the spread of STIs. Greater male involvement would result in a range of benefits for maternal and child health, primarily through greater access to services and interventions for women and children (Davis et al., 2016).

Men in Namibia enjoy and exercise considerable decision-making power in the sociocultural sphere, and their participation in sexual and reproductive health can deliver enormous benefits to everyone concerned. A male involvement project, supported by the UNFPA designed to encourage partnering and gender equity in areas of sexual and reproductive health was initiated during 1997-2001[Phase 1] and 2002-2005 [Phase 2] (Dairo & Shigwedha, 2001). The project grew out of research conducted in Oshakati town and in the Northwest Health region by the Ministry of Health and Social Services (MOHSS) and UNFPA to explore the perspectives of men about contraceptive services. The survey reported that 70% of men surveyed never used any family planning method, had limited knowledge about contraceptive methods, and were not inclined to use contraceptive methods themselves (Dairo & Shigwedha, 2001). The researcher's interest in the subject was motivated by his observations concerning access and utilization of family planning services mainly by women in his practice environment.

1.2 Background

The availability of a variety of contraceptive methods at public health facilities, combined with the availability of contraceptive information, should render contraceptive use an uncomplicated lifestyle choice. Despite these available options, contraceptive use is unfavorable. As a result, unintended pregnancies remain high and rates of STIs and HIV continue to rise. Global data shows that an estimated 210 million women become pregnant each year and about two-thirds or approximately 135 million pregnant women, deliver live infants (WHO, 2011). The remaining one-third of pregnancies is believed to culminate in stillbirths, miscarriages and induced abortions. It is estimated that one-quarter of all abortions in Africa are among teenagers aged 15 to 19 years (WHO, 2012). There are at least 42 million induced abortions each year, many of which are linked to unplanned and unwanted pregnancies (WHO, 2012). Often women

with unplanned pregnancies attempt abortion, contributing to approximately 42 million induced abortions (WHO, 2011). Abortion being illegal, one can presume that Namibia contributes substantively to the 20 million abortions performed in unsafe and unsanitary conditions by predominantly unskilled attendants. Unsafe abortions constitute a significant health risk and are linked to the deaths of an estimated 68,000 girls and women annually. This represents about 13 percent of all pregnancy-related deaths (WHO, 2011). An analysis of the Demographic and Health Surveys (DHS) in 20 countries in sub-Saharan Africa (SSA) from 1994 to 2008 found the mean induced abortion rate to be 13 per 10 000 women (Bendavid, Avila & Miller, 2011).

The total fertility rate (TFR) for Namibian women is 4.3 children in rural areas and 2.8 children in urban areas (Namibia Demographic and Health Survey [NDHS], 2006/2007). In comparison, the total fertility rate for Botswana, a country in the same region with an estimated population size similar to Namibia, is 2.3 births/woman (Botswana total fertility rate, 2016). In Botswana the contraceptive uptake was found to be 52.8% while the contraceptive uptake in Namibia was 53%.

In the Ohangwena Region, 10% of women aged between 15 to 19 years of age become pregnant with their first child (Namibia Demographic and Health Survey [NDHS], 2006/2007). Contraceptive use increased from 23% in 1992 to 46 % in 2006/2007. Modern contraceptive use in the Ohangwena Region is 53% (NDHS 2006/2007). Unless medically indicated abortion is illegal in Namibia, therefore the actual abortion rate is unknown. The number of hospital-registered abortion cases in Engela district hospital between January-December 2012 was 112 (Engela District Annual Report, 2012). In the Ohangwena Region, the stillbirth rate is 75 per 1000 live births (Ohangwena Region Annual Report, 2011-2012).

It is important for women to have access to adequate family planning information and services in order to control their own fertility. In Namibia due to gender roles and male power, the privileges of males are often final. In Namibia 47% of women aged 15-49 years have access to modern forms of contraception (NDHS, 2013). However, significant regional differences in access have been noted ranging from a low of 28% in Ohangwena region to a high of 60% in Erongo region. Sexual and reproductive health in Namibia is characterised by various problems including the shortage of skilled personnel, inadequate referral facilities, limited availability of integrated reproductive health care, difficult geographical access, socio-cultural barriers to acceptance of reproductive health services especially among men and oppression of female reproductive rights and sexual freedoms (NAPPA Strategic Plan, 2010-2014). Other factors inhibiting access to contraception include lack of confidentiality due to lack of space in public health facilities, poor interpersonal communication and interaction between service providers and clients, and frequent shortages of family planning commodities and medications for STIs (NAPPA Strategic Plan., 2010-2014).

Globally there is greater emphasis on improving male involvement in sexual and reproductive health programs. The Cairo International Conference on Population and Development (ICPD) Programme of Action (1994) actively encouraged male participation in reproductive health, urging that:

“... special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal child health; prevention of sexually transmitted infections, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes” (ICPD 1994, paragraph 4.27)”.

In 1997 the Namibian government introduced the gender policy to improve equality between men and women. The purpose of this policy was to promote equality and equitable socio-economic development of women and men and the well-being of children. Despite this positive move, significant cultural practices that mitigate gender inequality continue. For example, men do not recognise rape within marriage and feel entitled to beat their wives into submission. Beating is often associated with suspected infidelity, refusal to have sex, and discussion of family matters with outsiders. Male adultery is tolerated and men beat women when confronted about extramarital affairs (Dairo & Shigwedha, 2001). Thus, involving men as equal partners in reproductive health services has remained a challenging task.

In Namibia, the government along with some donors **PEPFAR and WHO** introduced a male involvement program in 2009. This program was to encourage males within health professions, church leaders, **community leaders and politicians were proactively involved in the** health care of their spouses and their family, including activities related to pregnancy, child care and family planning. No previous studies have been examined male involvement in contraceptive choice and use in the Engela community. Understanding patterns of contraceptive use, specifically the perceptions and contraceptive behaviors of men in Namibia is a key to developing approaches to increase effective contraceptive use and improving health outcomes for women. It was thus of interest to the researcher is to conduct a study in this community to better understand the knowledge, attitudes and behavior of males in the Engela community regarding their role in contraceptive use. Report on a study on awareness, attitude and participation rate of men in family planning program in Iran was noticed not to be good but men's attitude was acceptable. It was also concluded in the study that the knowledge and practice

of men about family planning needs to be increased by educational programmes (Bani et al., 2014).

1.3 About the researcher

The researcher is a family physician practicing in a rural area in Namibia. He noticed the frequency with which women of different ages, cutting across different socio-economic and educational levels, consulted him for contraceptives. **Women routinely requested support in initiating family planning or for follow-up of already prescribed family planning recommendation.** Other women, on several occasions, presented to the clinic in tears and seeking assistance with abortion, which is illegal in Namibia. Often the male partners of the women deny responsibility for the pregnancy and refuse to support them financially and emotionally. The questions that arise are: “Where are the men? Why are men leaving this important issue in the hands of the women alone?” These questions continue to disturb him; hence he decided to explore these questions to find answers, if possible, through this study.

1.4 Justification for this study

Contraceptive use as presented in Engela district’s annual report shows a dramatic 85% coverage, but this is only for women’s visit/use. Condom distribution could not be monitored adequately (Engela District Annual Report, 2012). Considering the important role that men play in families and communities, their participation in family planning and contraceptive decisions can potentially contribute to the health and wellbeing of women in Engela District by advancing contraceptive uptake. Increased male involvement could potentially reduce the number of unwanted pregnancies and sexually transmitted infections and HIV, and thus improve the health outcomes of women and children. Additionally, if men felt a greater sense of involvement in the reproductive health decisions of which contraceptive use is one, it could foster healthy family

relationships, empower women, improve gender equality. Moreover, it would facilitate safer motherhood while also encouraging the practice of responsible fatherhood as men would be more involved in maternal and child's programs.

In Ohangwena district, very few to no studies or surveys have been carried out on this subject; hence more in-depth studies can yield insight into the complex interactions, specifically the values, perceptions and attitudes of men, that informs contraceptive decision-making and use.

1.5. Study Purpose

The aim of this study was to explore the attitudes, perceptions and experiences of men in the Ohangwena rural area of Engela District in the Ohangwena region of Namibia about sexual health and contraceptive use, and their involvement in reproductive health decision making.

By understanding the reasons, attitudes and behaviours of men with regard to contraceptive use, this research aimed to contribute to improved male participation in contraceptive use.

1.6 Research Questions

The study sought to answer the following research questions:

- What do men in the Ohangwena rural area of Engela District know about available contraceptives?
- What are men's attitudes, perceptions and experiences towards contraceptive use?
- How supportive are men in the contraceptive decisions and choices of women in Ohangwena Rural area of Engela District?

1.7 Study Aim and Objectives

General Objective

The general objective of this study was to explore the attitudes and perceptions of males to contraceptive services in Engela district of Ohangwena Region, Namibia.

Specific objectives

1. To gain insight into men's knowledge and perceptions on contraceptive use in Ohangwena rural area of Engela district in Ohangwena region, Namibia.
2. To assess the role men in Ohangwena rural area of Engela district play in contraceptive decision making of their spouses.
3. To explore innovative ways and strategies to enhance male involvement in reproductive health services.
4. To assess the contraceptive needs of men in Engela district.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The main purpose of this chapter is to place the study in the context of existing studies on the same topic. The chapter presents an overview of published documents pertaining to males' attitudes and perceptions regarding contraceptive services. It also reviews factors that influence males' attitudes and perceptions to contraceptive services. A literature review was conducted to explore the evidence and opinions regarding attitudes and perceptions of males to contraceptive services. The information gathered was used to justify the investigator's research question, to substantiate the need for further investigation, and identify existing interventions that could be adapted for this population. The review was aided by Google Scholar, PubMed, Medline, WHO, and the Ministry of Health and Social Services. The following search terms: "reproductive health", "contraceptives", "family planning", "male involvement", attitudes and perceptions of contraceptives" were used during the review.

2.2 Importance and benefits of contraception

Contraceptives are helpful in preventing unwanted pregnancies and offer some protection against STIs and HIV. Contraceptives are effective in improving the socioeconomic conditions of people as they enable users to control child bearing (Zeyneloglu et al., 2013). One of the easiest and most cost-effective ways to empower women and increase their quality of life is to make sure they have access to birth control. Women who maintain independence and control over the timing and conditions of their childbearing have greater opportunities for better education, more job opportunities, and greater economic security. It is believed that the entire country benefits economically when women have access to contraceptives and can participate in

the workforce (PAI, 2014). The Alma-Ata Declaration on Primary health care impressed on all nations and governments the need to make health care to all people affordable, accessible and within the cultural context of the people (WHO, 2008). In the same declaration the importance of making family planning available to the people was emphasized. Many countries, especially in the developing world are not making progress in the area of family planning and contraceptive use. Between the early 1960s and 1998, fertility rates in the developing world have only declined from 6.1 to 3.3. The sharpest declines occurred in East Asia--from 5.9 to 1.8--and Latin America--6.0 to 3.0. High fertility can impose costly burdens on developing nations. It may impede opportunities for economic development, increase health risks for women and children, and erode the quality of life by reducing access to education, nutrition, employment, and scarce resources such as potable water. Furthermore, surveys of women in developing countries suggest that a large percentage--from 10 to 40%--want to space or limit childbearing but are not using contraception. This finding indicates a continuing, unmet need for contraception (Darroch, Sedgh & Ball, 2011). To some extent this can be attributed to the non-committal attitude of men (Zeyneloglu et al., 2013). In most African countries, most men rely on their partners for the use of contraceptives, linking the refusal of the use to their lack of knowledge on the matter (Adongo et al., 2013). It is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable contraceptive methods of their choice. Additionally, both men and women should have the agency to choose their preferred method of birth control and should be granted the right to access appropriate health care services that will support a healthy and safe pregnancy and childbirth a (United Nations [UN], 1995). The landmark Declaration, adopted by the United Nations General Assembly, reaffirms that “All human beings are born free and equal in dignity and rights” and that “everyone is entitled to all the rights and freedoms set

forth in the declaration, without distinction of any kind, such as race, color, sex, language, religion, birth or other status” (Universal Declaration of Human Rights (UDHR), 1948). The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is the only human rights treaty which affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations (UN General Assembly, 1979).

