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MALE PARTICIPATION IN FAMILY PLANNING: RESULTS FROM A QUALITATIVE STUDY IN MPIGI DISTRICT, UGANDA

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Summary. The aim of this study was to determine men's perceptions about family planning and how they participate or wish to participate in family planning activities in Mpigi District, central Uganda. Four focus group discussions were conducted with married men and with family planning providers from both the government and private sector. In addition, seven key informants were interviewed using a semi-structured interview guide. The results indicate that men have limited knowledge about family planning, that family planning services do not adequately meet the needs of men, and that spousal communication about family planning issues is generally poor. However, almost all men approved of modern family planning and expressed great interest in participating. The positive change of the beliefs and attitudes of men towards family planning in the past years has not been recognized by family planning programme managers, since available services are not in line with current public attitudes. A more couple-oriented approach to family planning is needed. Measures could include, for example, recruiting males as family planning providers, offering more family planning counselling for couples, and promoting female-oriented methods with men and vice versa.

Introduction

Traditionally, family planning programmes have been directed towards women, since it is women who become pregnant and face the health risks associated with pregnancy and childbirth and thus have presumably the greatest motivation to prevent unwanted pregnancies. Moreover, women are more likely to be in contact with the health care system because of their overall responsibility for family health, especially for the health and welfare of infants and children under five years of age. An additional

reason is that women, in general, desire fewer children than men, as suggested by research evidence from sub-Saharan African countries (Bankole & Olaleye, 1993; Ngallaba *et al.,* 1993). The limited involvement of men in either receiving or providing reproductive health information is somewhat surprising, given the strong evidence indicating that in sub-Saharan Africa, men play a crucial role in the decision-making about the use of contraceptives (Fayorsey, 1989; Mbizvo & Adamchak, 1991). In fact, studies have shown that the limited impact of many family planning programmes, particularly in some sub-Saharan African countries, can be attributed to a continued neglect of men as both agents and clients of family planning (Khalifa, 1988; McGinn *et al*., 1989; Chipfakacha, 1993; Ezeh, 1993; Terefe & Larson, 1993; Agyei & Migadde, 1995). The neglect of men with respect to their role in family planning has contributed to a situation in which men have remained passive or non-participatory in reproductive health-related studies and have generally not been included in most of the research on family planning and use of modern contraceptives. Thus, compared with women, less is known about men's perceptions about family planning in particular and reproductive health in general. With the exception of some fragmentary survey data, pertinent information from sub-Saharan Africa on male perceptions about reproductive health and sexual behaviour is virtually non-existent (Finkel & Finkel, 1983; Mbizvo & Basset, 1996).

One of the few studies providing information on male participation in family planning comes from Zimbabwe, where it was found that those women who did not discuss family planning with their male partner had a 2·8-fold increased risk for an unplanned pregnancy (Mbizvo *et al*., 1997). Also in Zimbabwe, Diller & Hembree (1991) found that male knowledge of family planning was high, and the majority of men indicated that they approved of family planning and were willing to use modern methods of family planning. In the 'Male Motivation Project' for family planning in Zimbabwe, it was found that men were very amenable and receptive to a public family planning campaign and substantially increased their use of modern contraceptives (including condoms) within a relatively short time after the intervention was completed (Piotrow *et al*., 1992).

Both the literature and field experience suggest that there is a wide gap between men's stated willingness to participate in family planning and the reality of their actual participation in family planning programmes; a situation that is probably a reflection of failure on the part of both the men themselves and the family planning services that have yet to adequately consider men in their programming. For example, in many community-based family planning programmes in sub-Saharan Africa, only female agents or volunteers are recruited for delivery of family planning information and products and they are inclined to serve female clients almost exclusively. In other family planning programmes where both male and female agents are recruited, the provision of services is often divided such that female agents serve female clients (promoting mainly contraceptive pills) and male agents serve male clients (promoting mainly condoms). In both of these programme examples, few opportunities are created to enhance discussion between women and their male partners. This remains the status quo even though the literature suggests that partner communication about family planning is associated with and is often essential to increase levels of knowledge, improve attitudes, and enhance the use of family planning

methods (Khalifa, 1988; McGinn *et. al.*, 1989; Chipfakacha, 1993; Agyei & Migadde, 1995).

