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Men and Family Planning in Rwanda: What Affects the Integration of Men in Family Planning?

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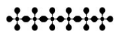

MEN AND FAMILY PLANNING IN RWANDA

What affects the integration of men in family planning?

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
HW	health worker
CHW	community health worker
FP	family planning
IUD	intrauterine device
LARC	long-acting reversible contraceptives
MCH	maternal and child health
MEDSAR	Medical Students' Association of Rwanda
MOH	Ministry of Health
PMTCT	prevention of mother-to-child transmission
RH	reproductive health
STI	sexually transmitted infection
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing

1. ABSTRACT

Objective: This study was undertaken to understand what affects the integration of men in family planning (FP) in Rwanda, mainly in villages of Southern Province and Kigali City Province. A secondary objective of the study was to identify the factors that facilitate the integration of men in FP services through other services at healthcare facilities such as voluntary counseling and testing (VCT), antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), and antenatal care (ANC); and the public's awareness on this issue.

Methods: This qualitative, community-based, participatory research was conducted in 24 healthcare facilities in Kigali City Province and Southern Province of Rwanda. Focus group interviews were conducted with 24 healthcare providers, 96 community health workers (CHWs), and 366 women and men.

Conclusion: The factors that facilitated the integration of men in FP include radio talks, Rwanda Ministry of Health (MOH) trainings at healthcare facilities and the community level, CHW teachings and visits to families, and FP counseling in health centers integrated with different services, namely FP, VCT and ANC, though the lack of a defined calendar for FP services to men in these services impended service delivery. Other factors that facilitated the integration of men in FP through other services included: 1) the selection of counselors and their training level in FP methods, 2) the decentralization of the healthcare system through CHWs, and 3) basic trainings offered to healthcare providers and CHWs. The main factor encouraging men to take a role in FP issues is concern over the financial status of their families; however, they face barriers to use such as misconception about side effects of FP methods, religious beliefs, wives willing to continue having children, and few methods available for them.

The MOH's interest in integrating men into FP services is an attempt to make services more accessible and efficient. Through discussions with healthcare providers in the two regions, the research team identified several suggestions for improving the process of integration in the future. Those suggestions generally fall into two main groups: 1) improving the content and follow-up of trainings in FP at different levels including healthcare providers, CHWs, and couples; and 2) taking into account the local context of service delivery to improve FP services, especially for men, and setting up permanent FP services involving men from the healthcare facility to the village. If FP services are to be offered in a more effective and sustainable manner, awareness programs need to be strengthened to prevent and address rumors about FP that are circulating in communities. Local leaders need to be the first examples; more trainings need to be offered to healthcare providers and CHWs, taking into consideration cultural and religious values; more FP methods, especially pills, need to be found for men; and FP services should be offered with other reproductive health services at facilities such as VCT, ANC, PMTCT, and ART.

2. BACKGROUND

Providing adequate access to family planning (FP) services continues to be an ongoing challenge for all concerned: Rwanda Ministry of Health (MOH) officials who develop policy, donors who advise and/or provide funding, directors of healthcare facilities who direct implementation, and healthcare providers who actually deliver the services. There has been sustained interest in many countries in integrating FP into existing reproductive health (RH) services to improve access to services and ultimately to improve the well-being of communities and the overall population. This is especially true in countries with a high population density and low gross domestic product, such as Rwanda. The Medical Students' Association of Rwanda (MEDSAR), through its health teaching programs with communities, has realized that men are not well-catered for in FP services. In addition, the MOH has expanded its focus to include couple counseling in FP, recognizing that the man has great influence on a couple's FP decisions.

The 1993-1994 male motivation campaign in Zimbabwe demonstrated that men can be reached with FP messages.[1] One of the lessons learned from the campaign was that efforts to engage men in FP have a greater likelihood of success when the target audience has a high awareness of FP methods. This foundation has already been established in Rwanda. According to the 2010 Rwanda Demographic and Health Survey, men are slightly more likely than women to have heard of a modern method (100% and 99%, respectively) and a traditional method (91% and 90%, respectively). The mean number of methods known is a rough indicator of the breadth of knowledge of FP methods. All women and men age 15-49 know an average of 9.8 contraceptive methods.[2]

There are opportunities to integrate FP into existing RH services already being offered in many health facilities: maternal and child health (MCH), FP, antenatal care (ANC), postnatal care, sexually transmitted infection (STI) prevention and treatment, and voluntary counseling and testing (VCT). Some offer other HIV services such as preventing mother-to-child transmission of HIV (PMTCT) and antiretroviral therapy (ART).[2] The most common combination includes FP with ANC and VCT services. However, male involvement in FP is still poor, not only in healthcare facilities but also in their families. The study aimed at establishing factors influencing male integration and to propose improved approaches to the integration of contraceptive methods education and practice to families, and mainly men.