2.3 Male Involvement in Family Planning and Contraception

In many countries, women carry the burden of preventing unwanted and unplanned pregnancies without the support of their partners. This is because power structures and gender inequality make it difficult for women to negotiate safer sex with their partners and exercise their sexual rights (Davis et al., 2016). The violation of women’s sexual rights leaves the woman to bear the outcome of the problem alone. This may eventually lead to unwanted pregnancies and STIs (Davis et al., 2016). This resulted in past family planning programmers mainly directing the program towards women (Blackstone & Iwelunmor, 2017). Secondly, most modern family planning services were offered at maternal and child health as women had to take their babies to the clinic, and to reduce maternal and infant mortality through the use of modern methods of contraceptives (Onasoga & Ekanem, 2013).

Absolute reliance on contraceptive methods for men has fallen off dramatically since the advent of the birth control pill. Women have long been the almost exclusive focus of international family planning and reproductive health programmes (Family Care International (n.d). Some family planning programs viewed men as a difficult group to work with in reproductive health and therefore concentrated on providing the programs to women. This has contributed to dissatisfaction amongst women with the lack of male involvement in the issues of

family planning. Family planning programs have been predominantly directed towards women perhaps because women bear children and there are more contraceptive options for women than for men, hence family planning services have been offered in maternal and child health clinics and family planning outlets which are predominantly set up for women (Kabagenyi et al., 2014). Yes, this could be a reason. Yes. This is true in some cultures and all these contribute to patriarchy leading to gender-based violence.

Contraceptive services are free of charge at public health facilities so that any woman can visit any clinic requesting contraceptive pills, and they are given without any consent of their partners as in line with the human rights approach to family planning services (Population Reference Bureau, 2015). This contravenes the spirit of oneness of the couple as women are seeking contraception care without their partners' knowledge and approval. Egocentric/masculine nature of men lead to this and the upbringing and cultural belief in some areas that a male child should have authority over the female sex.

It is uncommon for men to accompany their pregnant partners to clinic visits in the public health services and for contraceptive services. Yes, men are not held accountable. Some men take this pregnancy period as a time of freedom to stay away from their partners (Adongo et al., 2013). For this reason, men tend to ignore the programme. This notion, created a long time ago, needs to be revisited for both partners to see the programme as being a joint responsibility. Women cannot achieve gender equality and sexual and reproductive health without the cooperation and participation of men. Family planning services should help both men and women reach their reproductive health goals (Argago et al., 2015).

In many developing countries the decision to use contraceptives, and the choice of a particular contraceptive method, very often depend on the approval of the husband (Argago et al., 2015). Unfortunately, men are generally cold toward family planning services and many men are not aware of what or which family planning methods their spouses are using. In some cases, it is so bad that many men are unaware if their partners are using any family planning method. To some men, women who use family planning are tagged as “unfaithful and cheats” (Matlala, 2010).

In order to be successful, family planning programmes must also involve men. Additionally, health workers should be trained in counseling men about safer sexual practices, communicating accurate information, and educating men male methods for controlling conception and STI transmission (Dehlendorf et al., 2010). Men should also be involved in encouraging their wives to visit the available reproductive health care facilities. With the recognition of men’s dominant role in many societies and their influence on women’s contraceptive use and reproductive decision-making, decision makers of population and development programs have increasingly been promoting the idea of male involvement (Davis et al., 2016).

2.4 Factors Influencing Family Planning and Contraceptive Decision Making

Complex interrelated factors such as Psycho-social, Cultural, Environmental, Biological, Religious, and Educational inform contraceptive decision-making and use.

2.4.1 Psychosocial Factors

A variety of factors influence and are associated with health and longevity, including economic status, ethnicity and access to care of both men and women (Thorpe Jr, 2013). In sub-Saharan Africa (SSA), gender roles and norms are very important, resulting in decisions about the acceptability and the use of family planning and other devices, and the issue of masculinity plays an important role in this. Masculinity is defined as a set of characteristics, qualities or roles which are generally attributed to men (Van Haven & Hopkins, 2009). To most men masculinity or manliness is reflected in being able to take care of oneself, being tough, strong and healthy; emphasis on competition; devaluation of women and engaging in violent and risk taking behaviours (Fazli Khalaf et al., 2013). Men, who generally know little about the use of family planning, and who do not use them are often the primary decision-makers regarding family size and their partner's use of family planning methods (Adelekan et al., 2014). Opposition from male partners is regarded as stemming from patriarchal African cultural settings which empowers men as the sole and final decision makers for the family. Men are often placed in dominant positions due to their patriarchal privilege (Adongo et al., 2013). Societal expectations about what it means to be a man generally gives power to men to influence and determine the reproductive health choices of women. This is inclined to render women vulnerable in the sense that they have diminished ability for protecting themselves from unwanted and unplanned pregnancies, STI's and HIV (ESHRI Capri, 2014). Men often have economic power over their female partners. In many African settings men are the sole bread winners providing for their families. They are looked upon for most of the family needs and upkeep. This role creates in men the "almighty providers" in all matters affecting the family including family size, spacing of children and contraceptive use (Krug, 2017). Power is might in men and they try as much as

possible to cling to this self-assumed power in all realms of the family setting. They fear losing control if they share decision making and discuss reproductive goals with their spouses (Kругu, 2017). There is the tendency for men to view this as a weakness and this perspective makes men avoid dialogue with their spouses on many issues, especially regarding family planning (Matlala, 2010). The underlying belief is that accepting and participating in family planning programs will be watering down their power (Adongo et al., 2013). For women on the other hand, gender inequality often manifests in sexual coercion, reduced negotiating power and partnering with older men, all practices that heighten risks for HIV infection (Chiver et al., 2013).

Even when a man sees a reason to want to own up to the ideas of his partner, he will be afraid of his friends, extended family members and the community, that they will laugh and ridicule him, hence refusing to consider sharing knowledge and information with his partner on the issue (Matlala, 2010).

Gender stereotypes are issues used by the society in the construction of gender, and these are generally believed to be typical either of women or men (Brewer, 2016). Gender-based stereotypes put men and boys under social pressure such as the strongly endorsed health-related beliefs that men are independent, self-reliant, strong, robust and tough (Fazli Khalaf, 2013). In this way, men use health beliefs and behaviours to demonstrate dominant and hegemonic masculine ideals that portray them as men but which on some occasions may prove detrimental to their health.

The desire for many children is driven largely by economic, sociocultural, egoistic and religious factors (Matlala, 2010). In many African settings, community norms promote large families; hence the idea of contraceptive use may appear to be incongruent with societal norms.

It is regarded that the more children a man has demonstrates his power and prowess. Men always want to look to their children for support and assistance in old-age hence, limiting the family size is not considered. These factors contribute to polygamy, in preparation for old-age (Adongo et al., 2013).

2.4.2 Financial Factors

Financially, in many African settings, men are the sole breadwinners of the family (Mtshali, 2016). Women are mainly financially dependent on men, thus financial status is a key factor in men determining the number of children to have, who to marry, and what **women** should do. Women have little or no say in the affairs of the family because the man controls the purse of the family.

The United Nations expert group on women and finance estimated that women constitute 70 % of the world's population living on less than a dollar a day. Women tend to have less education and have fewer job opportunities. These influence their maternal health seeking behavior and maternal health outcomes.

2.4.3 Cultural Factors

Cultural factors play a significant role in sexual and reproductive health practices. Giddens (1989) defines culture as, “the values the members of a group hold, the norms they follow, and the material goods they create” (p. 29). Cultural norms are behavior patterns that are typical of specific groups. Such behaviors are learned from parents, teachers, peers and many others whose values, attitudes, beliefs and behaviors take place in the context of their own organizational culture. Some norms are healthy while others are not. Often some norms are strongly ingrained in an individual's daily belief that he/she may be unaware of certain

behaviors. The impact or effect of the norm may only come to light when such beliefs are compared to different cultures (North Central Regional Educational laboratory [NCREL], undated]. African culture creates an environment of male dominance in which a male child is looked upon as a leader, a commander and the head of the family. African culture gives power to the male child in all spheres of life. The girl child is to be seen and not to be reckoned in African context. These egocentric beliefs tend to be ingrained into the mindset of all males and its influence is reflected in family planning service utilisation in the district (Matlala, 2010). Men feel that they should be responsible for women's behaviour and that women have no right to make decisions for themselves (Argago et al., 2015). The patriarchal society of an African setting encourages men to want to have a male child at all cost regardless of the health of the woman (Adongo et al., 2013). It makes many men to disallow their wives/partners from using family planning services and if and when the woman cannot conceive a male child, she is pushed aside and the man looks outside the home to get another woman to bear him a male child. To some men, this desire for a male child and more children overrides the benefits of contraceptive use (Matlala, 2010).

Women have little say and control about everything, including fertility decisions. The reproductive preferences and decisions of women are still largely determined by their husbands' reproductive motivations (Adongo et al., 2013). Clearly many men consider themselves to be the primary decision maker regarding reproduction and have no wish to abdicate this role (Population Reports, 1994). This dominant masculine role encourages men to have sexual relations with more than one woman and also to have more children than women from different women (Adongo et al., 2013). Even within the same culture, opinions differ widely regarding appropriate male and female responsibilities with respect to reproduction. The male dominant

role is believed to contribute to intimate partner violence leading to rape, domestic violence and emotional and psychological abuse (Moore & Miller, 2009).

2.4.4 Environmental Factors

The planning of family size plays a significant role in sustaining the environment. Even though there is not an ironclad case that could convince everyone that family planning is an absolutely critical investment for environmental sustainability, prior research suggests abundant support for the idea (Engelman, 2016). This is because a large population negatively affects the environment. The higher the population growth, the worse effect it has on carbon dioxide and other forms of emissions which negatively affect the universe (Center for Biological Diversity, 2009). Contraceptive use by both males and females maintains an ecologically balanced environment that is conducive for the well-being of the people. The link between global warming and unbridled population growth emphasizes the urgent necessity for political action to promote effective forms of contraception (Trollip et al., 2009).

Population growth also threatens the environment by reducing the area of land available for farming leading to malnutrition and also increasing the demand for water. Hence, male involvement in the use of contraceptives **may** positively affect the environment leading to controlled childbirth and reducing the adverse effects of the population on the universe (Center for Biological Diversity, 2009).

2.4.5 Biological Factors

Biologically, women alone face the health hazards associated with pregnancy and childbirth; women with sexually transmitted infections may have no symptoms and are more likely than men to experience serious complications such as infections and infertility. Women are

more susceptible than men to infection by the acquired HIV virus because their physiology is more vulnerable to sexual transmission. Women also are the ones that experience the health hazards associated with abortion or the inconveniences associated with menopause (Conde-Agudelo, 2012). In the context of the prevention-of-mother-to-child-transmission (PMTCT) of HIV, Prongs 1 and 2 emphasize prevention of HIV transmission in the general population and in women of child bearing age respectively. Family planning and contraceptives are tools that could help achieve HIV prevention in these populations. With male involvement in family planning, and especially with the barrier methods, the health of the couple will be affected positively leading to a reduction in the sexually transmitted infections affecting the couples (Adongo et al., 2013). This will also bring large potential health and survival benefits for their children. It can thus be concluded that promotion of contraceptive use which is inclusive of male involvement has the potential of averting maternal deaths and improving the life expectancy of women and the whole family.

2.4.6 Religious Factors

Religion is directly related to culture in the African setting. This gives power to tradition which does not recognise family planning. In Namibia, more than 90 % of the citizens identify as Christians (International Religious Freedom Report, 2007) The belief that sex should be used for creating new life is common among many religions and is clearly expressed in the Roman Catholic doctrines. In a study carried out by Hill et al. (2014), it was shown that Catholics are more likely to use certain methods of contraception than other religious groups. Birth control is strictly forbidden and any sex that is deliberately frustrated in its natural power to generate life is seen as an offence against the law of God (Contraception, 2009). The Roman Catholic Church frowns on tubal ligation while some protestant sects see the use of condoms as promoting

promiscuity and adultery. Islam is strongly pro-family and regards children as a gift from God. Gyimah et al. (2012) in a study carried out in Ghana found that while there were no differences between women of different Christian faiths, non-Christian women (Muslims and Traditional) were significantly more likely to have never used contraception compared with Christian women. Religion alone was not only the factor affecting use of contraceptives. This was shown in a study in India where it was shown that religious differences in contraceptive adoption are explained by socioeconomic characteristics of the religious groups (Agadjanian, 2013). In general, most Muslim authorities permit contraception to preserve the health of the mother or the wellbeing of the family (Contraception, 2009).