In 1995, Uganda adopted the National Population Policy which has as its overall goal the 'influence of future demographic trends and patterns in desirable directions in order to improve the quality of life and standard of living of the people' (MoFEP, 1996). One of the objectives of the policy is to enhance the role of men in planning for the family, a role that will include the promotion and utilization of family planning activities. To date, however, family planning has not received the political commitment needed to successfully implement nationwide comprehensive family planning services in Uganda. This low level of commitment is reflected in a low national contraceptive prevalence rate and one of the highest total fertility rates (TFR) and population growth rate in the world. In contrast, political commitment to family planning has been stronger and more effective in Kenya. In 1994, President Moi made a strong commitment to family planning by stating that each Kenyan couple should not have more than one or two children. Between 1984–88 and 2003, the TFR in Kenya dropped from 6·7 to 5·0 (KDHS, 2003).

In an attempt to bridge this gap, a qualitative study was conducted investigating married men's perceptions, attitudes and behaviours regarding family planning in Mpigi District, Uganda. The study had the following objectives: (1) to assess the levels of knowledge and attitudes of married men towards family planning; (2) to identify barriers that may inhibit or prevent married men from using family planning; (3) to identify means by which male involvement and participation in family planning can be encouraged; (4) to provide information to the family planning programme in Mpigi to facilitate and encourage the involvement and participation of men in the ongoing family planning programme.

Background information

The Republic of Uganda covers a total land area of 241,139 km^2 in the East African region. The country has a total population of 24 million inhabitants, with a female/male ratio of 96/100 (1999 est.). The annual population growth rate is estimated at 2·72%, which will double the population in approximately 26 years (MoFEP, 1996). Uganda has a young population with about 50% of its population below the age of 15 years. Uganda is also one of the least urbanized countries in sub-Saharan Africa. Only 15% of the population live in urban areas and most of these are in the national capital Kampala (Population Information Network, 1998).

Fertility in Uganda is high, with women having an average of 6·9 births by the time they reach the end of their child-bearing years (i.e. the total fertility rate (TFR) is 6·9) (2000/2001 DHS), a rate unchanged since the DHS 1995/96 survey. Uganda has the highest TFR of countries in east and south Africa that have recently participated in the DHS, including its neighbours Tanzania and Kenya (KDHS, 2003). The level of contraceptive use in Uganda is one of the leading factors contributing to high fertility. The contraceptive prevalence rate (CPR) for modern contraceptives in Uganda is 16·5% (2000/2001 DHS), lower than the rate in eastern Africa (18%) and in sub-Saharan Africa overall (24%) (Population Reference Bureau, 1999). Recent evidence has suggested that there is considerable unmet need for family planning

services in Uganda. Unmet need refers to those women who say they want to space or limit their births, but are not using any form of family planning. The unmet need for family planning is 38% in Uganda and 25% in sub-Saharan Africa (Population Information Network, 1998). Together, these indicators demonstrate the urgent need for increased family planning services in Uganda to meet its National Population Policy goal to 'influence future demographic trends and patterns in desirable directions in order to improve the quality of life and standard of living of the people' and thus to make progress towards sustainable social development.

Mpigi District is one of the biggest districts in Uganda, both in landmass and population. It has a land area of 4514 km^2 and a population of over 1 million individuals, resulting in a population density of 222 persons/km^2. At 71%, the literacy level for women in Mpigi is much higher than the national average of 50%. Fertility is high with a TFR of 7·1 and a population growth rate of 2·9% (MoFEP, 1992). Maternal mortality ratio is estimated at 500 deaths per 100,000 live births. Within Mpigi District there are 56 government health service delivery points, including hospitals, health centres and dispensaries. A unique difficulty for family planning in Mpigi District is accessibility to services, owing to a largely rural population.

The types of modern contraceptives available in Mpigi area include oral contraceptives (the pill), Depo-Provera injections and male condoms. The supply of such contraceptives is unreliable in the study area and no systematic stock system is in place. Thus, supply shortages are not uncommon. Norplant, IUD, diaphragms/cervical caps, foam/jelly and female condoms are not readily available.

The family planning providers in the research area are mainly nurses, medical assistants and nursing aids. Some are directly involved in family planning activities and some are indirectly involved (in a supervisory and/or service planning role). These individuals are not volunteers and primarily work out of the clinic. A programme using community-based distributors (CBDs) is being initiated to distribute contraceptives in the research area; however, a thorough analysis of the number of CBDs and their effectiveness has not been conducted.

A systematic programme for male participation in reproductive health including family planning has been considered in Mpigi District, but not yet planned or developed.