3. METHODOLOGY

To gain an understanding of healthcare providers' experiences with integrating FP services into other RH services provided, the research team conducted one-on-one interviews with 24 healthcare providers and 96 community health workers (CHWs) in 24 healthcare facilities in Southern and Kigali City Provinces of Rwanda (Table 1). The providers were invited to a two-day workshop on integrating FP services into services offered by their healthcare facilities. The facilities were randomly selected. Only the healthcare providers in charge of FP services were selected for this study, with each facility being represented by one provider; and male and female clients were randomly selected from the FP, ANC and VCT services of the healthcare facilities and asked to participate in the study.

The trained research assistants interviewed the healthcare providers and CHWs and conducted single-sex focus group interviews with clients. To get the healthcare providers and CHWs to talk openly about their work, trainings, and the services they provide, and the couples to talk about the services provided to them, the research assistants used a three-page conversational outline in Kinyarwanda that had standard, general introductory questions as well as a list of related topics to be covered in any way appropriate. The information was collected in Kinyarwanda and later translated in English and summarized by the research assistants' team.

Table.1. Summary of the Research Coverage.

Healthcare facilities	**Rural**	**Urban**
Kigali City Province	8	4
Southern Province	3	9
Providers	**Males**	**Females**
Nurses	7	17
Community health workers	48	48
Focus groups	**Rural**	**Urban**
Men	64	59
Females	141	102

3.1. Interviews with healthcare providers

All of the interviewed healthcare providers were nurses (17 females and 7 males), primarily those in charge of FP in their facility with at least two years of professional experience and trainings in FP. The majority of the nurses had worked in these health facilities for several years while others had experiences in other health centers or hospitals. Many of the providers were interested in acquiring further education, and had participated in courses and workshops on MCH, PMTCT, FP, VCT, and so forth; in their absence, these services were frequently suspended in the facilities where they worked or other nurses were allocated to those services. Many of the respondents interviewed had been involved in a variety of training programs that had enhanced their knowledge, skills, and confidence, allowing them to provide services in various specialized areas. These providers greatly appreciated the knowledge and experience gained from their work and the various training programs in which they participated. However, they were not confident enough with their knowledge about all FP methods and specific side effects, hence they found it challenging to integrate men in FP through the different RH services, especially when it came to deciding which FP method is appropriate for different situations and counseling men on vasectomy.

The interviews with providers were conducted in their respective facilities. The focus was on the nurses in charge of FP and the health center directors, though the directors' busy schedules prevented them from being available for interviews. Before the interviews were conducted, most of the nurses provided FP services with the research assistants observing while waiting for the FP provider to be available for the interview. Most of the interviewed providers were selected

because of their work related to FP, PMTCT, ART, or ANC. However, the majority of nurses rotate among RH services and the outpatient department; therefore, they have a good understanding about what brings men to the health centers, which FP services they need, and among which services FP could be integrated with in order to better serve the men.

At the same time, the large area of expertise and the heavy workload challenged both the nurses and CHWs. Sources of frustration expressed by healthcare providers and CHWs included low salary, lack of per diem or compensation for off-site obligations, shortages of medical supplies, and the perception that their superiors do not provide sufficient materials.

3.2. Interviews with CHWs

Two male and two female CHWs were interviewed in each healthcare facility. The research assistants discussed different services provided by the CHWs with an emphasis on FP services for men. The interviewed CHWs have been trained in areas such as FP, MCH, malaria, hygiene, nutrition, etc. In relation to FP services offered to men, they provide FP counseling and condoms, and address negative attitudes toward FP in general or against specific FP methods. The CHWs interviewed were all from the villages served by the health centers where the nurses in this study were interviewed. They greatly appreciated the work they do and their training, however they stressed the importance of having more training and a deeper knowledge of FP methods and different alternatives for men.

3.3. Interviews with men and women focus groups

Focus groups were conducted with men and women, all parents either married or not, at 24 healthcare facilities. The interviewed families were served by the same facilities affiliated with the providers and CHWs who were interviewed. Male participation was low because they do not frequently visit healthcare facilities. The research assistants used only a question guide to collect data. Families provided information about the status of FP services in different facilities and services provided by the CHWs. The lack of regular awareness programs and FP services for men and inadequate explanations of FP methods available to them was mentioned repeatedly.