2.4.7 Educational factors

Education has been shown to play an important role in the acceptance and use of family planning for both males and females. Azuike et al. (2017) showed that literate and educated women in Ethiopia discussed family size and contraceptive use with their partners. The same was reiterated by Pirincci & Oguzoncul (2008) amongst Turkish men. In Namibia it has been reported that the educated and urban dwellers are more likely to use contraceptives than the uneducated and rural dwellers (NDHS, 2013).

2.5 Gender aspects of reproductive health

Gender roles and gender norms are salient in reproductive health decisions. In general, in Namibian society women are considered as being subordinate in their families, in society and a whole, and in their intimate relationships with male partners. Consequently, their reproductive health choices tend to be subsumed by the preferences of their male partners. Gender roles tend to be inflexible, and men are still viewed as heads of households, the principal breadwinners, providers and hence decision-makers. Women's roles tend to relate to childcare and maintaining

the household even though women may in fact be working and earning an income. Women who challenge the decisions made by men are at risk for physical abuse and other forms of violence. Cultural values that favor male privilege make it difficult for women to make their own reproductive health decisions. Despite the power imbalance between men and women, men in the study nonetheless were not involved in making reproductive health decisions (Kabagenyi et al, 2014).

When addressing power relations and gender roles, condom use emerges as a decisive symbol. Although women might prefer to use condoms the ultimate decision tends to rest with the male partner. Men argue against condom use based on the belief that it interferes with their experience of pleasure and undermines their manhood. Cultural expectations tend to encourage sexual risk-taking in men. *It seems like a cultural shift is needed. But changing cultural mores (norms, traditions, and behaviors) is challenging. It can be done through education and involvement of men in reproductive health programs. By so doing, a gradually cultural shift might be achieved.*

2.6 Summary

This chapter reviewed the literature on attitudes and perceptions of males to contraceptive services. It brought into focus what other researchers have done on this topic and the researcher was able to learn from other works that had been done by these researchers. The chapter highlighted the importance and benefits of contraception and the pivotal role men could play in improving the health and wellness of women and children through their understanding and involvement in reproductive health matters, especially family planning and contraception. The attitude of men and their role on contraceptive decision making by women was well covered in this review. Various factors that influence contraceptive decisions were also reviewed. The next

chapter will focus on the methods that the researcher used in collecting data for this study to realize the research objectives.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter describes the methodology applied to this study. The research aims and objectives are outlined and the rationale for the research design is presented. Details about the research process are explained, including participant recruitment, the methods employed, data management and data analysis, and ethical issues relevant to the conduct of the study.

3.2 Study design

The study used a qualitative design to describe the attitudes and perceptions of males pertaining to contraceptive services and contraceptive use. Qualitative research in public health has become increasingly important and has proved to be useful for understanding the context, processes and meaning surrounding healthcare (Curry, Nembhard & Bradley, 2009). Qualitative research methods, if done with due sensitivity and consideration, can elicit the meaning of social phenomena and are focused on the experiences and accounts of participants. In order to explore the issue of male participation in contraceptive use in Engela rural area, an emergent design was used. This design was adopted because the sociocultural and contextual factors that inform gender relations and participation in sexual and reproductive health tend to be complex. According to Lincoln & Guba (1985), this method accommodates an unfolding of meaning and understanding between the researcher and the phenomenon being studied. The researcher was able to observe participants freely, listen to their discussion and develop a deeper understanding of participant perceptions relevant to the topic. Additionally, an emergent design allows for adaptation of the research process as understanding about the phenomenon grows. The research

The Ohangwena region is the second most populated region in Namibia with a population of 245, 446 (Namibia Statistics Agency, 2012). The population density is 21.0 persons per square kilometres which is the highest among the 14 regions of Namibia (Parliament of Namibia, 2013). Ohangwena Region has three health districts – Eenhana, Engela and Okongo. Engela district is situated in the western part of Ohangwena Region, and its catchment population is 210 000 (Namibia National Census, 2011). The commonly spoken languages are Oshikwayanma as the first language, while English is used as a second language. Some people who come across the Angolan border of Oshikango town speak Portuguese as their first language. It is a semi-urban setting with a good infrastructure with several schools, and tarred and gravel roads linking it with other major cities. The unemployment rate for Ohangwena region is 34.6 percent; hence there are insufficient job opportunities in the community (Namibia Statistics Agency, 2012). Among households in Ohangwena region, 78 percent have access to safe water but only 11 percent to modern sanitation facilities. Only about 4 percent of the households have electricity for lighting but 72 percent have access to radio which is the commonest means of information and education for the populace. Economically, regarding the households' main sources of income, 52 percent derive it from farming, 13 percent from wages and salaries, 5 percent cash remittances that includes old age pension, disability pension and other state grants, 8 percent from business or non-farming, and 20 percent from pension from previous employment (NPC, 2012).

The population density of Engela district is 82.1 persons per km². The total population of those aged 15 years and above is 14,374, with females being 8200 and males 6174. The socioeconomic profile of the population aged 15 years and above by sex for Engela district showed that a total of 4324 females and 3578 men were economically active. The unemployment rate for the district is 43.5 percent. Ohangwena is one of the poorest regions in the country but

Engela district has the lowest incidence of severe poverty of 12 percent in the region (NPC, 2002). One of the cultural characteristics of the Oshikwayanma people was that men and women do not sit down together to discuss family planning and contraceptive issues. As an African set up the culture characteristics of this setting does not differ to a great length from other African settings. Men are respected and women are submissive. Women do not discuss sexual issues as much as possible with the men, or rather cannot take final decisions on sexual and reproductive issues alone without the blessings of the male partners.

3.4 Selection of Study Participants

3.4.1 Inclusion and exclusion criteria

Men and women between 18-60 years of age, either single parents, married, or those in a legal union or cohabiting who live in Engela community were eligible for participation in the study.

Men and women who were non-Namibians and of ages less than 18 years or above 60 years were excluded from participation in this study. They were excluded because the study is for Namibians and including a Non-Namibian in the study may affect the outcome of the study. This is because we will be learning mixed cultural issues on FP and contraceptives. People under the age of 18 were excluded because in Namibia, 18 years old is still regarded as a minor. Non-Namibians were excluded so as not to dilute Oshikwayanma culture with a foreign one. Participants of age less than 18 were excluded because in Namibia an 18-year-old person is still regarded as a minor. The researcher excluded men above 60 years of age with the assumption that they might have been in relations with women above the ages of 45 years and as such would not need the use of contraceptives in their relationships, although this assumption does not hold

true in all cases and with the new study on an increasing trends in HIV prevalence among people aged 50 years and older (Mahy et al; 2013).

3.4.2 Study sample

A purposive sampling strategy was used to recruit study participants. This is a judgmental or selective sampling method which is a type of non-probability sampling technique. It focuses on sampling techniques where the units that are investigated are based on judgments of the researcher. Patton (2002) stated that purposeful sampling enables the researcher to find participants who will be able to capture and reflect on the topic in study. Many people were contacted to participate as participants in the research, some declined from participating due to lack of interest, and it was only those that were keen on participating that were enlisted by the research assistants. The researcher was able to recruit participants who, after discussing the topic with them, expressed interest in the topic and were able to reflect on the conversation. Two research assistants were trained by the researcher and recruited all the participants for the study. Men were recruited from men's social clubs, playing fields, Shebeens, parties and informal community gatherings. These are popular spots that men usually gather for social entertainment and merriments and are known by the research assistants. Women were recruited from clinics and community trading points. These were the best places noted in the community where women participants could be recruited because a large number of women are seen regularly at these sites most time of the day. It was purposeful in that the researcher only recruited participants who met the inclusion criteria and who were willing to participate in the study. A total of 66 participants met the criteria within the time period of two weeks and the sample thus consisted of 66 participants made up of 44 males and 22 females. Participants were grouped into six groups for the focus group discussions, made up of four groups for men and two groups for women, each

group consisting of 8-10 participants. The sample size for the FGD members was determined by those who were available at the time of the study enrollment program and were willing to participate in the study while for the KII, they were selected based on their roles and important activities they are carrying out in the community. The focus group discussions were held at the private clinic of the researcher in the community at times mutually accepted to by the researcher and the participants. The FGD were conducted in both the English and Oshikwanyanma languages to allow for free expression of ideas and information of the participants. An audiotape was used to record the discussion during the sessions and observation notes were also used to note all that happened during the meetings. Audiotaping was discussed with participants and recordings were agreed upon by all participants in the study.

Six KII participants were also selected from the community. The key informants were those the researcher and the research assistants identified as being the key persons with influence, well respected in the community and knowledgeable in the topic the researcher was exploring. The identified study participants residing in the community were approached by the research assistants to participate in the study. Those who met the inclusion criteria were requested to sign the informed consent form after it was explained to them.

3.4.3 Ethical considerations

The researcher obtained ethical approval from the Research Ethics Committee (REC) at the University of Cape Town, Faculty of Health Sciences and the Ministry of Health and Social Services of the Government of the Republic of Namibia. The ethics approval from both parties is attached as appendices. Confidentiality was maintained throughout the research process. To maintain confidentiality participant's names were not used; rather the participants were all given codes which are known only to the researcher. Research assistants also committed to keeping the

identity of research participants confidential. Field notes, interviews and tape recordings of the FGD and the KIIs were safe-guarded by the researcher in a locked cabinet to which only the researcher have access. All the data will be kept for the duration of five years and then destroyed. The researcher complied with the three core principles important in human research as stated in the Belmont Report (The Belmont Report, 1979) and the Declaration of Helsinki (World Medical Association [WMA], 2008). These core principles are:

- ***Respect for persons***: This is protecting the autonomy of all people and treating them with courtesy and respect and allowing for informed consent. All the research participants were treated with respect and dignity and they were informed that their participation in the research is voluntary and they could withdraw at any point during the research process. The objectives of the research were explained to them and informed consent obtained verbally for the FGD participants and in writing for the KI before proceeding with the research. Data collected were de-identified and the existing key code is only accessible to the researcher (Privacy & Confidentiality).
- ***Beneficence and non-maleficence***: This is the philosophy of "do no harm" while maximizing benefits for the research project and minimizing risks to the research subjects. For this study the researcher explained to the participants that the outcome of the research will enable the Ministry of Health and Social Services and other stakeholders to design programmes that would enhance male involvement in reproductive health and contraceptive services, thus improving the health and wellbeing of women and child and the community at large. The participants may not have direct benefits but will ultimately benefit from the outcome of the research as members of the community. Also, since the research was conducted in an atmosphere which was

conducive and convenient to the participants no harm was inflicted on the research participants. They were appreciated for their participation in the research.

- **Justice:** With this, ensuring reasonable, non-exploitative, and well-considered procedures are administered fairly — the fair distribution of costs and benefits to *potential* research participants — and equally. The research ensured that the research participants were not exploited during the research process. Those who spent money on transport to come for the scheduled FGDs were refunded their transport money. The key informants were interviewed in their usual place of work at a mutually agreed time with the researcher. The potential benefits of the research were explained to all and as members of the community they all stand to benefit from it equally.

3.4.4 Study population, sample and data collection instrument

The population consisted of males and females between ages 18-60 years, residing in Engela community. The females in the study allowed for the views of women on attitudes and perceptions of men to contraceptive use to be explored and corroborated by the women.

Demographic data evaluated the name, age, sex, occupation, marital status and the educational level of the participants. It also captures the addresses (residential information) of the participants (*Annexure G*). Data collection instrument and a guide on focus group structure was developed based on the research and information was gathered from tools used for similar studies. All these were reviewed by my supervisors.

3.4.5 Data collection

Enrollment for data collection was carried out in designated community places for men and at clinics and community markets for women. The research assistants also acted as

interpreters for the researcher in situations where the participants could not understand English. Focus group discussions were carried out in January 2015. After informed consent was obtained, FGD sessions were convened and sessions held using an FGD guide developed by the researcher to guide the interviews. A separate guide was used for men and women (Appendix E and F). The guides were used to assist in the discussions in order to provide answers to issues in the setting that could be linked to program development and health of the people. These guides were reviewed by the supervisors before they were used. KI Interviews were also carried out amongst selected community workers using a KI interview guide developed by the researcher (Appendix D). The researcher tried to maintain confidentiality of the participants by using codes for them individually. The participants were also explained to that due to the sensitivity of the study, they should as much as possible refrain from discussing anything about the study outside the discussion premises, though this might be difficult. This may also be one of the limitations of the study.