Methods

Semi-structured interviews with key informants and focus group discussions (FGD) with married men from Mpigi District were conducted. The interviews and FGDs were conducted in late 1999. Seven key informants were identified on the advice of staff from the District Health Management Team (DHMT), which is responsible for planning and implementation of family planning programmes. The key informants were knowledgeable individuals with a vested interest and involvement in family planning issues and could therefore offer various perspectives on the extent of male involvement in family planning that has been achieved, barriers to their participation, and methods for increasing male participation. The seven key informants included members of the DHMT (including administrators and providers), private providers of family planning services in the district, and representatives of the Mpigi Town

Council and the Family Planning Association of Uganda (FPAU). Interviews were conducted separately, in English. The interview guide consisted of questions designed to identify barriers to male use of and participation in family planning as well as methods to encourage male involvement in family planning.

Complementary to the interviews, four FGDs were conducted. The first FGD was composed of married men who were currently using family planning (themselves or their spouses) (referred to as 'users') and the second FGD was composed of married men who were not currently using family planning (themselves nor their wives; referred to as 'non-users'). The remaining two FGD sessions were conducted with health staff from the Mpigi District health services. The focus groups of the health staff were done separately for males and females. All of the health staff who participated in the 3rd and 4th FGDs were involved in family planning through the provision of contraceptives, advice and/or counselling.

The participants for the first two FGDs were selected through the use of snowball sampling from two sub-counties (Mpigi Town Council and Mutuba I). Eight participants were identified for participation in the FGD with family planning users, while seven participants were identified for participation in the FGD with family planning non-users. Users and non-users were recruited from the same area to minimize the effect that distance between residence and the clinic would have on user status. These FGDs were led by a trained facilitator from Mpigi who was familiar with family planning issues. The FGDs were conducted in *Luganda*, the local language. A member of the local research team was present to observe and take notes. One of these (A.K.) was also present to take notes on the order of the speakers, body language and other elements that would not be captured on the audio-tapes.

The 3rd and 4th FGDs with male and female health staff were conducted in English by A. Kaida. The FGDs were audio-taped and an assistant was present to take notes. The interview guide for these FGDs was similar to that utilized for the key informant interviews. These participants functioned as a focus group of key informants. All FGDs were held at the Mpigi Health Centre in late 1999.

The FGDs were audio-taped. The transcripts from the audio-tapes were translated into English by a qualified translator. The English translations were back-translated into *Luganda* and compared with the original transcripts. Differences in the two scripts were noted and the best possible option was entered into the final English version of the transcripts. Translation assistance was provided by staff from the Institute of Languages at Makerere University.

Transcripts from key informant interviews and from the FGDs were entered into Microsoft Word 97. Key themes were extracted from the transcripts and compiled. A coding framework was developed from the list of key themes and was used to code the transcripts for analysis. Quotes were extracted from the raw data to provide evidence for each of the themes and categories extracted. The analysis was completed using manual categorization methods. Reliability and internal validity of coding of themes extracted from the interviews and the FGDs were tested by two independent coders. Percentage agreement between the investigator and the independent coders was calculated and reported.

This study was granted ethical approval by the Health Research Ethics Board Panel B of the University of Alberta and the National Science and Research Council

Table 1. Composition of key informants

Code	Classification of key informant	Gender	Age
KI-1	Family planning administrator (government sector)	Female	54
KI-2	Family planning provider (government sector)	Male	47
KI-3	Family planning provider (government sector)	Female	37
KI-4	Government administrator	Male	39
KI-5	Family planning administrator (private sector)	Female	52
KI-6	Family planning provider (private sector)	Male	36
KI-7	Family planning administrator (private sector)	Male	45

Table 2. Composition of focus group discussions (FGDs)

Code	Description of FGD	No. of participants	Gender
FGD-1	Family planning users from community	8	Male
FGD-2	Family planning non-users from community	7	Male
FGD-3	District health workers	6	Female
FGD-4	District health workers	3	Male

of Uganda. Approval was also granted by the District Medical Officer (Mpigi), the Director of the Mpigi Health Centre and two local political representatives (Local Council 3 Chairmen). On behalf of the communities within their jurisdiction, the two LC3 Chairmen granted consent to conduct the study on behalf of their communities within their jurisdiction. All study participants were provided an information letter describing the study and were asked to sign a consent form to participate in the study. The information letter and consent form were available in English and *Luganda*. Participants were assured that they could leave the study at any time without any repercussions. In the interest of protecting the privacy and confidentiality of information, no names of participants were recorded. The research assistants were also trained to ensure that consent to participate in the study was given voluntarily and without coercion.