4. RESULTS

4.1. Interactions with healthcare providers

4.1.1. FP services experiences

Through different programs in the healthcare facilities, men accompanying their wives to FP visits are provided with such FP services as free condoms, sensitization, about taking part in FP, and FP counseling and referrals. However, in some healthcare facilities there was no defined calendar for FP services for men apart from free condom distribution, and men rarely accompanied their wives to the facilities. In all 24 healthcare facilities, it was found that men believe that FP is a women’s issue; hence, few men come for FP services other than condoms. The FP services in villages and cities target males and females, 14-50 years of age. In general,

men care more about economic concerns than preventing conception. In all the facilities, the interviewed providers mentioned that few men participate actively in FP but there has been a positive change, despite the lack of adequate understanding of men about their role in FP. Addressing rumors that are incorrect, such as vasectomies causing impotency, is also a big burden for FP promotion. In addition to the lack of knowledge about FP, men are generally not committed to FP education or condom use, and are afraid of vasectomy.

Men view FP in relation to their financial situation; such as, "a bigger family is the worse" because of additional expenses. They are more aware of the increased responsibility of having a big family. However, lack of education, religious beliefs, and community attitudes interfere with FP promotion; men, healthcare providers, and CHWs do not understand the methods available to them, such as vasectomy. Apart from a minority that joins the FP programs, most men are opposed to vasectomy and some would not consider condom use with their spouse. One of the biggest issues among couples is shared decision-making power between the man and woman; most men consider themselves participating in FP by just letting their wives join the program and women, they feel, are not supposed to go if their husbands don't give their permission.

The major challenges facing men willing to practice FP are primarily due to inadequate knowledge owing to discouraging rumors in Rwandan communities concerning available FP methods; no differences were noted between men in cities and villages. Incompatible religious beliefs are another big challenge. For couples that have different beliefs, the FP issue is one of the most frequent sources of disparities. Women willing to participate in FP were found to face more challenges than men; namely, lack of knowledge, incorrect rumors about FP methods such as the belief that some methods cause excessive weight gain and massive bleeding, husbands not allowing access to FP services, healthcare facilities far from home, religious beliefs discouraging FP use, and men forcing certain FP methods on their wives. In cases where husbands leave their wives and have children with other women, some women take the risk of secretly practicing FP because their husbands may not approve. Only one of the 24 providers mentioned that men are affected more because they do not have an effective reversible method.

In cases of unwanted pregnancy, the healthcare providers assist concerned women and young girls with counseling and encourage them to seek ANC, PMTCT and FP services. These programs involve only women because, by choice, men do not accompany their partners. Apart from the five religious-led facilities that were involved in this research, FP services are available to people five days a week, from Monday to Friday.

Awareness is raised about protected sex with regard to HIV prevention in all healthcare facilities that were involved in the research; healthcare providers conduct educational teaching sessions to communities about condom use with condoms distributed afterward. When men come to the hospital for other purposes, they can benefit from FP services; however, HIV/AIDS discussions have dominated the sexual education agenda and FP awareness efforts among men. The number of people participating in FP services has increased, but this may be due to the increase in the Rwandan population rather than signifying a higher contraceptive prevalence rate.

Although healthcare providers are offered FP trainings on roughly an annual basis, they do not feel this is adequate, especially for vasectomy, which is normally done at the district hospital level. However, district and MOH supervisors provide some on-the-job training by observing healthcare providers counseling clients on FP. There is no continuous and regular training program that includes parallel theory and practice. Among the interviewed health care providers, 80% participated in training. Because of busy work schedules, 20% did not participate.

Among the men involved in this study, 55.5% were not easily reachable for teaching FP in healthcare facilities. Efforts are made to reach out to men through community meetings and workplace events, but the availability of men or health staff is a challenge. Men attend more often if there is an official invitation from the government. Nearly 90% of the healthcare providers are convinced that men are not committed to practicing FP because few show up for FP outreach or services, as they think that it is not their issue. They defer participation to their wives, which is not enough, while others do not even let their wives participate. They are discouraged by the possible side effects of female methods and they fear vasectomy. Roughly one quarter of participants think that there would be a negative impact from men being involved in FP if condoms and vasectomy are the only alternatives, given that some women do not think condoms are appropriate for family use, and that vasectomy may be a source of divorce if the wife wanted to have a baby. Among the healthcare providers, 57% realize that culture plays a role in the participation of men in FP; men equate vasectomy with castration, which has a critical significance in Rwandan culture. Furthermore, some men do not care much about FP because of cultural proverbs that encourage them to procreate as much as possible and consider children as power and blessing.