3.4.6 Data capturing and analysis

Data analysis is the process of making meaning from collected data (Simon, 2011). Bogdan and Biklen (2003 pg. 145), define qualitative data analysis as “working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others.” In order to do this, the data capturing took place immediately after the interviews. Responses in Oshikwanyama were transcribed verbatim by the two research assistants into Oshikwanyama and these were then translated into English. The translation was again given to someone well conversant in Oshikwanyama and English languages but not part of the research team for back-

translation in order to reduce distortion of facts. Patton (1990) stated that qualitative researchers tend to use inductive analysis of data, meaning that the critical themes emerge out of the data. The responses from the FGD were transcribed and content analysis and evaluation carried out for areas of emphasis, domain and theme. This process of immersion was carried out whereby words with the same meanings are cut and pasted. Major themes and collective opinions were developed and integrated into models. The main framework used for analysis was exploratory. Areas of discrepancies between the different respondents (minor opinions) were also noted and highlighted. The emerging subsuming themes and subthemes were further explored for schema, in that results from the different FGDs were analyzed separately and then integrated. The same process was carried out for the six KIIs. One participant, a student, 22 years of age and single reiterated that, “Family planning is to plan on the number of kids you are going to have in future and the time interval between your babies.” This is coded as knowledge.

Another participant, 28 years old, and a businessman expatiated further, “I can only support for us to make a use of condom, because if my girlfriend uses other forms of contraceptives, it is a sign of being unfaithful.” This is coded as attitude.

3.4.7 Presentation of findings

The findings of the study are presented in chapter four. Descriptive tables were used to present the results. Where required for emphasis, the verbatim quotes from some of the respondents are inserted.

3.4.8 Trustworthiness of data.

Some of the critical issues in qualitative research relates to how the researcher ensures credibility, dependability, conformability and transferability of the research findings. Credibility in a qualitative research study must be established. This is for trustworthiness. It clearly links the research study's finding with reality in order to demonstrate the truth of the research study findings (Lincoln & Guba, 2000). Also, how the researcher immersed himself in the data and minimized bias are important in ensuring the validity and reliability of the research findings. Validation exercises by the researcher and the research assistants took place after the FGD sessions (Sousa, 2014). Any response in Oshikwanyama was transcribed verbatim by the two research assistants from Oshikwanyama and this was then translated into English by an independent person conversant in both languages.

3.5.1 Credibility/member checks

Data analyzed from the study was given back to some of the participants as feedback to ascertain the credibility of the information gathered. **This was done with the assistance of the research assistant who knew some of the participants.** By this participant validation strategy, the researcher was able to gather comments and clarifications from the respondents which may lead to some necessary alterations or adjustments. This exercise enhanced the credibility of the study (Lincoln & Guba, 1985). The use of another independent person to carry out the transcription and translation process also increased the credibility of the study (Carter et al., 2014).

3.5.2 Confidentiality

The study explored a very sensitive topic. At the beginning of each FGD session participants were briefed on the need for confidentiality about all that was discussed at the sessions and appeal made for them to refrain from discussing any part of these in the community.

However, the researcher and the assistants explained that they had no control over what participants discussed outside of the FGD (Lincoln & Guba, 2000). Participants were asked not to share any confidential information, including who participated in the FGDs and what each said.

The participants were coded and were also encouraged to keep the study discussion with the context of the study as privately as possible. But the researcher could not guarantee how and to what extent this was done outside the confines of the study site.

Trustworthiness is conformability and reliability. All documents collected during the study were safely kept and are available if needed for similar studies. The supervisors also reviewed the raw data. Conformability and reliability encompassed most of the points. All documents were kept and steps needed for similar studies were followed. The supervisors reviewed the raw data and development of data collection instrument. A guide on FG structure based on research objectives of the study was done.

3.5.3 Dependability

In order to enhance dependability, the results were looked at from various perspectives: that is the convergence of all field notes and audio recordings (methodological triangulation) (Patton, 1990). This is the traditional quantitative view of reliability concerned with whether the same results would be obtained if we were able to repeat the FGDs and interviews (Lincoln & Guba, 1985). Also, the data analyzed from the FGDs for both men and women and from the KIIs were compared to identify areas of convergence and areas of discrepancy.

All documents used during the study were kept as part of the research record (Carcary, 2009).

3.5.4 Rigour

This was addressed by making available the transcripts from the FGDs to colleagues and the supervisors. The transcripts were given to a second reviewer in order to resolve discrepancies in interpretation (Krefting, 1991). By having access to the original data, readers could judge the accuracy of the claims and see how the distinctions were drawn (Guba, 1981). This enhances the research because the researcher is very close to the research and may not be able to scrutinize the data adequately (Lincoln & Guba, 1985).

3.5.5 Applicability (Transferability)

The sampling strategy that was used in the study covered diverse range of individuals' age, sex, occupation, beliefs and settings. Also, the study employed both FGD and KIIs. All these fit into contexts outside the study situation that are determined by the degree of similarity or goodness of fit between the two contexts (Krefting, 1991). This enhanced its applicability.

3.5.6 Conformability

Conformability was accomplished by making sure that the data used are the true ones collected from the interviews and not any fabrications of figures or information by the researcher. Reflexive analysis was also used to ensure that the researcher was aware of his influence on the data (Lincoln & Guba, 1995).

3.5.7 Bias

Bias can occur in the planning, data collection in the research and during the analysis process. It can also occur during the publication phase of the research. Measures were put in place to minimize bias as much as possible. To eliminate sample bias, participants selected for the study were unknown to the researcher and the research assistants and it was the responsibility

of the research assistants to carry out the recruitment process (Pannucci & Wilkins, 2010). The research papers were given to other colleagues for review/critique to overcome researcher bias. Frequent debriefing sessions between the supervisors and the researcher were put in place. This makes the focus on the study to be widened as information and ideas were shared between the two parties, thereby reducing bias and making the study more conformable (Pannucci & Wilkins, 2010). However, as the majority of the study participants were mostly single or unmarried, systemic bias could not be entirely eliminated but the views they expressed during the interviews are held as valid. Additionally, as the study used purposive sampling and the FGD participants were those who showed willingness and enthusiasm to participate and the key informants which purposively selected bias could not be entirely eliminated.

3.6 Summary

This chapter presented the methods and the approach the researcher adopted in conducting the research in order to realize the purpose and the objectives of the research. The research design and settings, participants' selection and enrollment procedures were highlighted. The type of data collected and how they were collected and analyzed were also explained. The ethical issues including informed consent, confidentiality and approval procedures that ensured the research was conducted satisfactorily were highlighted. Ensuring that the research findings were valid and reliable was covered through the discussion on credibility, conformability, rigour and minimization of bias. The next chapter will present the details of the research findings.

CHAPTER 4

RESEARCH FINDINGS

4.1 Introduction.

This chapter presents the results of the research based on data analyzed from the FGDs and KIIs. There were four FGD for men and two for women, and KI interviews with six respondents. The demographic data of research participants are presented first; next the themes and subthemes that emerged from analysis of FGD are presented. in relation to the corresponding research questions and study objectives. The data from the KIIs are presented thereafter and correlated with the findings from the FGDs to highlight the key elements of knowledge, attitudes and perceptions of men in Engela district about contraceptives and family planning.

4.2 Demographic data of Participants

The profiles of the participants were as follows:

For the first male FGD [group 1], the age ranged from 19-46 yrs. Although these participants were primarily single, many were cohabiting with their partners.

For the second male FGD [group 2], participants ranged in age from 19-34 years. They were all single with some cohabiting.

For the third male FGD [group 3], participants ranged in age from 19-37 years. These men were single and cohabiting.

For the fourth male FGD [group 4], participants ranged in age from 19-42 years. Of this group, only 1 was married. The rest were single but cohabiting.

For the first female FGD, [group 1], the age ranged from 20-38 years, only 1 was married while the rest were single.

For the second female FGD [group 2], the age ranged from 23-34 years and only 1 was married.

Men

Sixty-five men participated in the FGDs which were held at Ohangwena town in the Ohangwena Region. The age range of men in the FGDs was 19 to 46 years. Of these participants, 62 were single, of which 24 were cohabiting with their partners only three were married.

Academically, eight of the participants had tertiary education, 40 had between grades 6-12, five were students while 13 did not attend any school. Their jobs cut across teaching (2), paramedics (3), sales representatives and shop attendants (4), police officers (2), librarians (3), civil servants (15), businessmen (7), secretaries (10), dental assistant (1), banker (1) and the rest (17) were unemployed. (*see appendix*)

4.3 Findings from the FGD for men

4.3.1 Common health problems and source of health information and treatment

As a prelude to understanding the general and reproductive health needs and challenges of men in the community, information about common health problems experienced by men in the community and how they addressed health issues were discussed. The findings are presented below:

Substance abuse (including alcohol and drugs), sexually transmitted infections (STIs), and human immunodeficiency virus (HIV) infection were the most common health issues identified. One participant who was a teacher and cohabiting with his girlfriend declared: “Alcohol abuse and sexually transmitted infections are the common health issues in the community” (32, Male). Another participant, who completed high school, was single and had two children stated, “Men only get sick with disease like HIV and are not too worried with other STIs” (33, Male). Another participant who is a graduate in education, stated, “We have problems when it comes to our sexual organs diseases, like gonorrhoea and syphilis” (30, Male). Another participant, 24 years single and a bartender stated: “*We need contraceptives.*” There is no real co-relationship between education and attitude. It depends on the upbringing of individuals well as their beliefs

Common reproductive health needs of men: Family planning was identified as the top reproductive health need of families in the community, and the risks associated with unprotected sex, STIs, and erectile dysfunction were regarded as the main reproductive health concerns and needs of men. Another common concern regarding condom use was ineffectiveness because of their sizes. As one participant said, “Some condoms are too big for use, therefore not convenient.” The young people were not ready for family responsibility.

Sources of health information and treatment:

Hospitals, health centers and clinics, including private clinics were the main centers at which men seek help for their reproductive health needs. A proportion of men approached social workers for assistance. Other sources of information for health needs included the internet, relatives and elders, churches, traditional healers and witchdoctors.

A 34-year-old single businessman, cohabiting with his girlfriend and who had one child stated, *“We also seek help from witchdoctors where we sometimes get misleading information.”*. Another participant, a 24-year-old single student, said, *“We also go to churches, to seek help from the Lord.”*

4.3.2 Knowledge of contraceptives and family planning

(a) General knowledge on contraceptives and family planning

One of the key objectives of the research was to explore men’s knowledge about contraceptives and family planning. All participants in the four FGDs for men stated that they had heard of family planning and contraceptives. However, the meaning and implications of family planning seemed to differ among participants. A 44-year old businessman, single, opined on contraceptives thus, *“Family planning has to do with budgeting the number of kids you want depending on your income.”*

Another participant, a student, 22 years of age and single reiterated that, *“Family planning is to plan on the number of kids you are going to have in future and the time interval between your babies.”*

Sources of information about family planning and contraceptives:

The participants claimed that they got information about family planning and contraceptives from hospitals, private clinics, and health centers and from the internet. A 35-year old married man, who worked as a secretary, had this to say, *“We go to the nearest hospitals,*

private clinics and the health centers for information". Another participant, a 24-year old student and single said that they also sought information from the internet.

Participants were questioned about what family planning means to them. The general meaning ascribed to contraception and family planning was the understanding that it allowed people to limit their number of children or births.

Another perspective was that family planning refers to planning the number children, and others stated that family planning refers to ways of avoiding unwanted babies to prevent poverty.

Family planning was also looked at by some participant as being determined by the income of the couple. Some participants saw family planning as a means of protection against diseases or imposed by health conditions as two of the respondents stated. A participant who happened to be a teacher aged 26 with 2 children said, "Sometimes you might find yourself in a situation whereby after the second child, one of you gets infected with HIV, and then automatically you will stop giving birth. This is an agreement that has to be made between the partners." Another participant (Secretary) from his own opinion stated, "when a woman gives birth through operation/surgery then she could only give birth to three children."