Results

To protect confidentiality, each key informant and each focus group was given a unique identification code which was used throughout the analysis to identify quotes from the same sessions. The compositions of the key informant interviews and the FGDs are shown in Tables 1 and 2, respectively.

To test for reliability of coding, fifteen responses from each of the eleven transcripts were randomly chosen and given to two other reviewers. Each was asked to assign a code (from a provided list) to each of the responses given. Both reviewers

were familiar with qualitative research techniques and family planning. The average percentage agreement between the independent coders and one of the research team (A.K.) was 80·4%. This indicates a high degree of inter-rater reliability and suggests that coding was performed rigorously and reliably.

The content analysis revealed six major barriers that inhibit or prevent men from practising family planning. These barriers include: (1) lack of information or misconceptions, (2) side-effects associated with using family planning methods, (3) unavailability/inaccessibility of family planning services and supplies, (4) lack of trust in family planning personnel, (5) lack of couple communication, trust and counselling, and (6) cultural and religious factors.

Lack of information or misconceptions about family planning

Lack of information or misconceptions about family planning were demonstrated by the men and were universally cited by the key informants as one of the greatest barriers inhibiting men from participating in and practising family planning. Some participants, particularly from the non-users FGD, provided definitions of family planning that were literal interpretations, making it difficult to gain a real understanding of their level of understanding. For example, one participant stated:

> Family planning, that's how a man plans for his family. (FGD-2, male)

Although most men could name at least one family planning method, few understood how this particular method worked. There was also confusion among the men about what constitutes 'safe days' in the context of periodic abstinence. One participant incorrectly reasoned that:

> … she tells you on such days I'll be having my periods and you can count about 3–4 days backwards and about 3 days after her period and that is when you can abstain [from sex] and that could also be a good method of family planning. (FGD-1, male)

This comment caused much confusion among the men in this FGD. Interestingly, although most FGD men did display a basic knowledge about family planning and family planning methods, they reported that *other* men in the community have little or no knowledge about family planning. The key informants echoed this view:

> … if you just try to go in deep, they know nothing about family planning. They are quite ignorant about that. (FGD-3, male)

General agreement from the group was reflected with head-nodding. Most men said that they got their information about family planning from the radio.

There were also widespread misconceptions and beliefs about the danger of contraceptives, especially the pill:

> There are rumours concerning family planning. That some people may say to you that I swallowed pills yet I became pregnant yet other people may say that so-and-so's wife swallowed pills and now she is permanently infertile. (FGD-1, male)

> But people have seen women who have produced five children normally, but when they started to take the pill, number six was abnormal. (FGD-3, male)

Rumours and general misconceptions about family planning were more commonly mentioned by non-users compared with users:

> People always keep these [rumours] in their minds. They always try to bring it up so that until the day they see a trusted authority coming to talk about the subject, they won't believe it. (KI-5, female)

Many key informants, particularly the family planning providers, corroborated these findings and reported that their potential clients often mention the inconvenience of using the pill and misconceptions about potential side-effects:

> Some of these men they fear that their wives will not take the pills every day, as it is too difficult to remember or because she will leave town for some days and forget these pills at home. He fears that if she misuses [forgets] taking the pill and then she becomes pregnant, that child will be abnormal. (KI-1, female)

In the FGDs with users and non-users, participants expressed concern that condoms can spread HIV/AIDS.

Side-effects associated with using family planning methods

Although attitudes towards family planning were, in general, positive among men who participated in the study, many men expressed fear about the safety and inconvenience of modern family planning methods. The FGD participants' concerns about side-effects were echoed by the key informants, especially by the family planning providers, as important barriers inhibiting men from practising family planning. The main concerns were related to the use of oral contraceptives and injectables, which were seen to be the most dangerous. Common side-effects mentioned included general sickness, menstrual disturbance, weight gain or weight loss, nausea, weakness, infertility, and malformation of new-borns. Concerns about side-effects were particularly pronounced among those with limited access to health care facilities:

> For those who are very poor and they start getting these problems like becoming very fat or very thin, she is always in her periods and always falling sick what about that? What should we do then? (FGD-2, male)

Unavailability/inaccessibility of family planning services and supplies

All participants stated that the unavailability and inaccessibility of family planning services present an important barrier inhibiting men from using family planning:

> For me why I don't use condoms is because they are never available. (FGD-2, male)

Most key informants reiterated that the supply of contraceptive devices was unreliable:

> If he comes for condoms or even for pills and we do not have, then some of them they stop using. When we have them again, maybe they will start again maybe some can decide 'Ah! This family planning. I cannot mind [bother] about it.' Then I think we have failed the whole purpose of family planning. (FGD-4, female)

Another key informant stressed the importance of offering a full range of methods, which is often not possible due to a national lack of certain contraceptives:

> All of the methods should be available because you cannot go to the community and tell them that you have all the methods and when they come to you they don't find the methods. But sometimes this is very difficult and maybe even impossible. (KI-3, female)

Distance to the nearest family planning outlet was mentioned by almost all participants as a barrier to receiving family planning services. Problems with distance were reflected in discussions about the cost/availability of transportation and time to get to the clinic:

> You know some people don't come because of the distance. When she calculates, even if the services are free, she has to use a *boda-boda* [motorcycle taxi] … It's 400 shillings or 1000 and so she comes and the time you might find the health worker very busy. You have to sit there for one hour. Who is doing the work at home? (KI-2, male)

With respect to gender differences, male FGD participants considered their access to family planning services to be poorer than for women:

> For us men, we really like to bring those services nearer to us because the women come here [to the health centre] for antenatal clinics and when they bring children to be immunized they are taught about family planning. Yet we, who don't bring children to be immunized, don't get that information of the methods. (FGD-1, male)

Some of the key informants noted that male visits to the family planning clinic depend partly on condom availability. This is reflected in the following interchange with family planning providers from a government health centre (FGD-3):

> Facilitator: Do you see a lot of men coming to the clinic? For counselling, for services, or for supplies?
>
> Participant 1: Not at all.
>
> Participant 2: I haven't met one, except when you are in casual discussion. As you can find the man is here and he can ask you this and that. But actually here in the family planning clinic, very rare.
>
> Participant 3: They used to come for condoms, but not any more.
>
> Participant 2: And there are few who come with their wives.
>
> Facilitator: Okay, so few come alone and fewer come with their wives? Or how is it?
>
> Participant 2: No. Now fewer come alone and a few come with their wives.

Explanations provided for the decrease in the number of male visitors to the family planning clinics for condoms included that the clinic had an unreliable supply of condoms and that condoms can often be readily purchased from private providers, where the supply is generally more reliable.

Relatedly, included in the issue of accessibility was the often prohibitive cost of the method:

> The problem with condoms is that you go to buy condom like *Protector* [local brand]. On it, they should be 100 shillings yet they sell them for about 400, which people cannot afford. (FGD-2, male)

Lack of trust in family planning personnel

Both family planning users and non-users expressed scepticism about the intentions of family planning personnel and programmes, questioning their motivations for encouraging individuals to use family planning methods. The distrust in providers was often described as a belief that providers were more concerned with

their own financial and/or other personal gains than the needs of the community. There were also concerns that family planning providers withheld important information about the associated health risks from community members. These sentiments were more often and more emphatically expressed in the non-user group:

> I wonder why these people advertise things which seem to have no benefits to us. Who is benefiting that people should talk so much about family planning? (FGD-2, male)

> For us we hear that the whites with these modern doctors of ours want to reduce Africans. That's why they have brought family planning so that they [Africans] can get cancer. So why should we support family planning? (FGD-2, male)

The lack of trust of providers may be, in part, driven by the described treatment of potential users by providers. Most participants expressed that the providers were sometimes rude, dismissing or disregarding their clients' fears about side-effects, and seldom countered misconceptions to dispel their clients' fears. Most key informants acknowledged this as well and were not surprised to hear such blaming about a lack of trust and rudeness. Many admitted to being privy to such encounters:

> Our health workers, some of them have a negative attitude towards their clients … The reason some community members do not practise family planning is not that they are against the methods, but that they do not like the services and personnel at family centres. (KI-2, male)

Most FGD participants said that men did not feel welcome at family planning centres, and held many reservations about attending because they feared discussing such sensitive and private issues with the provider, who is almost always a woman:

> Some health workers, she may even ask, how did you play sex? That's why they [men] fear to come back, it makes it hard. (FGD-1, male)

One key informant who was a private provider of family planning services stated:

> … some people when they are working in the government, they are sometimes harsh, but for us [private providers] we have to be very kind … Because sometimes they [government providers] don't have time to explain to clients, clients come to me saying they don't get counselling there, they can't get methods, they need some help with side-effects, you know. (KI-5, female)

Many of the FGD participants had concerns about the quality of the services and the information given in government facilities:

> Even the instructions that came with the pill were in English, not *Luganda* [the local language]. (FGD-1, male)

KI-1 explained that while the local language is used to communicate with clients in government facilities, most of the family planning supplies are imported from abroad and the instructions for use are not translated into *Luganda*.

