Published in final edited form as:
AIDS Care. 2015 January ; 27(1): 31–37. doi:10.1080/09540121.2014.954982.

Providers' perspectives on male involvement in family planning in the context of an RCT evaluating integrating family planning into HIV care in Nyanza Province, Kenya

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Abstract

Integration of family planning (FP) services into HIV care and increasing male partner involvement in FP are being explored as strategies to reduce unmet need for contraception. Providers' views can give valuable insight into current FP care. We evaluated the perspectives of HIV care providers working at HIV clinics in Nyanza Province, Kenya on male partner involvement in FP.

This qualitative study was part of a cluster-randomized trial evaluating the impact of integrating FP into HIV services on contraceptive prevalence among HIV-positive patients in Nyanza, Kenya. Thirty individual interviews were conducted among healthcare workers at 11 HIV care facilities in Nyanza, Kenya. Interviews were conducted from integrated and control sites one year after implementation of FP/HIV integration. Data were transcribed and analyzed using grounded theory methods and Atlas.ti.

Providers supported male partner inclusion when choosing FP and emphasized that decisions should be made collaboratively. Providers believed that men have traditionally played a prohibitive role in FP but identified several benefits to partner involvement in FP decision-making including: reducing relationship conflicts, improving FP knowledge and contraceptive continuation, and increasing partner cohesion. Providers suggested that integrated FP/HIV services facilitate male partner involvement in FP decision-making since HIV-positive men are already established patients in HIV clinics. Some providers stated that women had a right to choose and start FP alone if their partners did not agree with using FP.

Integrated FP services may be a useful strategy to help increase male participation to reduce the unmet FP need in sub-Saharan Africa. It is important to determine effective ways to engage male partners in FP, without impinging upon women's autonomy and reproductive rights.

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No conflicts of interest declared.

Keywords

HIV; family planning services; delivery of health care; integrated; health care provider; men; Kenya

1. Introduction

While progress has been made in expanding FP provision and access, many countries in sub-Saharan Africa (SSA), such as Kenya, continue to report high rates of unintended pregnancy and low contraceptive prevalence (Darroch & Singh, 2013). National statistics show that 25% of married couples have an unmet need for FP and many people prefer families smaller than their actual family size (Kenya National Bureau of Statistics and ICF macro, 2010). With its 5.6% prevalence of HIV infection, and with women more affected than men (Kenya Ministry of Health, 2013), Kenya's unmet need for contraception is especially high among women living with HIV (WHO, UNICEF, UNFPA, & UNAIDS, 2010).

Service linkage between FP and other health services has gained popularity as a potential mechanism for increasing FP uptake. The integration of FP and HIV services in the prevention of unplanned pregnancies in HIV-positive women – one of the four pillars of and an often neglected aspect of PMTCT strategies – has been utilized to improve FP access, encourage dual contraception use, and increase opportunities for male partner involvement (Ngure et al., 2009; Fleischman, 2006). Recent studies on FP integration suggest that it is cost effective (Perchal, Collins, Assefa, & Babenko, 2006; Shade et al., 2013), maintains quality of care (Family Health International, 2007), and is acceptable to patients and providers alike (Church & Mayhew, 2009; Liambila et al., 2009; Maynard-Tucker, 2009; Spaulding et al., 2009). Service integration has been shown to increase condom (Kosgei et al., 2011) and modern contraceptive use (Grossman et al., 2013) in certain settings. However, further evaluation is needed to explore the non-structural mechanisms through which integration may increase contraception use, such as facilitating partner involvement in FP decision-making.