A perspective that emerged from the FGDs is that family planning does not necessarily mean using pills or injections. *As an example, a 28- year old man, married with one child, said, "Contraceptives is also done when partners sleep in different bedrooms."*

(b) Knowledge of any contraceptive methods for men

Many of the respondents had some knowledge of the contraceptive methods for men. The methods mentioned by respondents included abstinence, condoms, male sterilization, and the

withdrawal method. For example, a 24-year old paramedic, single, stated that, “*Contraceptives for men include condoms, abstaining from sex and sterilization.*”

Another participant, a 23-year old student listed female contraceptives such as injections, pills, abstinence from sex, femidom, morning after pill, loops, safe period, removal of the wombs and sterilization as popular contraceptive mechanisms. This proved that men seemed to be more knowledgeable about contraceptive methods for women, rather than for themselves. He mentioned condoms as the only form of male contraceptive. I think it is because women’s contraceptive options are many compared to the few available for men and these are being talked about in the health facilities regularly. It is worthy to note that traditional superstition has been playing a negative role in place of modern sexual education. For another example, a 30-year old single businessman and father of three children, narrated her belief:

An interesting traditional method of contraception practiced in some families within the community is during menstruation, a woman takes a drop of the menstruation blood and puts it in Amarula nut and then placed it in the ceiling in a kitchen. This acts as a family planning method, preventing the woman from becoming pregnant.

4.3.3 Men’s attitudes about women who use contraceptives

An important question in this study centered on men’s attitudes toward women’s contraceptive use. Participants’ attitudes about women who use contraceptives varied widely. While some men agreed that contraceptives were good and recommended they be used, others had reservations. One view shared by several participants was that all female contraceptives damage the woman’s body and that the only one that is safe is the femidom or female condom. A 27-year old technician, single and cohabiting and who had one child, stated, “*It is only right to use female condoms because other family planning methods damage the reproductive system.*”

Some participants would like contraceptives to be used after a woman might have had “enough” children. In the opinion of a 19-year old student, single and with no children, *“Women can use family planning after they have had enough children.”*

A common concern was that the use of contraceptives gives women the freedom to “sleep around;” hence men lose respect for women who use contraceptives. A Secretary, 37 years old, married with two children, stated, *“Women who sleep around use contraceptives to avoid pregnancy.”* Another participant, a secretary, single, in support of the above statement also said, *“Ladies who use those contraceptives don’t have self-respect. She knows that by sleeping around she might fall pregnant, so she has to use contraceptives.”* The notion that women who are using contraceptives are unfaithful and that using these methods leads to future infertility was also supported by other participants. As explained described by a 33-year old teacher, who was single and cohabiting, *“Contraceptive usage can increase unfaithfulness. It can also delay bearing children later in life.”*

Contraceptive use was supported by some participants who believed that women who use contraceptives are genuinely trying to prevent unwanted pregnancies. This was the view of a 26-year old paramedic, who was single and had no children. He said, *“We really do not regard ladies who use contraceptives as people who sleep around but that they wanted to prevent themselves from unwanted pregnancy.”*

Some of the participants disagreed with the use of contraceptives by young people maintaining that the use of contraceptives by young people may prevent them from getting pregnant in future. This was elaborated by a teacher, 34 years old and single, who stated, *“It is*

dangerous for young girls to use family planning because when she gets married, there will be no pregnancy.”

4.3.4 Attitude and support of men for their partners who use contraceptives

The researcher sought an understanding of the attitude of the participants on partners who use contraceptives and how they support or have supported their female partners who use family planning methods. Some of the participants offered conditional support, stating that they would only support their partner's use of femidom or condoms. One participant, 28 years old, and a businessman expatiated further, *“I can only support for us to make use of a condom, because if my girlfriend uses other forms of contraceptives, it is a sign of being unfaithful...”*

Others indicated that they would only support their partner's use of emergency contraceptives including the use of morning after pills. Some participants supported their partner's use of any form of family planning only after their partners had enough children. This view was opposed by a handful of participants who instead wanted their partners to have as many children as possible.

4.3.5 Contraceptives decision making

On this issue, the researcher sought to know from the participants what would be their reaction if they should find out that their partners use contraceptives without their knowledge. When a partner unilaterally decided to use contraceptives without the knowledge or consent of the man, many of the participants frowned at such an action and strongly indicated that it will meet with their wrath. Some claimed that such action may lead to separation. As a 34-year old

businessman, who was married with two children stated, *“Should this happen and I find out, we should just go our separate ways.”* Similarly, another participant, a 29-year-old clerk, single with no children said that it will be better for the relationship to be dissolved if there is no agreement. He stated, *“If there is no agreement, we will dissolve the relationship.”* Some of the participants were so enraged and even very angry about the idea of their partner using contraception without their knowledge that they claimed it would lead to a fight. This is how a 34-year old teacher, single, stated it, *“If I should find this out, it can lead to exchange of blows (punches).”* **Yes. This is another example of gender-based violence. The women are mostly at the receiving end. It is bad**

Another participant, a single 36-year-old businessman who has one child said, *“Such a partner should just pack and go,”* implying dissolution of the relationship. Some participants disagreed with such drastic actions preferring instead to consider the issue and listen to their partner’s reasoning for doing it in secret so that they can forgive and continue with their relationship.

4.3.6 Men’s involvement in contraceptive decision making

On this issue some of the participants in the FGD reiterated that their involvement in contraceptive decision making was preventing unwanted pregnancy. In order to do this, participants indicated that they would seek contraceptive advice and guidance from elders and health facilities prior to a decision making. One participant aged 32-year businessman stated, *“We will go to elders for advice and visit hospital for guidance on this.”*

4.3.7 Men’s decision making in the prevention of unwanted pregnancy

The FGD participants were divided on their involvement on issues of unwanted pregnancy. Some claimed that they would seek guidance from the hospital on the issue, while others indicated that they would seek advice from their elders. Few participants shared that they would resort to masturbating in order to prevent pregnancy. As a single 26-year old student said, *“We will be masturbating so as to prevent pregnancy.”*

Whereas some other participants loved the idea of the government introducing educational programmes to help them manage these issues. One participant stated, *“The ministry should organize campaigns in order to educate men.”* Moreover, other participants expressed wanting access to male contraceptive options.

4.3.8 Men’s involvement in health service development

On this issue, some of the men stated that they have never been involved in such activity but will be willing to form health organizations to help in addressing men’s health issues. They reiterated that it had been elders in the community and traditional authority members that had been doing this before. This is how one 34 years old participant, who was married, but had no children explained his involvement, *“I have never been involved; Elders and traditional authority are those involved. The ministry should introduce video shows to educate men.”*

4.3.9 Involving men in improving women’s health

The researcher explored issues with the participants on how men are or could be involved in improving women’s health. On this, some of the participants would love their partner’s health status to improve. The things the participants wished to carry out in order to improve women’s health included respecting the women, assisting pregnant women, and avoid stressing the

women. This is what a 42-year old security guard, single but cohabiting with his partner said, “*A stress-free woman does not contract too many diseases.*” Another participant, a bank clerk, aged 27 and single, also shared, “*Men should help their women to understand things better and should solve their needs.*”

Other ways the participants stated that could improve women’s health included providing the women with healthy food, showing love to the children and pregnant women, not cheating on the women, and both partners avoiding use of alcohol. Avoiding gender-based violence was a pivotal issue and as one participant, a 24-year old electrician, single, put it, “*Men should treat women like eggs.*”

4.4 Findings from the FGD for women

FGDs were conducted with two groups of women, some of whom were partners of the men who participated in the study. Issues related to common health issues and reproductive health needs of the women were explored. Also explored was knowledge and use of contraceptives, contraceptive decision making in the family, and partner support for contraceptive use. The findings from the discussions are summarized below.

4.4.1 Common health issues facing women in the community

Some of the participants alluded to the fact that HIV/AIDS/STI’s, is a great problem to them in the community. Others mentioned cancer and alcohol abuse. *Not so much, other than the few mentioned above.pg. 57*

4.4.2 Main reproductive health needs of women in the community

Some of the participants reported that contraceptive needs and reproductive health education were the main reproductive health needs in the community. One of them, a 33-year old entertainer said, *“We need contraceptives.”* The participants further stated that they go to state hospitals, clinics (including private), friends, church elders and pastors and community counselors to seek information, treatment and counselling for their reproductive health needs.

4.4.3 Knowledge of family planning and contraceptive methods for women

4.4.3.1 Knowledge of family planning

All female FGD participants described themselves as being knowledgeable about family planning and contraceptives. Comments such as, *“Yes, we have heard about it,”* were commonly expressed. Most participants are of the opinion that family planning means limiting the number of children that a woman can have and allowing enough time between pregnancies. As explained by one participant, *“We should give birth to a small number of children.”*

4.4.3.2 Knowledge of contraceptive methods for women

The participants were requested to name the contraceptive methods for women they know about. All the participants echoed some of the following contraceptive methods: pills, condoms, femidom, injections, loops and caps. Most participants reported having sought these family planning methods at one time or the other. One participant stated, *“Yes, I have used it because we want to care for our children”*. Participants also used contraceptives especially the condom and femidom to protect themselves from diseases such as HIV/AIDS and STIs.

4.4.4 Role of women in contraceptive decision making

Although all the women who participated in the FGD indicated having used some of the contraceptive methods they listed, they also admitted that the decision to use the contraceptives

is not an easy. Some made the decision alone, while for some, it was in conjunction with their partners. They claimed to have had discussions on the decision to use family planning with their partners and that some of their partners supported the idea. Although the topic of family planning is not an easy thing to be discussed by women culturally, they tried as much as possible to discuss the topic with their partners. According to one member of this group, *“We are not often free to discuss about it.”*

One participant decided using family planning on her own because she already had a large family. She said, *“I did it (FP) because the family was already big and there is no money to feed the children. The income is low. I took the decision myself.”* This means that FP could be related to source of income for some individuals.

Regarding who should make the decision for women to use contraceptives for family planning, some of the women felt that they have a say. However, the women also acknowledged the difficulties of negotiating this because men often refused and were stubborn. This was what one participant said, *“Sometimes the men will take the condom to use but will eventually refuse to use it. This is because they are stubborn.”*

All participants also felt that they should have the right to decide on contraceptive methods themselves. However, a few believed that both partners should have the final say on contraceptive use. Some of the women also reiterated that if the men are not ready to listen to them, the men can leave them alone and go. One participant, single and not having any child said, *“We can go our separate ways”*. She is young, not married and having no child.

4.4.5 Knowledge on contraceptive methods for men

The researcher opted to find out from the participants what they know, if at all about the contraceptive methods for their partners. This was to find out how open they had been with their partners on this issue. The participants mentioned the following as the contraceptive methods for men: Condoms, sterilization, abstinence and withdrawal methods. Because of the sensitivity of this topic, the researcher was unable to explore the contraceptive choices of the participants' partners in a group setting.

4.5 Findings from Key Informants Interviews

4.5.1 Introduction

Key informants' interviews (KII) are qualitative in-depth interviews with people who know what is going on in the community (UCLA, DATA PROGRAM). KII were conducted in this research with six prominent figures in the community on the topic for the research. These included the school principal of one of the local schools, Police superintendent responsible for the area of the study, a Councilor of the local council, an NGO official serving the community, a Pastor of one of the local churches and a senior health worker in the District Health management team.

The aim was to collect information from this wide range of people, who have firsthand knowledge about the community especially pertaining to the use of contraceptives and family planning services in line with the research aim and objectives. The main issues explored with these key informants related to use of contraceptives by men and women, decision making in the family on contraceptive use and access to contraceptives and other related health issues and challenges in the community.

4.5.2 Men's use or support of use of contraceptives

The researcher sought to know from each of the participants if men use and or support the use of contraceptives. The answers varied from it being rare in the community for men to use contraceptives to some using condoms only. Others mentioned vasectomy to which men rarely consent. Some use family planning to protect against diseases and unwanted pregnancies.

Some men support their partners while others do not. One KII participant also said that most men don't approve their partners using family planning and further stated that men are not involved in the choices of their female partners. One respondent said, *"I don't think men are involved in the choices of their female partners. They feel a woman should be responsible for their reproductive rights."*

On the issue of communication about FP, it was claimed that this sometimes depends on the seriousness of the relationship. Participants also stated that married people talk about family planning than single/ unmarried people. One respondent said, *"It depends on the seriousness of the relationship and its motives. Married people are most likely to talk to their partners about contraceptives than single people."* Another participant echoed this view, *"I believe they talk about it, more especially married partners"*.

4.5.3 Use of Family Planning by the KII participants

Most of the KII use contraceptives themselves, whereas a few did not. One participant stated that she used FP many years ago, but had to abandon it due to its adverse effect on her. She said, *"I only used the patch once but stopped it because of its adverse reaction on me."* Most KI got information about FP from awareness campaigns, their partners, and doctors. Their reasons for using contraceptives were to guard against STIs, HIV/AIDS, and to prevent unwanted pregnancies.