Lack of couple communication, trust and couple counselling

Most FGD participants and key informants expressed lack of couple communication, trust and couple counselling as major obstacles for the involvement of men in family planning. Lack of communication between couples was in part attributed to the widespread perception that contraceptive use was commonly associated with promiscuity and infidelity:

> Some ladies, they can tell you that if she would talk to her husband about using these pills, he could think she is a prostitute … a woman who cannot be trusted to be faithful. (KI-1, female)

Most FGD participants said that they would be very angry and suspicious if their wives made the decision to use contraceptives without consulting them. As described by a female key informant:

> … she can be very worried because they can even divorce! He can even chase away the wife if he learns that she is using family planning. The marriage can even break. (KI-2, female)

The opposite of this situation was also mentioned, albeit less commonly, as men expressed that it was their wives who became jealous and angry when they caught their husbands with condoms:

> For me I fear quarrelling with my wife should she see a condom in my pocket it will be real quarrelling, telling me that I am a prostitute, getting women. So I can't dare use condoms. (FGD-1, male)

The secrecy of using contraceptives by the wives was mentioned by the key informants as one reason for the high demand of injectable contraceptives.

Most groups said that family planning providers give only information about female-controlled methods to women and about male-controlled methods to men. It was also expressed in most groups that counselling of couples is rare and instead, providers prefer to counsel men and women separately. It was also said by some participants that the different information about family planning given to men and women can contribute to more mistrust between couples.

> Those condoms, those people who teach about how to use them only teach men as such the women don't know about them. So the women look at condoms as if they are depriving them of their rights. (FGD-1, male)

The lack of couple counselling was discussed with the key informants. The female family planning providers reported that they are more comfortable counselling women only due to a comfort level of women talking to women about sexual issues, and men talking to men.

Cultural and religious factors

Most men expressed a desire for many children. Discussions about ideal family sizes revealed that the reasons for this were multi-factorial and complex and included: (1) having many children enhances prestige in the community; (2) children are important for labour and social security; (3) concerns about the high rate of child mortality. Participants explained that the common preference for sons over daughters was at least partially because boys become members of their father's clan and continue on the clan name, thereby increasing the power, status and longevity of that clan. Another relevant cultural factor was the practice of polygamy. Participants explained that the competition between wives for a husband's love is often played out with the number of children, most importantly sons, borne by each woman. As explained by one of the female participants:

> … I think women, we think the more [children] that we produce, the more the husband will love you … and then she'll tell you, 'you know my co-wife is still young and is still producing'. It is

> a competition. So they continue competing, competing, competing. My co-wife has produced so now I also must produce. (FGD-4, female)

Religion was widely considered by all participants to be a barrier to contraceptive use. Overall, participants reported that the Anglican Church tended to be more accepting of modern methods compared with the Catholic and Muslim denominations:

> I think one of the reasons for resistance [to family planning] is religion, especially Catholics and Muslims. The ones who are very serious feel they are committing a sin when they use family planning. (KI-2, male)

Motivators/means to encourage male involvement in family planning

The majority of the male FGD participants stated that they approve of and want to be involved in family planning. The most commonly mentioned strategy for promoting male involvement and practice of family planning was to improve family planning information, education and sensitization in general, but also specifically directed at men. Several participants suggested providing family planning information during community seminars conducted by a well-respected local individual. Other participants suggested that family planning information should be available where men are (e.g. workplaces, bars and other community areas where men tend to congregate). As radios were identified as an important source of family planning information for men, participants suggested that radio messages should be strategically aired:

> … during programmes that men like to listen to, such as football matches' (KI-6, male)

since

> at these times you may be sure of getting about 70–80% of men's attention. (FGD-1, male)

Participants, including key informants, also stated that:

> … materials [about family planning] have to be printed in the local languages so those who can read can read it. And they should be distributed at household level. (FGD-1, male)