Several studies have explored men's role in reproductive health and suggest that partner involvement in FP could increase contraceptive uptake and use in SSA (Grabbe et al., 2009; Becker, 1996; Mbizvo & Bassett, 1996). With the importance of dual contraception method use in the HIV-positive population and the need for male acceptance of condom use, male partner involvement could also help prevent HIV transmission. Positive outcomes have been reported when men are involved in their partners' reproductive and HIV care, including increased adherence to PMTCT services (Farquhar et al., 2012; Kalembo, Zgambo, Mulaga, Yukai, & Ahmed, 2013; Aluisio et al., 2011; Msuya et al., 2008) and increased contraceptive use (Adongo et al., 2013; Shattuck et al., 2011; Terefe & Larson, 1993). Furthermore, studies in Kenya and elsewhere have shown support from women, men, and healthcare providers for male partner involvement in some aspects of reproductive care, including in consultations, counseling, and fertility decision-making (Muia, Olenja, Kimani, & Leonard, 2000; Newmann et al., 2013a; Steinfeld et al., 2013; Theuring, Nchimbi, Jordan-Harder, & Harms, 2010)

FP providers play an essential and influential role in the quality of reproductive health services and in patients' access to these services (Isaacs & Creinin, 2003; RamaRao, Lacuesta, Costello, Pangolibay, & Jones, 2003). Providers also offer valuable insights into the challenges, benefits, and acceptability of FP programs (Maharaj & Cleland, 2005). Despite growing literature on integration as a means to improve reproductive health outcomes, there are few studies in SSA that explore the attitudes of healthcare workers who provide FP integrated services (Mutemwa et al., 2013; Maharaj, 2004; Baumgartner et al., 2013). While studies have reported provider attitudes towards male involvement in maternal health care (Kululanga, Sundby, Malata, & Chirwa, 2012) and antenatal care and PMTCT services (Theuring et al., 2010), to our knowledge provider perspectives on male partner involvement in FP have not been described in the context of integrated FP/HIV services. This study sought to explore the perceptions of and experiences with FP provision, with a particular focus on male partner involvement in FP, among HIV healthcare providers working at HIV care and treatment clinics in Nyanza Province, Kenya.

2. Methods

2.1 Sites

This qualitative study was conducted between October and November 2011 as part of the endline data collection for a cluster-randomized controlled trial (RCT) evaluating the impact of integrating FP into HIV services on contraceptive prevalence among HIV-positive men and women enrolled in HIV care in Nyanza, Kenya (http://clinicaltrials.gov/, NCT01001507; Grossman et al., 2013; Steinfeld et al., 2013; Harrington et al., 2012; Newmann et al., 2013a; Newmann et al., 2013b; Shade et al., 2013). Healthcare providers were recruited for this study from 11 of 18 public-sector HIV treatment clinics participating in the RCT in the Kisumu East, Nyatike, Rongo, and Suba districts of Nyanza Province. These eleven facilities included one dispensary, six health centers, one sub-district hospital, and three district hospitals. Six facilities were randomized to the intervention of integrating FP into HIV care where FP methods (including pills, injections, implants, and intra-uterine devices) were provided within the HIV clinic. Five facilities were control sites and continued to refer patients to FP clinics when contraception other than condoms was desired. Regardless of integration status, staff from all facilities underwent training on FP counseling and method provision and were trained to ask all patients about their contraceptive use and interest in starting a contraceptive method. All sites provided HIV care including antiretroviral treatment and were supported by Family AIDS Care and Education Services (FACES), a collaboration between the University of California, San Francisco (UCSF) and the Kenya Medical Research Institute (KEMRI) (Lewis Kulzer et al., 2012). This study was approved by the Committee on Human Research at UCSF and the Ethical Review Committee at KEMRI.

2.2 Eligibility and sampling

Facilities to be included in the study were selected using random tables. Two facilities were selected from each district except Suba which was oversampled due to the higher number of study facilities in the district. At each participating facility, two or three HIV healthcare providers, depending on the size of the facility, were selected to be interviewed. The

healthcare providers included clinical officers (mid-level health practitioners), nurses, and clinic community health assistants (CCHAs, lay community health workers). Providers on duty on the day of the interview and who had worked more than six months were assigned random numbers for that facility and those assigned to the first two to three numbers were approached for interviews. All thirty providers approached for the study agreed to participate. Each participant provided voluntary written informed consent and received approximately $4.00 USD for their participation.