4.5.4 Common concerns of people when they talk about contraceptives

One KI stated that some men feel it is wrong to talk about FP and contraceptives from the Christian point of view. The fear of STIs and HIV, however, did encourage some discussion. Some women talked about FP and contraceptives because of their body changes when they use contraceptives.

One participant said that people were hesitant to use FP because they feared not being able to have children later in life. He said “...people will not be able to have children if they use contraceptives.”

Another common concern regarding condom use was ineffectiveness because of their sizes. As one participant said, “Some condoms are too big for use, therefore not convenient.”

4.5.5 Decision making about family planning

One KI suggested that male partners were unhelpful with decision making on contraceptive choices and were unwilling to use condoms. She alluded, “Culturally, it is a taboo for a female to bring a topic about sex to a man, hence females refused talking about it.” Furthermore, the decision to use contraceptives is often left to the woman who may do so in secrecy.

4.5.6 KII Participants’ recommendations on family planning

The researcher sought KI’s opinions on conditions that would warrant contraception use for women and when they would recommendation use for community members. Some KI recommended contraceptive use for women who were breastfeeding to allow for enough time

between babies. Other times KI recommended contraception to protect against STIs and HIV, to reduce baby dumping; and for young people studying. A 42-year-old police officer who was married with three children said, *“In the police station, we give health information to our officers about contraceptive use, HIV, and STIs.”*

4.5.7 Source of information about contraceptives

Some of the KII participants heard about FP from their partners while others got the information during marriage seminars. Some also heard about it while in the university or at workshops. Some health workers from the Ministry of Health also disseminated information to them. Some of them did personal studies to learn about it. A 32-year-old Principal, who was with three children stated, *“We get information on contraceptives while in school and from the health centres.”*

4.5.8 Knowledge on contraceptives and the benefits of family planning

Most members of the KII knew most of the available contraceptives- condoms, pills, tying of the tubes, injections, femidoms, loops, and patches. They claimed that people **did not** talk more about male contraceptives and that all these contraceptives are readily available at the clinics, hospitals and private clinics. It was also revealed that the health facilities guide people on choices available. A 32-year-old Principal, married and having 3 children stated, *“We all know the different types of contraceptives available, but we don’t talk about it, especially the men on the use of condoms.”*

Some of the KII participants stated that contraceptives are good for child spacing and to limit the numbers of children. It also creates room to plan for the children a couple wants and to

prevent unwanted pregnancies and HIV/AIDS and STIs. A nurse, single and having no child have this to say: *“Contraceptives are useful for child spacing and also to limit the numbers of children a couple should have.”*

4.5.9 Information dissemination about family planning

The KII participants expressed the need for more information dissemination on family planning. They stated that experts on the topic and health workers should be involved in disseminating information on contraceptives and family planning in the community. They also emphasized that people should desire to know about the contraceptives and seek additional information. They suggested that contraceptive education be introduced beginning at age 12. Parents and community leaders should lead in information dissemination on contraceptive availability and usage. Only few of the KII participants were aware of the morning after pill as a contraceptive method and called for wider dissemination of information on this and its use by those in need. A 32-year-old principal married with three children said: *“On information about contraceptives, people should seek for information from the library and internet. They should also get information from the health centres.”*

A nurse, single and having no child stated thus: *“Boys and girls should be made aware of contraceptives as early as the age of twelve. Their parents should also give them information on this though we are doing this in the health facilities.”*

4.5.10 Views on sex outside marriage, abortion and HIV control

All the KII stated that they were against extramarital sex, which leads to baby dumping and to breaking up of families. Although prohibited by religion, the KI admitted that it is still

happening. KII participants also condemned abortion and viewed it as an unacceptable practice in the community. A 36-year-old married pastor with four children said, *“Abortion is illegal in the country and not good for the people.”*

Although viewed as termination of life, some participants agreed that in some cases abortion may be considered. This was said by a 42-year-old Police officer, married and having three children: *“On abortion, I cannot comment. It depends on the reasons why, circumstances, for example rape or life-threatening diseases.”*

On HIV control in the community all the KII participants agreed that everybody should be tested for HIV and that there should be no age limit for the testing. An NGO officer, 34-year-old, single stated thus: *“Everybody should be tested for HIV, but more especially the men.”*

4.6 Summary

This chapter presented the findings from the FGDs for men and women and the interviews conducted with select community KI. The findings revealed that reproductive health concerns are common in the community. Findings also indicated a high level of awareness on family planning and contraceptives among men and women in the community. Many women in the community have had access to contraceptives but decision making on use of contraceptives are often left to the women. Men may view seriously the decision of women to use contraceptives without discussion and approval by them. There is a clamor by the KI for more information dissemination on contraceptives and family planning for which all the research participants see as beneficial to the health of women and children in the community. The next chapter will discuss these findings and compare these with the findings from other researchers in the field.

CHAPTER 5

DISCUSSION, LIMITATIONS OF THE STUDY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a discussion of key findings. Findings are organized according to the aims and objectives. Implications of the findings and their alignment with existing research follow. Conclusions and recommendations that emanate from this research are subsequently presented.

The level of knowledge that emerged from the FGDs with men and women suggests that public health messaging and service delivery continue to drive family size, family spacing and limiting the number of children as the central goal (Najafi-Sharjabad et al., 2013). Public health services and media were the primary sources of information for participants in this study. Participants commonly mentioned receiving information about family planning and contraceptives from family members, friends, health facilities and the internet. The majority understood family planning as relating to planning and limiting the size of the family and avoiding unwanted pregnancy. What was obvious was the limited attention given to the media such as radio, television and newspapers as the source of family planning information. It is difficult to know if the information the participants gathered from the internet correct with the

national policy on reproductive health, including FP services (Ajaero et al., 2016). The impact of mass media in Namibia creating positive awareness and educating the populace on the availability and use of FP was also apparent. Namibian media try to highlight many issues relating to FP and contraceptives; and because abortion is illegal, to unwanted pregnancies. The media outlets proactively support the government's efforts in providing contraceptives to the populace in all the health facilities (Namibian Sun, 2017). The goal of the Namibian government is to actively implement reproductive health which as enshrined in the Namibian National Policy for Reproductive Health and anchored on a rights-based approach to reproductive and sexual health. They are important factors of quality of life, human and national development. Reproductive Health is a new concept, which includes men and women's health. It embraces all the critical phases of life from conceptions, birth, childhood, adolescence, and adulthood to old age (National Policy for Reproductive Health, 2014). Reproductive health services continue to be medicalised and reproductive health issues remain depoliticized and in a manner that facilitates health service delivery while simultaneously ignoring the social and structural origins of sexual health (Padilla et al., 2010). Sexual and reproductive health extends well beyond pregnancy and STI prevention.

Sexual and reproductive health rights (SRHR) have to be realised at the individual, relationship, family and community levels (Klugman, 2014). The 1994 International Conference on Population Development (ICPD) held in Cairo broadened the understanding of contraception in a manner that recognised the salient role of sexual and reproductive rights. Public health services in Namibia persist in reducing sexuality and sexual and reproductive health rights to individual problems that can be subjected to medical control (Padilla et al., 2010). FP and contraceptive services are provided free of charge at public health facilities and at outreach

points. Some youth and adolescent-friendly health services have been established in clinics and youth centers throughout the country. However, the structure of delivery of these services is still largely focused on women and may need transformation to make it more couple-friendly to ensure better male involvement (Murithi et al., 2016).

In the FGD conversations with men they identified HIV as the primary health concern, while other STIs were not well understood. This can possibly be linked to behavioral interventions that tend to focus on individual factors to the exclusion of social inequalities like gender, socio-economic, and class disparities that are known to influence HIV infection (Klugman, 2014; Padilla et al., 2010). Erectile dysfunction emerged as a male concern at the individual and community level. Men in Namibia visit health facilities and traditional healers for their erectile dysfunctional problems. It is also to be noted that some men have erection dysfunction as the result of the use of condom (Man Talks Blog, 2016). With this problem, some of the affected regard their sexuality with pride and see erectile dysfunction as a problem that relegates their prowess with their partners. In order for them to overcome this problem, some develop some aggressive nature and attitudes to their partners ranging from verbal abuse to gender violence physically.

In this study the perception about women who use contraceptives was mixed. In one sense it was seen as women being proactive in making decisions about family size, in consultation with their male partners. On the other hand, women who chose to use FP or contraception without their partners consent were viewed as...Prior studies have reported the way in which harmful gender norms promote male dominance over women which prevents women from practicing safer sex and using contraceptives (Amin, 2015; Stern, Cooper, & Gibbs, 2015). For instance, women often have less economic power than men which increases their

vulnerability to STIs because men feel entitled to deciding terms of the sexual relationship, specifically with regard to the use of contraceptives and condoms (Stern et al., 2015). Gender empowerment is been associated with the use of FP with positive results (Corroon et al., 2014). Results in this study revealed that empowered women were more likely to use FP. The freedoms to choose FP and contraception among some female participants in the current study were oppressed by their partner's threats to end the relationship and use violence.

5.2 Discussion of the Key findings of the study in relation to the study objectives

There were two main objectives of the research and the findings are discussed in relation to the research objectives.

Objective 1: To gain insight into men's knowledge and perceptions on contraceptive use in Ohangwena rural area of Engela district in Ohangwena region, Namibia.

This study revealed that men in Ohangwena region of Engela district have knowledge about contraceptives for men and women. Additionally, men in this study understood the purpose of FP as child spacing and limiting family size to reduce economic strain. Most FGD the participants were knowledgeable about common modern contraceptive methods such as condoms and femidoms, pills, implants, intra uterine contraceptive devises (iucd), abstinence, sterilization, and rhythm methods. These findings contrast those reported by Dehlendorf et al. (2010) and Adelekan et al. (2014), which showed that men had little knowledge about male and female contraceptives. It was also noted that black men in Cape Town were unlikely to recall other than commonly used methods (citation?). Our findings also counter those reported by Matlala & Mpolokeng (2010), who reported that few men in South Africa were knowledgeable about contraceptives and willing to share the responsibilities of choosing a method with their partners.

Although the majority of participants in the current study were aware of modern methods of FP and contraception, some still relied on traditional methods of FP like rings and application of a drop of menstrual blood in Amarula nuts. Access to health information and behaviour change communication may be a factor to be considered **and cultural norms and believes** in this regard. However, some of the participants in the focus group and some of the key informants reported participating in health education activities and awareness campaigns which might not have been sufficient to cover the target population.

Participants in this study were aware of their need to visit health facilities for assistance on contraceptives needs and other health needs. Some also preferred visiting traditional healers and faith houses for assistance. **It would be nice to carry out a study on the impact, if any on traditional healers and faith uses and the use of FP and contraceptives.** This corroborates findings reported by Adongo et al. (2013) in a study on male involvement in reproductive health in Southern Ghana. While men in their study were aware of the core issues involved with FP and contraceptive choices for both men and women they viewed women who used contraceptives wayward, socially unacceptable, and expressed tendencies to react violently if their partners used contraceptives without their knowledge and consent (Adongo, et al. 2013).

The perceptions of the participants about women who used FP varied among the respondents. Some believed that it was right for women to use contraceptives but this should be only after having had enough children. What constitutes enough children was not explicit as traditionally the people in northern Namibia including Engela constituency where the study took place are known to have large families. Most of the time, men determine the number of children for the family and, should the women refuse, men will have more children with another woman. The Namibia Housing and Population census report of 2011 showed that the number of children

per household in Ohangwena Region was 6.3 while the National demographic and health survey of 2006/2007 reported total fertility rate of 5.3 for women in Namibia.

Some participants in this study viewed women who use contraceptives as “loose” or wayward. This correlates with findings of Matlala (2010) who stated that women who used contraceptives were looked upon as loose. Some of the participants in this study claimed that women who used contraceptives lacked self-respect. This finding has significant implications for reproductive health services and maternal and child health in the district and Namibia in general. Indeed, the perception goes further to the extent that majority of the participants indicated that they would not accept their spouse or partner using contraceptives without their knowledge and doing so would result in a fight or breakdown of the marriage or relationship. Men view the decision to use FP or birth control as their birthright or a cultural imposition and feel that they must either make the decision for their partner, or be involved in their partner’s decision to use contraceptives.