4.1.2. Concerns of the healthcare providers

Taking into consideration the current realities, there are different factors that could facilitate the involvement of men in FP and the integration of FP services for men in other RH and general care services. These include: finding successful testimonials and stories from families that have had successful FP experiences; finding new ways to improve FP promotion and dispel rumors at all levels via radios, Web sites, posters, and movies; improving FP trainings for health staff at different levels as well as CHWs; setting policies that both include men in FP and give freedom to women to access FP services even if their husbands oppose; and initiating strategies to reach more men through other health services, community meetings, behavior change talks, and family visits. The availability of FP methods should be improved, and alternatives other than condoms and vasectomy should be found for men. (A pill option for men was mentioned repeatedly.) On the community level, men should be aware of what their responsibilities are towards their wives and children in reference to FP.

In order to prevent unwanted pregnancies, much more effort should be put into FP education, starting from youth. Specific curricula should be prepared for youth, women, men, and widowers. Special emphasis should be put on the consequences of unwanted pregnancies – not only in young people but also in families. Overall, the work done in integrating FP services for men in different services at the healthcare facilities should be improved with more effective strategies to reach men being a priority. The already established programs in the health centers

such as ANC, PMTCT, VCT, ART, and general care services should provide good ground to integrate this program. The healthcare providers believe that the existing CHW channels of village meetings and national community work day (the last Saturday of every month) should be adequate to mobilize men to seek FP services and accompany their wives for healthcare.

Communities could benefit from the integration of men in FP. With men being considered as chiefs of the families, they could assist their wives and adolescent children in learning about FP, which could potentially lead to fewer unwanted pregnancies, reduced family size, less poverty, reduced street children, better family support for children in education and health, and improvements in the country's development in general. However, male involvement may not be easy, considering the mindset of FP being a "women's issue" and conservative beliefs among some.

4.2. Interactions with CHWs

4.2.1. FP services experiences

At the healthcare facilities, FP services are available for all people interested, but there is no permanent timetable specifically for men. Men come mostly to collect condoms. However, village meetings are good opportunities to talk to men about FP. CHWs have different activities to reach men such as family visits, FP talks at village meetings after monthly community work, and FP talks at the local health center.

Despite sensitization programs in healthcare facilities, male participation is still low, and some men do not believe in FP. However adolescents and young men are more motivated to collect condoms. There is a positive change as men become conscious about family size and the financial needs accompanied with it.

The interviewed CHWs confirmed that all men have at least heard about FP, but their knowledge is vague and not always accurate. The CHWs think that neither the nurses who train them nor the CHW themselves have enough FP knowledge. There is need for good counseling about available methods for men, especially vasectomy. One of the CHWs who had had a vasectomy stated, "It is a hard decision to make because you are not sure if you may need children after or if you can become impotent from the vasectomy; before I had it, I took long to decide."

The majority of CHWs think that FP is necessary; but illiteracy, ignorance, and lack of adequate sensitization and education about FP affect uptake of FP services. More attractive strategies and FP options are needed to integrate men in FP. The available opportunities for teaching men and training providers and CHWs are not enough. Men willing to participate in FP are challenged by lack of accurate information, poor attitudes toward FP, and the negative perception toward male involvement because "men do not get pregnant". Half (50%) of the interviewed CHWs are convinced that one of the biggest issues preventing men from participating is that vasectomy is irreversible and a difficult decision, while over a third (35%) think that religious beliefs play a big role.[3]

The major challenges faced by women willing to practice FP include partners not allowing or unsupportive of FP use, fear of side effects, lack of adequate knowledge, FP service providers unable to provide accurate information about the FP method choice, incompatible religious beliefs, or fear of losing their husbands in case they experience such side effects as weight gain or decreased libido. Women have few options when their husbands do not want them to use FP, and there is no program or policy to help those in such a situation. Instead, they end up having problems in their families if they practice FP without their husband's consent.