Further evidence supporting the importance and timeliness of increased information about family planning was provided by both male and female research assistants who remarked on the levels of enthusiasm they met in the community from individuals interested to know more about family planning. As one research assistant commented:

> … the interest in family planning by men in our communities surprised even us! They want us to come back to them with more information. (FGD-3, male)

Almost all participants from the four groups requested family planning services that are tailored towards the needs of men and delivered nearer to men:

> … they have to bring services to where we stay. In most cases we work so much so that if the services are not near to us, we may not get interested. (FGD-1, male)

Participants also suggested that some of the family planning providers should be men:

> If some community-based providers are men and then they go and talk to fellow men about family planning, I think somehow they will respond. Because now if a woman goes and talks to a man about family planning, he can feel threatened and not respond. (KI-7, male)

Also, contraceptive choice was emphasized as important to encourage men to use a method:

> Whatever a person wants is what he uses. If the method he wants can't be there, he might not use it. (FGD-2, male)

Focus group discussion participants as well as key informants expressed that encouraging communication between husbands and wives and between providers and couples would serve as an important motivator to stimulate male involvement in family planning. It was also expressed by most participants that if family planning providers were to counsel couples together, this may alleviate some of the distrust associated with a woman approaching her husband to begin practising family planning, and vice versa:

> These things for family planning, they should explain to both, the woman and the husband. So that women don't complain that they fear being looked at like *malayas* [prostitutes] and can't be trusted. (FGD-1, male)

Some participants felt that the responsibility to actually use or take the family planning method was that of the wife. Others stated that, in addition to participating in the decision to use family planning, men could perform some important and helpful roles.

> ... family planning should be decided upon by two people because they are aiming at achieving the same goal. Each one will be responsible, and will look after one another. (FGD-1, male)

Counselling of couples about family planning was mentioned by most key informants as an important step towards male participation but moving towards a community-based model was considered a critical component:

> Because if it is community-based, both of you, maybe on a Sunday or a Saturday when most people don't go out to work, and somebody can talk to both of them, together. Like we are saying about the respondents coming to the clinic together, that one is not feasible. They can't, they won't, because they work. (KI-2, male)

Although important and useful, key informants emphasized, however, that couple counselling should not be required to the detriment of an individual's need or want to use family planning methods. If a woman is in need of using family planning due to health concerns, for example, but her husband is strongly opposed, encouraging couple counselling:

> … should be considered secondary to ensure that a woman's family planning needs are met. (KI-7, male)

Discussion

This study represents one of the first attempts in Uganda to obtain information from Ugandan men on their knowledge, views and attitudes towards family planning. The following three major themes about male participation in family planning emerge from this study.

Lack of family planning knowledge and/or misconceptions

Despite the fact that men have limited knowledge about family planning, they want to be involved in family planning discussions and information sharing. This is somewhat surprising and contradicts the general notion that men are not interested in family planning issues. However, approval of family planning by men has been found among men in Khartoum, Sudan (Khalifa, 1988). This is also consistent with findings by Eleuther *et al*. (1998) in Tanzania, where most men interviewed expressed a positive attitude towards fertility regulating methods. Also, Piotrow *et al.* (1992) reported from Zimbabwe that men were very amenable and receptive to a public campaign about family planning. A quantitative study in Mpigi demonstrated that approximately 90% of married men were interested in gaining more knowledge about family planning (Kaida, 2001). Consistent with this finding, the FGD participants in this study emphasized that they want to gain more knowledge about family planning in order to make them competent partners in discussions with their spouses and health workers about family planning. The lack of knowledge was seen by most men as not reflecting a lack of interest in family planning, but a lack of opportunity to learn more about family planning matters.

Misconceptions about hormonal contraceptives were very common and were expressed vividly by many men. They included reducing men's sexuality, producing congenital malformation in new-borns, causing permanent infertility of women, developing cancer and spreading HIV/AIDS (through condoms). Providers and key informants saw this as a major obstacle to the practice of family planning. Men's concerns about the side-effects of hormonal contraceptives were similar to those expressed by women about side-effects in other studies in Uganda (Flaherty, 2001; Ndyanabangi & Kipp, 2001).