Objective 2: To assess what role men in Ohangwena rural area of Engela district play in contraceptive decision making of their spouses

The second objective of the study was to assess the role men play in contraceptive decision making of their spouses. The inhabitants of Engela district remain immersed in traditional values and cultural practices. Most of the men in the study indicated that they would be offended if their female partner used contraceptives without their knowledge. This finding correlates with those of Adongo et al. (2013) who reported that the decision to use contraceptives by women depends on the approval of their husbands. Adongo et al. (2013) reported that men wanted to be aware of the FP women use, when, why and how. They want to be in control of the woman’s choice of contraceptives. But in my study, men opposed women using contraceptives

because they feared the contraceptives would damage the woman's body and causing women to become old faster. It is to be noted that not all the participants have the belief that the use of contraceptives causes women to become old faster. While some men in this study believed that FP could cause female infertility, a few felt that women should be allowed to use contraceptives to prevent unwanted pregnancy. This perception and demand by men also has implications on issues related to domestic violence and on-going efforts in Namibia to combat domestic and gender-based violence. The Ministry of Gender Equality and Child Welfare has indicated in the National Gender Policy 2010-2020 that gender based violence is rife in Namibia and has set as one of its objectives to address gender-based violence and all issues pertaining to women and child welfare by 2020 (MGECW, 2010).

Although men expressed a strong desire to be involved in their partner's decision to use, because of cultural beliefs that contraceptives not be discussed with women, most were uninvolved in the actual contraceptive decision making of their partners. Men often frown at any woman who raises the issue of contraceptive and little or no discussion on the matter is entertained in the family. These findings highlight the persistent inequality in reproductive health decision-making and male dominance over women's reproductive rights. The report from the key informants and the FGD for the women supports this assertion. The findings also corroborate with those from the women FDG's. These findings align with those of Alemayelu (2012), who reported that contraceptive decision making depends on the male partners. Decision making regarding the use of contraceptives is very important for a couple and, in order to be acceptable to both parties, should be done with a spirit of togetherness. Anything short of this may lead to mistrust and confusion.

Communication is essential from the point of view of both the provider and the beneficiaries of health care programmes. Where communication is not entertained or practiced due to cultural issues the right of access to sexual and reproductive health and services becomes truncated. Contraception and FP have been demonstrated to help in reducing sexually transmitted infections and maternal and child morbidity and mortality. Communication and education are needed so that men can get more involved in the FP and contraceptives use of the couple.

Improving access to sexual and reproductive health services and ensuring a participatory approach to service delivery are key issues in reaching the target set in the Sustainable Development Goal 3 relating to reduction in child mortality and improving maternal health (UNDP, 2017). From this study, men were not found to be actively involved in the health service development of their community. The report of the key informants and the FGD for women supported this assertion. This correlates with findings of Raj et al. (2016) who reported that males were not actively involved in FP and contraceptives programmes. Involving men in the development of health services could potentially improve male acceptance and participation in contraceptive decision-making, uptake, and use. Tapping into the local knowledge and skills of the community members in issues bordering on sexual and reproductive health and contraceptives and FP in particular could provide a new opportunity and beginning and as all the participants in the FGDs and key informants indicated, they would love to be involved in programmes and activities that seek to promote the health and welfare of the women and children in the community as “they need to be loved and cared for.”

5.3 Limitations of the study

It is important to highlight the limitation of this study. Sexual and reproductive health is a very sensitive topic that culturally, many may not want to discuss openly. This could have

influenced participant responses. The study was also conducted in Engela Health district only among mostly the Oshivambo-speaking Namibians. Therefore, the findings may not be generalized to other cultures and settings.

The female participants may not have been honest about their use of birth control methods for fear that their partners may find out somehow. However, as the majority of the study participants were mostly single or unmarried, systemic bias could not be entirely eliminated but the views they expressed during the interviews are held as valid. Some meanings/contexts of the study might have been lost in translation process.

5.4 Summary, Conclusion and Recommendations

This section presents an overall summary of the findings from the research, draws conclusions and makes recommendations based on the research findings. The recommendations are focused on the third objective of the research which was to explore innovative ways to enhance male involvement in sexual and reproductive health services. The recommendations are therefore targeted to specific actors in sexual and reproductive health services in Engela district and the Ohangwena region in general.

5.5 Summary of the research objectives and findings

The research was aimed at exploring the knowledge, perceptions and practices of men in Engela district of Ohangwena region on contraceptive services and FP. It was anchored on two main research objectives – namely to gain insight into the knowledge and perceptions of men on contraceptives and to explore what role men play in contraceptive decision making by their spouses. The study has highlighted that most of the men are aware of the core issues in FP and what are the contraceptive choices available for both men and women. However, many men see

women who use contraceptives as being wayward and unacceptable in their society and would seriously feel offended and react violently if they were to find out that their partner used contraceptives without their knowledge and consent. Although sexual and other reproductive issues are often not discussed in the family circle between the men and their spouses, men often want to make decision on these issues and many women risk the wrath of their partners when they need to use contraceptives, often without their consent. The need for strengthened family and community education and improved communication within the family set up and in relationships has been highlighted.

5.6 Recommendations

Based on the findings of the study the following recommendations are made to improve male involvement in reproductive health, specifically FP services and contraceptive use in Engela health district and the Ohangwena region in Namibia:

- i. Improved community awareness of the benefits of FP and contraceptives. This is very necessary so that men and women will be able to benefit from the contraceptive use. This can be done through the collaborative efforts of the Ministry of Health and Social Services, NGOs, Regional and town Councils and with support from other Ministries and parastatals such as the Ministry of Information and Communication Technology, Ministry of Gender Equality and Child Welfare and the Namibian Broadcasting Corporation.
- ii. Improved sexual and reproductive health services for men including men's health clinics/services. This is important so that all stakeholders will be aware of sexual reproductive health services available to them and will be able to benefit from

such. Consideration should be given by the Ministry of Health and Social Services to the establishment of Men's Health clinics or clinic days within the existing health system.

- iii. Involvement of community activists and leaders in contraceptive education and other sexual and reproductive health services. This will open up opportunities for community members to participate in sexual and reproductive health services for their own advantage. Consideration should be given to include community activists and public figures as reproductive health champions in the community.
- iv. Reform cultural practices and strengthen interpersonal communication, family values and cohesiveness. This is a very important recommendation and will need to be done in a manner that respects local cultural and traditional practices. The Ministry of Health and Social Services should engage the Traditional Authorities on the way forward in this regard.
- v. Inclusion of FP issues in Life skills education in primary and secondary schools. This should be jointly pursued by the Ministry of Health and Social Services and the Ministry of Education. Strengthening school health services to emphasize reproductive health issues should be undertaken by the Ministry of Health and Social Services through continuous intersectoral collaboration.
- vi. Enhance Women empowerment initiatives. This should be actively pursued by the Ministry of Gender Equality and Child Welfare together with the Regional and Local Authorities and the civil society organizations.

vii. Areas for further research: The following areas have been identified for further research on the topic to provide a better understanding of the issues surrounding FP, contraceptive use and health promotion in the community:

- Gender development and fostering equality in tradition-oriented societies
- How best to incorporate contraceptive and FP issues in community engagement initiatives and projects
- How early life education and orientation impact on men involvement and acceptance of contraceptive services and FP
- The impact of HIV and AIDS on FP and contraceptive choices

5.7 Conclusion

This chapter presented a summary of the main findings of the study and made recommendations emanating from the study. The result of this study highlighted that most of the men who participated in the study are well informed about FP and contraceptive choices for both men and women. However, there is little involvement of men in women's decision to use contraceptives, although they want to be the decision makers. There is little or no discussion about reproductive health issues within the family, especially pertaining to contraceptive use, due to cultural practices. Recommendations for improving community awareness to advance male involvement in reproductive and contraceptive services were made. This will require cooperation and active participation from all stakeholders in the community. The study has also identified areas for further research including how best to incorporate FP and contraceptive issues in community engagement initiatives and projects.

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Appendix A: PARTICIPANT INFORMATION SHEET



My name is Dr Alexander Adedotun Alagba. I am doing a Masters Degree at the University of Cape Town. I am doing a research project to learn about the attitude and the feelings of men to the use of family planning in Engela District of Ohangwena Region in Namibia. You will participate in a group discussion with others to explore as a group your personal views and experiences about contraceptive use.

I am trying to learn from you about your experience and views because no one has any right or wrong answers so I would appreciate it if you could try to give as much information as possible, because your answers will help me understand the contraceptive decision-making experiences of men. Your participation is completely voluntary. You may refuse to answer any question and you can change your mind at any time and decide to opt out in this research. No-one will know what you have said to me. Your identity and information shall be kept private by the researcher and his team. Your participating in this research will not in any way affect your situation in the community. Please I want you to feel free to ask for explanations if you do not understand any

questions or something to do with this research. I want to reassure you that all the information you give me will be kept private.

If you have any queries, please feel free to contact:

J. Shea - Supervisor

University of Cape Town

School of Child & Adolescent Health

Tel: 021 6585030

Dr. Ebong E.Akpabio. – Co-supervisor

General Practitioner and Epidemiologist,

Cornerstone Wellness Hospital, Ondangwa, Namibia.

Tel: +264812535727

Appendix B: Consent form



Study purpose:

My name is Alexander and I am doing research for a Master's Dissertation at the University of Cape Town. I would like to know the attitudes and feelings of men in Engela district in Ohangwena Region of Namibia to the use of contraceptives.

Study procedure:

If you decide to participate in this study, it will be a FGD during which time you will discuss with other men from the community on the topic. This discussion will take about an hour of your time. The conversation will be recorded on a tape recorder so that I am able to listen while you answer the questions. That will help me to understand clearly what you discuss so that I can write down the conversation.

All information will be kept private and the strictest steps will be taken to make sure that no-one knows who you are when the information is collected from you. Only the researcher will know who you are. All notes, interviews and tape recordings will be stored in a locked cupboard which

only the researcher will be able to get to. Information on computers will have a special password so that only the researcher will be able to view this on the computer.

Right of refusal to participate:

You have the right to choose to participate or not in this study. It is voluntary. You may also decide at any time that you no longer want to take part in the study. If you feel uncomfortable with any questions, you may refuse to comment about them.

Confidentiality:

The information you give will be kept private. Nobody except the researcher will be able to hear or see the information you provide. Nobody will know your identity at any time. However the data may be seen by the Ethical review committee of the University of Cape Town to make sure that all i write about are correct and also that I am protecting the rights of research participants. The research findings may be published in journal and elsewhere but this will always be without giving your name or letting anyone know who you are.

Possible risks or benefits:

The researcher does not think there is anything that can put you at risk in being involved in this study. We only ask you for your valuable time and views. Although there are no risks to participants, some may feel uncomfortable discussing some of the things to do with decision-making processes with their partners. We will help you to find any counseling if you should need this. There may also be no direct benefits to you. However, the results of the study may help us to improve the understanding of how men feel and take part in the use of contraceptives and this can help the government to improve on the contraceptive services to the community.

If you have any questions, please do not hesitate to contact

The principal investigator:

Dr A.A. Alagba

Email: aalagba@iway.na

Dr. Alagba Consulting Room, Ohangwena, Namibia

Tel: +264812455838

Consent statement:

I have heard the aims and objectives of the study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aims and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way. I declared that I am above 18 years of age.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. I hereby give my consent to take part in the study, as explained to me in the participant information sheet, and by the Principal Investigator (PI). I understand that any questions I have will be answered, and that no one will know who I am in sharing my views.

If you have any queries, please feel free to contact:

J. Shea - Supervisor

University of Cape Town

School of Child & Adolescent Health

Tel: +2721 6585030

Dr. E.E. Akpabio – Co-supervisor

Cornerstone Hospital, Ondangwa, Namibia

Tel: +264812535727

Prof. M. Blockman

Chairperson, FHS Human Research Ethics Committee

Tel: (021) 406 6338

Signed: _____

Date: _____ / _____ /2014

I, _____ (name of PI), certify that I have explained the information sheet to the participant who has given verbal approval to participate in the study.

Signed: _____

Date: _____ / _____ /2014

Appendix C: Translated Consent in Oshikwanyama Language

Omukanda womapitikilo

Eyelifo

Ame Alexander ohandi ningi omapekapeko shi na sha no Master's Dissertation koshiputudilo shehongo University of Cape Town.

Oshinyangadalwa shange osha twa omufindo konghalo nomaliudo ovalumenhu ngeenge tashi ya komikalo dokukelelela oludalo moshitukulwa sha Ngela moNamibia.