As expected, unwanted pregnancies occur in all of the areas covered by the CHWs interviewed, and this is common in developing countries in general due to failure to switch after discontinuation of contraceptive.[4] CHWs help concerned girls and women with counseling by giving advice and encouraging them to seek ANC, VCT, and postpartum services. They discourage them from clandestine abortion, considering that abortion is legally allowed in limited circumstances. Women who get pregnant while using contraceptives are encouraged to use contraceptives correctly and consistently if they do not want this to happen again. In addition, the healthcare providers and CHWs explain side effects, the efficacy of different contraceptive methods, and the factors that maximize the efficacy of the available methods. Including continuous and improved trainings for providers, CHWs, and families can help prevent unwanted pregnancies. Organized visits to people who successfully practice FP and work to improve the involvement of both men and women in FP needs to be done. One of the CHWs stated, *"There might be changes in teaching techniques. Empower the community health workers more, have specific programs for men and women, new strategies to encourage more men to join, and involve all young girls and boys of reproductive age."*

CHWs teach various FP methods. The hormonal methods (combined and non-combined) include pills and long-acting reversible contraceptives (LARC) such as intrauterine devices (IUDs), implants, and injectables. They also educate community members on emergency contraception, the female and male condom, and natural FP methods (namely, periodic abstinence, withdrawal, lactation amenorrhea, and the standard day method or cycle beads). CHWs have different teaching materials that are used for different occasions in their respective villages. The focus of the discussions is on HIV, STI, and unwanted pregnancies.

Nearly all (94.7%) think that their work in integrating men in FP is not good enough due to a lack of systems and strategies for involving men, few skills and trainings for CHWs, little assistance from community healthcare providers, an insufficient number of CHWs, limited involvement in FP from local leaders, and the cost of conducting education programs (e.g. local transportation, communication, food). There has been an improvement compared to the CHWs' previous work, including moving FP education from the health centers to the village level through CHWs (while still offering FP at facilities). LARCs have been moved from the hospital level to the health center level. Vasectomy is still only available at district hospitals.

The CHWs were all trained, but all of them were convinced their current level of training was not enough. In addition, they do not understand vasectomy. Different training opportunities are offered by the MOH,[5-7] and occasionally some nongovernmental organizations such as the San Francisco Project; however, the topics do not vary, so that there is no new knowledge gained. A

CHW stated, "We always discuss the same topics in our meetings; so we don't increase our knowledge." More training and updates by professionals are needed especially about the specific differences of FP delivery for women and men. The integration of men in FP is needed considering that men can get involved in case no suitable methods are possible for their partners. Engaging men increases mutual decision making with their partners and prevents conflicts in families.

There are no planned, systematic means to reach men in families even though it is feasible through the CHW network. Men lack an interest in FP because they do not see a financial benefit to using in it and are extremely discouraged by rumors in the community to the point that they disregard the CHWs. A CHW stated, "They ignore us because we live at the same village!" Furthermore, some men are convinced that they are more skilled than the CHWs, as expressed by one CHW, "They instead convince us that they know more than we do!"

Men who understand and appreciate the role of FP are motivated to use it; however, with few alternatives for them, men get discouraged and leave FP to women. Additional assistance is needed for CHWs to reach men and families better. Some work has to be done in order to improve the trainings and follow-up to CHWs, recruit more national and international professionals and volunteers to assist CHWs on a daily basis, and garner support from administrative leaders to encourage men to take an interest in FP. The FP clubs for youth facilitated by CHW have the potential to be very useful in villages.

4.2.2. Concerns of the CHWs

Like the healthcare providers, the CHWs expressed concern that most men think FP is a women's issue. They said men typically only use condoms, are afraid of vasectomy, and seldom attend FP talks. The extent of some men's involvement with FP is taking their wives to an FP visit while others have no interest in either the program or accompanying their wives. In fact, 17.5 % of the interviewed CHWs were convinced that men don't let their wives exercise their right to access FP and women are afraid of going against their husbands out of fear of losing them.

However, men are aware of the impact of FP, such as reducing poverty and family expenses, but commitment is still a problem. Some men think it is enough for the family if the woman joins the program while others do not allow it for religious reasons. Some names given to children reflect religious beliefs toward conception. For example, the name "Habyarimana" means "it is God that makes babies" and the name "Harerimana" means "it is God that raises." Rwandan culture also plays a certain role where children are considered a treasure or power for the family, thus encouraging a large family size. In some instances, men avoid using FP because they are trying for a boy, based on a cultural priority placed on male children. Different Rwandan proverbs and the fact that women primarily raise the children influence the thought that FP is a women's issue.

Men are not aware of what an impact their participation in FP can be at the family and community levels. Since men are leaders of the families, they are needed for compliance to the methods used. FP success stories are needed, especially from local leaders, in order to motivate

men more. CHWs need assistance from nurses and other skilled people while conducting community education.

Taking into consideration the current reality, the factors that could facilitate the integration of men in FP include radio talks, conducting FP trainings through different cooperatives, providing the means (e.g. funding, materials, human resources) for CHWs to carry out teachings and visits to families, instituting permanent FP advisory services for men in health centers incorporated into non-FP visits, starting youth health clubs in villages, amending public policies to explicitly give women the autonomous right to access family planning without requiring their husband's consent, and finding more male-focused alternatives other than vasectomy or condoms.