2.3 Open-ended interviews

Interviews were conducted one year after the initial training on FP counseling and provision as part of the FP/HIV integration cluster RCT. Providers were interviewed using a semi-structured interview guide that was adapted from a guide used in a study of providers' perspectives on the reproductive intentions of HIV-positive individuals in Cape Town, South Africa (Harries et al., 2007) and similar to a baseline study on providers' perceptions of integration prior to integration implementation (Newmann et al., 2013a). The interviews included open-ended questions exploring providers' views on appropriate FP counseling and provision for HIV-positive patients, opinions on the current model of provision of FP for HIV-positive individuals at their clinical site, and views on partner involvement. Participants at non-integrated sites were asked about their thoughts on integration of FP and HIV care services. Participants at integrated sites were asked about their experiences with integration. The hour-long interviews were conducted in a private room at the health facility. Interviews were conducted in English because all the providers were fluent in English and used English as the primary language for medical discussion. Interviews were audio-recorded with provider consent and subsequently transcribed. No identifying information was included in the transcripts or interview notes.

2.4 Data analysis

Data were managed in ATLAS-ti 6.2.23 (ATLAS-ti GmbH, Berlin, Germany) and qualitatively analyzed using a grounded theory approach (Charmaz, 2006). Investigators conducted initial coding of the transcripts using a codebook created from the interview script and developed inductive codes based on themes and concepts that emerged from the data. After initial coding, major themes such as male partner involvement in FP, views on integration, and attitudes towards appropriate healthcare of HIV-positive patients were explored further through subsequent analyses with sub-codes. The final codes were developed iteratively to allow for refinement of our analysis and themes. For this study, male involvement was coded when the interview involved dialogue about including a male partner in FP discussion, counseling, or decision-making. Coded transcripts were reviewed by a second investigator and discrepancies were resolved through discussion and consensus. Quotes presented in this paper are identified by the gender and role of the provider and the integration status and type of the clinical site.

3. Results

3.1 Healthcare provider demographics

An equal number of male and female providers were interviewed. The average age of study participants was 29 years. Providers were evenly distributed among healthcare provider roles. The majority of providers had 2–4 years of working experience as a provider, in HIV care, and at the facility where they were interviewed. (Table 1)

3.2 Men as barriers to FP

Along with myths, fear of side effects, and access issues, providers frequently cited male partners as a barrier to successful FP utilization. Providers described most male partners as unwilling to participate in FP counseling or use contraceptive methods as they felt FP was a woman's domain. Many providers reported that women used contraception secretively and that such clandestine use was difficult to conceal from the husbands. The fear of discovery prevented some female patients from attending the FP clinic at all. Providers stated that women could face separation, extramarital affairs, and physical harm if their partners learned of concealed contraceptive use.

3.3 Views on partner involvement in FP decisions

Almost all providers believed that both male and female patients should include their partners when deciding on contraception. Providers identified many benefits to joint FP decision-making. Reducing relationship conflicts was the most emphasized benefit. Providers believed marital strife could be avoided through open discussion with male partners before method initiation: "Before the client is started on family planning, he or she should consult with the partner… it is advisable they advise the other partner [for there to be] peace in the house." (Female nurse at integrated district hospital) Providers also stressed that the couple is a cohesive unit, one that should make decisions together. Many shared views similar to this female CCHA at an integrated health center: "If you want to do family planning, it is something that involves a family. That is… why it is called… family planning, because you plan together."

Emphasizing the benefits of collaborative FP decision-making, some providers thought that learning about contraceptive side effects together would benefit couples, enabling men to better care for their partners if complications arise. One female nurse at an integrated district hospital said, "If [the partner] is aware… if there is any [side effect] when the woman takes the family planning method, the partner will take her to the hospital if he was informed." Providers also suggested that joint decisions on the timing and spacing of children could reduce the financial burden for supporting the family that normally fell on men. Some providers also believed that couples who agreed on reproductive intentions had better contraceptive adherence. In describing her experiences with male partner involvement, a female clinical officer at an integrated district hospital said, "They'll agree on one thing and the partner will always remind the other one, you have to be going for the services."