Omukalo

Ekonakono e li ota li ka ningwa momukalo weenghundafana mougudu ,tadi ka ningwa kovalumenhu vomomudingonoko shelikolelela koshipalanyole kondadalunde osho tashi ka kundafanwa. Eenghundafana otadi ka la oule wovili imwe noyeetwa po aishe otai ka kwatwa nokutuvikilwa mokakwatimawi opo ndi dule okukei pwilikina nawa nokukei shanga.

Ouyeleele otau kala wa amenwa noitau ka hololwa nande okulye. Meenghundafana kape na out a holola kutya oove lyelye kakele ashike kunakuninga omapekapeko, oye ashike ta kala eshi kutya ovakufimbinga oolyelye.

Oinyolwa aishe tai ka nyolwa pefimbo leenghundafana opamwe nokakwatimawi otai katuvikilwa monhele ya amenwa, oshoyo ouyeleele oo tau ka tulwa mokompiuta kape na umwe taka mona oufemba woku u mona kakele komukonakoni mwene.

Oufemba weanyo kovakufimbinga

Ove onga omukufimbinga meenghundafana edi ou na oufemba uyadi okuanya ile oku efa po ekufombinga meenghundafana edi. Nongenge pefimbo leenghundafana ou udite ito dulu okunyamukula omapulo amwe ou na oufemba oku kala inoshi ninga.

Ekwashilipaleko leameno louyelele

Konima yomapulapulo kape na ouyelele tau ka pitifwa mo noka pen a nande oumwe taka shiiva oukwatya woye onga omukufimbinga. Ashike nande ngeno ongaho oidjemo yeenghundafana edi ile yomapekapeko aa otai ka konakonwa koka komitiye komapekapeko ko University of Cape Town op ova tale ngee eshi nda nyola onga omupekapeki oshi li tuu mondjila.

Pomhito imwe oidjemo yomapekapeko aa otashi dulika ika nyanyangidwe nande omomambo ile moufo vonhumba hava ningwa okuyandja ouyelele moshiwana, ashike eshi nande oshi ningwe oukwatya woye ile edina loye onga omukufimbinga italikayandjwa.

Omawii ile omauwa taa dulu okuholoka

Omukonaakoni ota yelifa apa kutya kape na oupyakadi tau ke ku hanga molwa ekufombinga loye, ota indile nefimaneko linene eliyambofimbo loye nomayele oye taa tungu.

Onga omukufimbinga, otashi dulika peemhito dimwe uka kale ino mangeluka nawa pefimbo leenghundafana ngeenge tashi ya koipalanyole ya kwatela mo ookaume vopaihole. Ohatu udaneke okukayandja eetundi dexungomwenyo pomhito ya tya ngaha ngee oyaka holoka pefimbo lomakonaakono taa ningwa.

Oidjemo yomapekaapeko otai ka kwafela okuxumifa komesho eudaneko lomaliudo nekufombinga lovalumenhu kelongifo lomikalo dokukelela oludalo, nomikalo edi otadi ka

kwafela epangelo li dule okuxwaxwameka nokuandjakanekaomikalo dokukelela oludalo moshiwana.

Ngeenge ou na epulo kombinga yaashi, manguluka u ninge ekwatafano nomupekaapeki mwene

Dr. A. A. Alagba

Email: *aalagba@iway.na*

Dr Alagba Consulting room. Ohangwena. Namibia

Tel. +264812455838

Epitikilo

Onda uda ko nawa oshitwa shopokati oshoyo omalalakano ekonaakono eli, nonda pewa efimbo la wana okupula omapulo nokudilaadila moule oshinima eshi. Omalalakano omapekaapeko okwa yeleda nge nawa noinandi fininikwa nande opo ndi kufe ombinga.

Ondishi udite sha yela kutya okukufa ombinga otashi di komaliudo a nge mwene, nondi na oufemba okudja mo keshe efimbo no inandi yandja nande etomhelo kutya omolwashike. Onghee ohandi pitike apa ndi kufe ombinga momapekaapeko apa ngaashi sha fatululwa kouyelele nda pewa momukanda womapitikilo oshoyo osho sha fatululwa komukonaakoni.

Ondi udite keshe epulo handi ka pula ota li ka nyamukulwa, nonda yeledwa yo kutya kape na umwe taka shiiva kutya ame olyelye onghee onda manguluka okuyandja ouyelele oshoyo omaliudo a nge.

Komapulo a wedwa po, manguluka u ninge ekwatafano:

J. Shea-Supervisor

University of Cape Town

School of Child & Adolescent Health

Tel. +27216585030

Dr. E.E. Akpabio-Co-Supervisor

Cornerstone Hospital, Ondangwa, Namibia

Tel: +264812535727

Prof M. Blockman

Chairperson, FHS Human Research Ethics Committee

Tel: (021) 404 6338

Eshaino _____ Efiku _____

Appendix D: Key Informant Interviews Guide

Thank you for agreeing to share your knowledge and insight into men and their reproductive and contraceptive behaviours with me. I am doing this research so that I am better able to understand the attitudes and perceptions of males to contraceptive services in Engela District of Ohangwena Region of Namibia.

1. I am really interested in understanding your opinion about whether men actually use contraception
 - a. Prompt question: In your opinion, when do men use contraceptives?
 - b. How involved do you think men are in the contraceptive choices of their female partners?
 - c. Do you think men and women talk about contraception with each other?
2. This may come across as rather personal, but please remember that the information will be kept private. Do you use any contraceptive method? When did you start using it? What helped you to make the choices you made?
3. When men and women talk to you about contraceptives, what are they most concerned about? What kinds of information do they request? Do they discuss some challenges or problems they have about this with their partners? If so, please tell me what the main problems are?
4. Are there ever situations in which you recommend contraceptive use to men or women? If yes, please tell me more about those situations.
5. Just out of interest, where did you get information about contraceptives?
6. What do you believe the benefits of contraceptives or family planning services are?

7. Please tell me what you know about these services and the contraceptives they make available to men and women.
8. I would like to hear your view about how individuals, and couples, should make contraceptive decisions?
 - a. For example, who should provide this information?
 - b. At what age should boys and girls be made aware of contraception and reproductive health?
 - c. Who should be discussing this with them?
 - d. Who should take responsibility for contraceptive decisions?
9. What is your view on sex outside of marriage?
10. What is your view on abortion?
11. What is your view on the morning after pill?
12. What about HIV? Should everyone be tested for HIV? At what age? Who should initiate HIV testing and contraceptive counselling

Appendix E: Focus Group Discussion Guide (For Men)

1. What are the most common health issues facing men in this community?
2. What are the main reproductive health needs of men in this community?
3. Where do men go to seek help for their reproductive health needs?
4. Have you ever heard of family planning and contraceptives? What do these mean to you?
5. Do you know of any contraceptive methods for men? Have any of you ever sought to have a male contraception?
6. What contraceptive methods for women do you know or have heard of? What do you think of women who use contraceptives? When should a woman really use a contraceptive?
7. Would you support your wife or partner to use a contraceptive? If you found out that your wife or partner has been using contraceptives without your knowledge what would you do?
8. What do you really see as men's role in contraceptive decision making by women? What should be done to prevent unwanted pregnancy or sexually transmitted infections among men and women?
9. Have you ever been involved in developing services for improving men's health? How can services for men's health needs be best done and by who?
10. How can men be better involved in services for improving the health of women and children and reduces the incidences of death among pregnant women and children?

Appendix F: FOCUS GROUP DISCUSSION GUIDE [FOR WOMEN]

1. What are the most common health issues facing women in this community?
2. What are the main reproductive health needs of women in this community?
3. Where do women go to seek help for their reproductive health needs?
4. Have you ever heard of family planning and contraceptives? What do these mean to you?
5. Do you know of any contraceptive methods for women?
6. Have any of you ever sought to have any method of family planning? What was the reason you decided to go for a family planning service? Who made the decision for you to go for this service?
7. Did you discuss the need for the family planning with your partner/spouse? If yes, what was his reaction on this?
8. Do you and your partner have on-going communication/discussion on the use of family planning/contraceptives? What is the nature of the discussion?
9. What do you consider as the role of women in contraceptive decision making? What do you see as the role of men in this matter? Who do you think should have the final say on your use of family planning/contraceptives and the type of contraceptive you use?
10. What contraceptive methods for men do you know or have heard of? Do you know of any man who has used any family planning/contraceptive method? Would you encourage your partner/spouse to go for contraceptive/family planning services for men?

Annexure G: DEMOGRAPHICS OF PARTICIPANTS

Code	Age	Occupation	Education Level	Marital Status
MM1	33years	Entertainer	Grade 12	Single
KJ1	25years	Business Man	Tertiary	Single
NT1	34years	Technician	WVTC Level 3	Single
RM1	24years	Electrician	Grade 10	Single
LH1	27years	Unemployed	Grade 3	Single
NS1	26years	Unemployed	Grade 10	Single
ME1	26years	Retail	None	Single
AZ1	46years	Security	Grade 10	Single
KM1	19years	Unemployed	Grade 10	Single
JS1	27years	Paramedic	Tertiary	Single
KS1	27years	Musician	Grade 10	Single
CG2	26years	Sales Man	Grade 12	Single
RN2	25years	Sales Consultant	Tertiary	Single
MH2	29years	Producer	Grade 12	Single
JK2	25years	Technician	Grade 12	Single
KB2	24years	Business	Grade 12	Single
WM2	21years	Unemployed	Tertiary	Single
NP2	21years	Unemployed	Tertiary	Single

NM2	27years	Unemployed	Grade 6	Single
KL2	34years	Teacher	None	Single
PM3	19years	Carpenter	Grade 8	Single
JO3	20years	Unemployed	Grade 10	Single
SJ3	25years	Joinery	Grade 10	Single
MS3	20years	Student	N2	Single
SJ3	21years	Student	Grade 10	Single

Code	Age	Occupation	Education Level	Marital Status
JE3	37years	Own Employee	Grade 10	Single
TJ3	27years	Front Disk Officer	Grade 12	Single
SM3	26years	Bank Clerk	Diploma in HR	Single
SW3	19years	Car wash man	Grade 10	Single
EW3	23years	Unemployed	Grade 10	Single
LA4	21years	Unemployed	N1 Certificate	Single
TN4	42years	Police officer	Grade 12	Single
MP4	42years	Security	Grade 12	Single
HV4	38years	Manager	Tertiary	Married
MM4	42years	Community Volunteer	Grade 12	Single

GK4	25years	Watchman(SRC)	Grade 12	Single
MN4	19years	Student	Grade 10	Single
SS4	19years	Unemployed	Grade 9	Single
KJ4	24years	Unemployed	Grade 7	Single
MN4	21years	Self Employee	Grade 9	Single

Code	Age	Occupation	Education Level	Marital Status
LSw1	38years	Dental Assistance	Grade 12	Single
TTw1	22years	ECP-Basic	Grade 12	Single
NAw1	37years	Secretary	Grade 12	Single
Fw1	28years	ECP- Intermediate	ECP- Intermediate	Single
MNw1	30years	Receptionist	Advance Diploma in HR	Single
HFw1	29years	Police Officer	Grade 12	Single
ENw1	32years	Secretary	Grade 12	Single
RNw1	28years	Secretary	Grade 12	Single
TDw1	30years	Secretary	Grade 12 & Certificate in	Married

			Secretarial	
NTw1	23years	Student	Grade 12	Single
NAw1	32years	Secretary	Diploma	Single
MRw1	20years	Student	Grade 10	Single
BHw1	26years	Student	Grade 12	Single
HSw1	29years	Assistant Library	Certificate	Single

Code	Age	Occupation	Education Level	Marital Status
WSw2	29years	Sale Lady	Grade 12	Single
BAw2	31years	Sale Lady	Grade 10	Single
WEw2	30years	Sale Lady	Grade 12	Single
NKw2	25years	Shop Assistance	Grade 12	Single
SNw2	30years	Shop Assistance	Grade 12	Single
HLw2	32years	2yc	Grade 12	Married
VLw2	32years	Cashier	Grade 12	Single
SNw2	24years	Administrative Officer	Diploma	Single
ONw2	23years	Librarian	Degree	Single
HNw2	29years	Librarian	Diploma	single
PIw2	34years	Librarian	Degree	Single

Age		No of men	No of women
19-25		20	
26-30		9	
31-35	3		
36-40	2		
41-46	4		

Marital Status			
Single	Married	Co-habiting	
25	04	15	
Academic Qualifications			
Grade 01-06	Grade 07-12	Tertiary Education	No Education
02	25	10	02
Occupation			
Unemployed	Employed	Students	
10	Paramedics [2], Teacher [2], others [21]	10	