4.3. Interactions with family focus groups

4.3.1. FP services experiences

Families think that FP services and practices do not interest or involve men enough and men are reluctant to participate. Therefore, in the absence of many options for male-focused methods, by default women are very committed to controlling pregnancy. Families start to practice FP only after they have already had children and the number of children is beginning to be burdensome. Condoms are the most used method for men but they think they should not be for family use. Men do not have enough knowledge about FP, particularly vasectomy; their mindset is that it is frightening and there is a direct relationship between vasectomy and impotency.

FP services do not use testimonies from people who have had successful FP experiences. Advice and counseling is needed for men who want to join. Men willing to assist their wives in FP face different challenges including concern about side effects and their partners' health, misinformation such as vasectomy causing impotence, negative social stigma associated with male involvement in FP, and the belief that encouraging FP with your wife leads to unfaithfulness. A 36 years old man stated, "We've never heard a single man who controlled birth in our district" (i.e., had a vasectomy). Since Rwandan men consider themselves the chiefs of the family, those who agree to practice FP are considered dominated by their wives. In addition, some elderly people, such as grandmothers or fathers, instruct their sons to have more children.

The challenges facing women willing to practice FP include a lack of understanding about FP methods available and possible side effects. The interviewed men and women expressed an understanding that women are more affected by the FP side effects because they are primarily the ones using the contraceptives. Nonetheless, men feel affected by FP choices too since they are responsible for their families and are directly affected when their wives lose their libido.

Strengthening the FP service delivery system and reaching the maximum number of men can prevent unwanted pregnancies. Integrating FP in different public and healthcare services may be adequate to reach the maximum number of people, including youth and couples. FP counseling after each hospital birth should become common practice.

Meetings and media are common channels through which the families are taught about FP. However, the messages were inadequate and the healthcare providers did not get enough training. In addition, although the CHWs teach about all methods, they do not provide enough details.

Among the interviewed families, 40% do not talk about FP issues easily. Men feel they do not have time for it, get home tired, or do not want to hear about FP. For other families, it is easier to talk about FP when it comes to the future of the family, paying for health insurance, or children's education. Unfortunately, the sentiment was that it is impossible to talk about it if people do not already have a child. Alcohol consumption also plays a role in reducing communication around FP within couples, thus hindering responsibility with sharing in decision making.

Families expressed the need for assistance to further involve men in FP and identified many of the same factors shared by the health providers and CHWs to facilitate this, including intensive training about FP in the community directed toward men, such as FP talks and awareness-building of FP programs in meetings and services in communities and at health centers, particularly in rural areas. Men need to be taught about FP at any event they attend because most of men do not have time to listen to the radio. Hearing from leaders who have successfully practiced FP, exclusive FP services including education for men, and taxes for families having many children were also mentioned. Religious leaders and churches should help to encourage male participation because of their widespread reach and influence. Sensitization in public areas and involving more people in FP awareness program are needed. A 37 year old stated: "Sensitization of men on family planning in public areas like markets can help mobilization and raise awareness." Again, students should also play a big role in training men about FP, emphasizing that it is the concern of the whole family rather than just a woman's affair. Students also have more updates about the changes taking place in their communities that are affecting new families. Lastly, officials need to be involved in FP programs and more methods for men need to be made available.

4.3.2. Concerns of the families

Even though men understand the reasons for FP, they still consider FP as a specific task for women, hence they're lack of commitment. Men urge their wives to participate when they cannot cover household costs such health insurance, school fees, etc. A woman stated: "Women try their best to control birth, but men are still very few." FP is stigmatized for men; men laugh at their colleagues who get actively involved in FP. People, especially women, need to be taught the possible side effects of contraceptive methods, both for men and women; and what to do if they experience a side effect. It is challenging for women to know what to do and how to use FP correctly and consistently if their husbands are not helpful or supportive.

It is difficult to have a discussion about FP if there is no actual problem in a family. Typically, women are pushed to initiate the conversations when men are not cooperative. A policy promoting the responsibility of men in FP may be useful, and calling upon men to assist their wives in labor may create further interest in FP.