Lack of credibility of family planning personnel and services

As reported by both FGD participants and key informants, the existing family planning services in Mpigi are not targeted towards men. As most family planning providers are women, most men said that they would feel uncomfortable talking to a female provider about contraception. The study results also indicate that very few men went to the family planning clinics alone or with their spouses, because they feel that they are not welcome, and there are few services available for them. Most men reported that a major deficiency in the current family planning programme was the availability of counselling services for couples. This, and the reported tendency of family planning workers to promote female-controlled methods only to females and male-controlled methods only to males, further enhances a female-biased approach to family planning. In their study in Zaire, Bertrand *et al*. (1996) found that women were more likely to know female-controlled methods and men were more likely to know male-controlled methods, which is similar to the responses provided by men in this study. The inadequacy of family planning programmes to serve men was also found in Mbeya, Tanzania (Eleuther *et al*., 1998). Another study from Nigeria revealed that the lack of male involvement in family planning was due to inadequacies of the family planning programme to reach out to men (Fakeye & Babaniyi, 1989). The negative attitude of many family planning providers in the public sector was clearly expressed

by the men and by the providers from the private sector. This attitude also appeared to contribute to the low acceptance and uptake of family planning services in Mpigi District.

Lack of spousal communication about family planning

The study revealed a lack of spousal communication about family planning in Mpigi District. This finding was widely expressed by the men and they attributed it to their poor understanding of family planning knowledge and to the common reluctance of (primarily female) family planning providers to include men in family planning counselling and other programme activities. Providers' comments were consistent with this reported problem. In addition, reports from the study participants confirmed previous observations and reports that women prefer injectables to pills because injectables can be used without their husbands' detection. It is obvious from observations that the family planning services could do much more to facilitate men's participation. For example, in Kabarole District in western Uganda, where male family planning agents serve female clients and vice versa, it was found that female clients of male agents were more likely to talk to their male partners about family planning compared with female clients of female agents (Kipp & Flaherty, 2003a). Several other studies in Africa have also highlighted the lack of joint decision-making in couples regarding family planning (National Research Council, 1993; Eleuther *et al.*, 1998). In Zimbabwe and Tanzania, partner communication regarding family planning was found to increase fertility-regulating behaviour (Beckmann, 1983; Mbizvo & Adamchak, 1991).

The authors could not find any published information on male involvement in family planning from Uganda, thereby limiting the possibility of comparing these results with other study findings from Uganda. To the best of their knowledge, Kabarole District in western Uganda is one of the few districts where the principle of male involvement in reproductive health is considered an essential element in family planning programming.

Conclusions

This study indicates that men want to be involved in family planning but lack the knowledge to be competent discussion partners with their wives. It also reveals that family planning services do not reach men adequately and family planning staff still consider family planning to be solely a woman's affair. There is an urgent need to broaden the scope of family planning programmes by including family planning messages directed to men. This would help to attract men as clients (together with their spouses) so that family planning services and counselling programmes would be more couple oriented. This could increase contraceptive use which otherwise would not occur. Relatedly, these findings highlight the need for non-clinic means of disseminating family planning information, services and supplies to improve use in rural Uganda. The great potential of trained volunteers as community-based distributors (CBDs) should be better explored. Experiences from other districts in Uganda demonstrate that CBDs are a very suitable group to bring family planning

services closer to communities, provided that strategies employed address motivation through volunteer recognition (Kipp & Flaherty, 2003b; Flaherty & Kipp, 2004). As similar study findings come from Tanzania and Zimbabwe, it is likely that the observations in Mpigi District relate to other parts of Uganda and to other countries in sub-Saharan Africa.

There is a great potential for family planning programmes in the region of eastern Africa and beyond to improve their effectiveness of service delivery by targeting men as well as women. The positive change in the beliefs and attitudes of men towards family planning in the past years (as documented in the literature) has not been adequately recognized by family planning programme managers, since the services are not in synchrony with current public attitudes. The results suggest that family planning programme managers adopt a more couple-oriented approach to family planning and use innovative measures to improve their outcome of service delivery. These measures could include, for example, recruiting more males as family planning providers, offering more family planning counselling for couples, and promoting female-oriented methods with men and vice versa. Further, there appears to be an opportunity for innovations in packaging contraceptives and developing/re-organizing new concepts in service delivery outlets. For example, in Uganda, the strategy to functionally and structurally integrate family planning with their very successful and internationally recognized HIV/AIDS control programme could be an additional opportunity to increase the success of family planing initiatives. Currently, fragmented services serve as an inconvenience to clients. One recommendation towards this is training multi-purpose skilled health workers and CBDs to deliver integrated family planning, HIV/AIDS and sexual health services.

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