To encourage partner involvement, a minority of providers said they ask for partner consent for contraceptive use. A female clinical officer at an integrated district hospital stated, "[We]

eradicate [issues with] adherence by making the client to bring the partner at least to consent together." A minority of providers also worried about male disapproval of FP and felt that females had a right to choose FP alone if their partners opposed FP:

> *It will depend on a type of partner this client has … this man has 4 children [and] he does not want the woman to use any family planning method, at that point I usually advise her to use and she should not inform the man.*
>
> (Male CCHA at non-integrated health center)

3.4 HIV clinics as sites for male partner involvement in FP

The majority of providers from integrated sites supported integration, and those from non-integrated sites desired integration of FP into their HIV clinics. Despite difficulties with staffing, space, and supplies, providers thought integrated services were cheaper and more convenient for patients, offered better continuity of care, and facilitated better FP follow-up. In addition, providers suggested that integrated services facilitated male partner involvement in FP since HIV-positive men were already established patients and accustomed to receiving care in HIV clinics. One female clinical officer at an integrated district hospital commented, "When women come for their clinics it's good that we book them on the same dates with their husbands, so that when they get that health talk concerning family planning at least [the] men [will also] get the knowledge and then they will decide [together]." The theme of the integrated FP/HIV clinic as a preferable one-stop shop for receiving care emerged in many provider narratives. Like female patients, male patients and HIV-positive male partners could now get contraception and HIV care under one roof. A female CCHA at an integrated district hospital commented, "We can capture both male and female… in that they come to seek medical care here. At the same time [they get] medical care [and] family planning." Some providers appreciated the ability to counsel both men and women about use of condoms and other contraceptives together, allowing them to better promote dual method use. Providers also suggested that convenience of both FP and HIV care at one visit would allow them to reach more patients compared to the traditional referral-based system.

4. Discussion

Our findings suggest that the HIV care providers in this study thought that integrating FP into HIV services might facilitate male partner involvement in FP. The interviews reveal that these HIV care providers see many potential benefits to male partner involvement in contraceptive decisions but that male acceptance of FP continues be a challenge. Our findings corroborate other studies that have called for recognition of the role men play in reproductive decisions in predominantly patriarchal SSA countries (Duze & Mohammed, 2007; Mbizvo & Bassett, 1996). Although male partners' attitudes have been a barrier to the adoption of modern contraceptives, studies have also found increased contraceptive uptake and continuation when couples participated in counseling and discussion of FP together (Becker, 1996; Sternberg & Hubley, 2004; Terefe & Larson, 1993).

The providers in this study suggest that FP/HIV service integration may provide an effective venue for FP services that is agreeable to men. Previous studies on male perceptions of FP in SSA have indicated that reasons for lack of male partner involvement are multifactorial and

include female-targeted services/clinics, social and cultural barriers, misconceptions and lack of knowledge about FP, mistrust of FP service providers, and lack of male FP service providers (Kaida, Kipp, Hessel, & Konde-Lule, 2005; Onyango et al., 2010; Steinfeld et al., 2013; Wambui, Ek, & Alehagen, 2009). Providers in this study suggested that integration of FP into HIV care allowed male patients to have access to trusted providers and normalized FP services for both men and women. If men desire more FP education and opportunities for greater FP involvement as other studies have proposed (Kaida, Kipp, Hessel, & Konde-Lule, 2005; Onyango et al., 2010; Steinfeld et al., 2013), integrated FP/HIV services may provide an acceptable venue for reaching HIV-positive men with FP education and counseling.

As studies have suggested that male opinions and desires can dominate reproductive health decisions (Duze & Mohammed, 2007), it is critical that efforts to increase male partner involvement in FP decision-making do not undermine women's reproductive autonomy. It is concerning that some providers (though a minority) in our study reported asking for partner consent in choosing a FP method. Care should be taken that providers' efforts to involve male partners do not impose barriers on women's reproductive choices. As men and women are often counseled differently by FP providers (Kim, Kols, Mwarogo, & Awasum, 2000), training to provide quality counseling and care to both male and female individual patients and couples should also be considered. Additional programming will be needed to reach HIV-negative partners in sero-discordant relationships who are not clients of HIV care facilities.