5. DISCUSSION AND RECOMMENDATIONS

Healthcare providers and CHWs have been trained in FP by the MOH and recommendations were given to involve more men in FP services. However, not all RH services in the study facilities integrated men into FP. The research team found that only 19 of the 24 health facilities offered FP services; the other five health facilities all had religious affiliations, and instead the service was moved to the administrative cells' offices in which the health facilities are located. An important barrier to family planning services is the fact that many religiously affiliated health facilities, especially Catholic-supported facilities, do not offer modern contraception; This is particularly important since 40% of facilities in Rwanda are religiously affiliated, and 18% are Catholic[7]; hence, in order to overcome the push-back from churches, training would be organized to providers and CHWs on how to promote natural FP methods, which are supported by the Catholic Church.

The way in which FP services were offered to men among the 19 health facilities varied greatly, with services being provided to clients generally in one of four ways: 1) the FP unit offers FP and counseling services directly to FP clients; 2) the VCT unit offers FP counseling (mainly condom use) to VCT clients and refers them to a separate FP unit within the health facility for contraceptives; 3) the ANC or PMTCT units refer their clients to the FP unit for counseling and advice; or 4) public FP education is offered to the patients seeking any care at healthcare facilities and patients are referred to the FP unit for further details.

None of the 19 healthcare facilities had a permanent calendar for FP services specified to men; however all of them offered routine FP services[8] for men integrated with VCT, FP, PMTCT, and ANC units on an ad hoc basis if men showed up. The VCT units mainly served men with condom use education for STI prevention; the ANC unit offered FP counseling, but referred clients to FP units for contraceptive methods and education. Most clients served by FP services were women with men presenting much less frequently. This was primarily due to: 1) the availability and use of human resources; 2) the cultural belief that FP is a women's issue; and 3) the lack of motivation for men due to limited FP services available for them. Some healthcare facilities have proved successful integration of men in FP by different ways: 1) mobilizing men to come with their wives for ANC and PMTCT services; 2) improving the supply and mode of providing FP materials whenever they are needed; and 3) harmonizing the system of record keeping, reporting, and follow-up to facilitate good communication among the people served, CHWs, and the healthcare providers.

Factors that facilitated the integration of men in FP through other services included: 1) the selection of counselors and their aptitude in FP counseling and methods; 2) decentralizing the healthcare system through CHWs; and 3) offering basic trainings to healthcare providers and CHWs. Factors that impeded the integration of men in FP services included: 1) the selection of healthcare staff and poor FP training; 2) religious beliefs; 3) the large workloads of counselors, leading to insufficient time offered to families; 4) the lack of supervision and follow-up by superiors; 5) lack of knowledge about FP in local communities, hence lots of rumors concerning FP methods outcomes; and 6) lack of direct interaction of healthcare providers or CHWs with

families, especially men, that leads to many men being uninformed about FP methods and messages and prohibiting their wives from joining FP.

Though the lack of male interest to engage in FP was repeatedly mentioned, more FP alternatives, especially pills, should be found for men. Researchers have conducted studies on two types of systemic birth control for men: hormonal male contraception and immunocontraception. Hormonal male contraception would use hormones (injected, implanted, or taken orally) to stop sperm production. Similar to hormonal female methods, these would be reversible. Immunocontraception would provide birth control by using a man's immune system response to prevent pregnancy.[9] This should be a priority research area.

A variety of other factors could positively influence the integration of men in FP:

- setting a permanent plan of action involving men in FP integrated into different RH services;
- increasing the number of staff trained in FP and structuring job roles and responsibilities to allow the trained staff to actively provide FP services;
- providing a variety of FP methods, by which CHWs and healthcare providers would have enough materials and funding to provide FP services at the community level;
- setting joint FP programs between healthcare providers and CHWs working in communities;
- implementing regular supervision for FP services provided by healthcare providers and CHWs; and
- rotating FP staff among RH units in healthcare facilities and the integrated program involving PMTCT, ANC, VCT and ART services (the staffs of different services should be trained on FP and the FP unit may facilitate the implementation).

Furthermore, the current law that requires mutual consent about FP methods use among couples is a barrier to access and one that significantly impacts FP use. During our research, a policy change was recommended by different participants in order to remove this barrier and give women the same decision-making rights and access to FP as men, especially considering how it was stated repeatedly that the responsibility for practicing FP in Rwanda falls almost entirely on women.

6. CONCLUSION

This study focused on understanding the experiences of healthcare providers and CHWs in 24 health facilities who had participated in an FP training workshop provided by the MOH to understand what affects the integration of men in FP in Rwanda, mainly in villages of Southern Province and Kigali City Province, and to identify the factors that facilitate the integration of men in FP services through other services at healthcare facilities. Focus groups were conducted at each of the 24 facilities to interview men and women about their daily experiences in families with an emphasis on the participation of men in FP.

Many of the providers and CHWs had been involved in training programs that enhanced their knowledge, skills, and confidence, allowing them to provide services in specialized areas. Although healthcare providers greatly appreciated gaining experience and knowledge from their work and participating in training programs, they were often challenged by lack of regular trainings and good understanding of vasectomy. The CHWs were not trained enough and did not feel sufficiently equipped with knowledge, materials and financial support to serve their communities well.

The interviews with families revealed the importance of integrating men in FP and providing FP services for men at different levels. Public awareness about FP practices with successes and outcomes is needed in order to encourage men to join. Implementing policies that promote men's role in FP will assist with addressing unfavorable gender norms that impede couple's decision making about practicing FP and which methods should be used. The presence of FP in different services offered at health facilities, namely VCT, PMTCT, ART and ANC, will facilitate to reach more men.

REFERENCES

1. Kim YM, Marangwanda C, Kols A. *Involving Men in Family Planning: The Zimbabwe Male Motivation and Family Planning Method Expansion Project, 1993-1994* [IEC Field Report Number 3]. Baltimore, MD, USA: Johns Hopkins School of Public Health, Center for Communication Programs; 1996:34.

2. National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF International. *Rwanda Demographic and Health Survey 2010*. Calverton, MD, USA: NISR, MOH, ICF International; 2012:85-98. Accessed 17 August 2012 at: *http://www.statistics.gov.rw/publications/demographic-and-health-survey-2010-final-report*.

3. Bayray A. Assessment of male involvement in family planning use among men in south eastern zone of Trigay, Ethiopia. *Scholarly J Med.* 2012;2(2);1-10.

4. World Health Organization (WHO), Department of Reproductive Health Research. Contraception discontinuation and switching in developing countries [WHO Research Policy Brief]. Geneva: WHO; 2012.

5. Decentralization and health program, Twubakane [final report]. Kigali, Rwanda: IntraHealth International; 2010.

6. United Nations Population Fund (UNFPA), PATH. Reducing unmet need for family planning: Evidence-based strategies and approaches. *Outlook*. 2010;25(1):2.

7. Solo J. *Family Planning in Rwanda: How a Taboo Topic Became Topic Number One*. Kigali, Rwanda: IntraHealth International; 2008. Accessed 15 August 2012 at: www.intrahealth.org/files/media/5/fp_in_Rwanda.pdf

8. Rwanda Ministry of Health Annual Report 2010-2011. Kigali, Rwanda: Rwanda Ministry of Health;2011:124-132. Accessed 11 December 2012 at: http://moh.gov.rw/english/wp-content/uploads/2012/05/MoH-annual-report-2010-2011.pdf

9. Birth control. Male contraception research [Web page]. Palo Alto, CA, USA: Palo Alto Medical foundation. Accessed 3 September 2012 at: http://www.pamf.org/teen/sex/birthcontrol/malecontraceptive.html, accessed on September 3, 2012

APPENDIX

QUESTION GUIDE FOR INTERVIEWS

Services

- What are the standard family planning services offered in health care facilities?
- How are men involved in family planning in health care facilities?
- Schedule and indicators for family planning service delivery? What they would like to change about the principles of service delivery.

Health care providers

- How do health care providers describe their current work? Activities of a typical day, specific responsibilities in regards to family planning, contact with patients, types of patients they see, and contacts with outreach units, relative satisfaction in working there.
- What are their past work experiences? Education completed, general training programs completed, past work experience, aspects of past work that were/were not satisfactory, how they came to work in this facility, how they see their professional future.
- What are their special training programs followed? Trainings in family planning services, Relative effectiveness of trainings and delivering the knowledge to families especially to men, how they use their trainings in their practices.
- How do health care providers increase awareness of men regarding family planning?
- What training/refresher in family planning do health care providers receive? When? By whom?
- How do health cares providers decide which clients should be told about family planning methods?
- Health care providers within the health care system. System of provision of directions for practices, system of supervision, record-keeping requirements, referrals provided, any training regarding family planning provided by the health care facility, role and activities of community health workers and suggestions for improvement.

Community health workers

- How do community health workers improve their awareness and knowledge about family planning?
- What do community health workers say to men in their local communities about family planning?
- How do men react to different family planning methods and do they practice them in their families?

Families

- How do families improve their awareness and knowledge about family planning?

- How do men contribute to family planning?
- How do wives feel about their husbands having knowledge about and practicing family planning methods?
- What can men and women do to achieve optimal family planning knowledge and practices in their families?