This qualitative study has various limitations. The results of this study are not intended to be generalizable to HIV care providers in Kenya or other parts of SSA. Although we included data from providers at both integrated and non-integrated sites, given the qualitative nature of the study and small sample size, we cannot make definitive conclusions about the association of themes and integration status of the providers' sites. Social desirability bias may have influenced providers' narratives. Observer bias may have also influenced our data despite our efforts to code the data impartially with multiple coders. As the interviews, transcription, and data analysis were done separately, nonverbal communication was lost and not analyzed for purposes of this study.

Our findings suggest that providers thought that facilitating male partner involvement in FP may have positive consequences for FP use and couple FP decision-making. The benefits of FP/HIV integration may extend beyond improved access to contraception for female patients, though further research is needed to explore whether FP/HIV integration improves contraceptive use through increased male partner involvement. Providers' recognition of the prohibitive role men can play – reported by many studies in SSA – also suggests that male partner involvement in FP has to be implemented carefully since it may not be a helpful and safe model for every couple. Further research and programmatic work is needed to determine effective ways to engage male partners in FP in the context of HIV care and treatment, without impinging upon women's autonomy and reproductive rights. Along with peer education, media campaigns, and outreach through community leaders (Onyango et al., 2010; Sternberg & Hubley, 2004), integrated FP services may be a useful strategy to help increase male participation to reduce the unmet FP need in SSA.

Acknowledgments

Funding

The study was funded by the Bill and Melinda Gates Foundation. Dr. Newmann was supported by the National Center for Advancing Translational Sciences, National Institutes of Health, through UCSF-CTSI Grant Number KL2TR000143. The contents of the manuscript are solely the responsibility of the authors and do not necessarily represent the official views of the funders.

We acknowledge the important logistical support of the KEMRI-UCSF Collaborative Group and especially Family AIDS Care and Education Services (FACES). We gratefully acknowledge the Director of KEMRI, the Director of KEMRI's Centre for Microbiology, and the Nyanza Provincial Ministries of Health for their support in conducting this research. We thank the providers who generously gave their time to participate in this study and Jackline Otieno and Luke Odhiamabo for their important contributions to this research.

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Table 1

Demographics and experience level among 30 study providers.

	Integrated sites		Non-integrated sites		Overall	
	N	**(%)**	**N**	**(%)**	**N**	**(%)**
Sex						
men and women	16	(53%)	14	(47%)	30	
women	9	(56%)	6	(43%)	15	(50%)
men	7	(44%)	8	(57%)	15	(50%)
Position						
clinical officer	4	(25%)	5	(31%)	9	(30%)
nurse	6	(38%)	5	(31%)	11	(37%)
community and clinic health assistant	6	(38%)	4	(25%)	10	(33%)
Age						
mean (SD)	29.4	(4.3)	29.4	(2.6)	29.4	(3.5)
range	21–39		26–34		21–39	
Years working at HIV clinic						
mean (SD)	2.6	(1.8)	2.3	(1.3)	2.5	(1.6)
≤1 year	6	(38%)	3	(21%)	9	(30%)
2–4 years	8	(50%)	9	(64%)	17	(57%)
≥5 years	2	(13%)	2	(25%)	4	(13%)
Years as healthcare provider						
mean (SD)	4.3	(2.2)	3.7	(1.4)	4	(1.9)
2–4 years	9	(56%)	10	(71%)	19	(63%)
≥5 years	7	(44%)	4	(29%)	11	(37%)
Years working in HIV care						
mean (SD)	3.5	(2.1)	2.9	(2.3)	3.2	(2.2)
≤1 year	2	(13%)	3	(21%)	5	(17%)
2–4 years	11	(69%)	10	(71%)	21	(70%)
≥5 years	3	(19%)	1	(7%)	4	(13%)