“If the woman doesn’t prevent, you will become pregnant”: exploring male involvement in contraceptive use preceding unplanned pregnancy in Sierra Leone

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ABSTRACT

Globally, millions of unintended pregnancies occur each year resulting in a host of social, economic, and health-related problems. Improving knowledge of and access to family planning services is an effective way to prevent unintended pregnancy, and research suggests that men’s involvement promotes greater contraceptive uptake. To explore this issue, we assess contraceptive knowledge, attitudes, and behaviors among Sierra Leonean men who experienced an unplanned pregnancy. Findings indicate that men’s participation in family planning was limited due to barriers including inadequate knowledge about contraception, poor access to services, and gender norms that consider family planning a woman’s responsibility. As a result, men often resorted to a pattern of control that put the onus of contraceptive use on women and blamed women when they became pregnant, without considering their own role in pregnancy prevention. We suggest that family planning policies and interventions both engage men and address the barriers to their participation in reproductive health.

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INTRODUCTION

Between 2015 and 2019 there were approximately 121 million annual unplanned pregnancies globally, with the highest rates in sub-Saharan Africa (Bearak et al. 2020). This is concerning because unplanned pregnancies carry substantial risks for poor health outcomes. It is estimated that approximately eight million abortions occur each year as a result of unplanned pregnancy in Sub-Saharan Africa, of which about three-quarters (77%) are considered unsafe (Bankole et al. 2020). Women experiencing unwanted pregnancies are also less likely to receive optimal antenatal care (Amo-Adjei and Tuoyire 2016) and are more likely to suffer from mental health problems (Faisal-Cury et al. 2017; Manikkam and Burns 2012) and poor treatment outcomes related to HIV/AIDS (Brittain et al. 2019). Further consequences include financial constraints, school drop-out, social stigma, and decreased marriageability (Burtscher et al. 2020; Hultstrand et al. 2020; Levandowski et al. 2012; Smith-Greenaway 2016). While limited, studies of men demonstrate that unplanned pregnancies impinge on their education and ability to provide and care for their families financially (Chili and Maharaj 2015; Kane et al. 2019).

Researchers who work in sub-Saharan Africa highlight a number of risk factors for unintended pregnancies. These include age, poverty, limited access to education, unequal gender power dynamics within sexual relationships which may limit individual agency in negotiating protection, and limited access to and poor knowledge of modern forms of contraception (Adeniyi et al. 2018; Calvert et al. 2013; Christofides et al. 2014; Gizaw et al. 2018; Hultstrand et al. 2020; Kaphagawani and Kalipeni 2017; Nyarko 2019). Reproductive health experts thus recommend the scaling-up of family planning services to prevent unwanted pregnancy and thereby reduce the aforementioned social and health consequences (Singh et al. 2014) . Beyond promoting maternal health, access to family planning services confers additional social benefits, by spurring economic development, increasing children's access to schooling, and promoting gender equity by allowing

women to participate more fully in the workforce (Canning and Schultz 2012; UNFPA and PATH 2008).

Although voluntary family planning is considered to be a global low-cost intervention to avoid unplanned or unwanted pregnancies (Jacobstein et al. 2013), strong regional disparities remain. While recent decades have seen a worldwide increase in contraceptive prevalence, sub-Saharan Africa continues to have the lowest rates of contraceptive use at 28% (UN DESA 2020). Globally 77% of women of reproductive age have their need for family planning satisfied, yet only 56% of women in sub-Saharan Africa who want to avoid pregnancy are currently using a modern method (UN DESA 2020). Documented barriers include a lack of sexual and reproductive health knowledge in addition to problems of access and cost (Bellizzi et al. 2015; Mkwananzi 2020; Munakampe et al. 2018; Singh et al. 2014). Other factors responsible for low contraception use include religious prohibitions, familial resistance, gendered social norms around sexual behavior, and health concerns—particularly the unwelcome side effects associated with hormonal birth control (Bongaarts 2014; Kassa et al. 2014; Plautz and Meekers 2007; Sedgh et al. 2007).

Recently, scholarship has focused on the role that gender dynamics play in perpetuating unplanned pregnancies within patriarchal societies. For instance, in many African countries spousal opposition to contraception and limited male involvement have been tied to low uptake of family planning services (Kassa et al. 2014; Kriel et al. 2019). This is mainly attributed to the elevated social and economic status of men in this context, which confers on them a major influence in healthcare decision-making (Dudgeon and Inhorn 2004; Kabagenyi et al. 2014; Morrell et al. 2012).

While such research is informative, it is often biased toward the female perspective, as family planning tends to be researched, evaluated, and intervened upon as a women's issue. The focus on women's needs and experiences have been critical in identifying inequalities across various levels of society, but, consequently, such perspectives have contributed to assumptions that men are barriers to, or uninterested in, sexual and reproductive health (Tuloro et al. 2006). Quantitative cohort studies,

however, demonstrate that male use of contraception varies widely by context, from 8% current use in an Ethiopian sample to 56% in a Nigerian sample (Ijadunola et al. 2010; Kassa et al. 2014). Studies point to a number of factors that influence men's involvement in family planning, including socioeconomic status, superstitions, limited relevant knowledge, and/or perceptions that contraception is a woman's issue (Adelekan et al. 2014; Ijadunola et al. 2010; MacQuarrie et al. 2015). That said, researchers using Demographic and Health Survey data find that many men feel contraception is a shared responsibility for men and women. In one study, the majority of men in six of ten African countries included disagreed that contraception is solely a woman's business, demonstrating both that men are interested in family planning but that contextual differences exist (MacQuarrie et al. 2015).

More research is needed to investigate men's knowledge, experiences, and perceptions regarding family planning or how socially-defined gender dynamics may intersect with other factors to determine men's involvement in this arena (Kabagenyi et al. 2014; Vouking et al. 2014). A deeper understanding of the barriers to and facilitators of male partner involvement within specific contexts—including a focus on men's own perceptions of their agency, roles, and responsibilities—is important for tailoring family planning services and policies intended to prevent unwanted pregnancies. To address this gap, this paper assesses the attitudes and behaviors surrounding family planning and contraceptive use among a sample of Sierra Leonean men who experienced an unintended pregnancy.

STUDY CONTEXT

As of 2019, 17% of births and current pregnancies in Sierra Leone were either mistimed or unwanted, and as compared with prior year statistics, the proportion of mistimed births appears to be on the rise (Stats SL and ICF 2019). These numbers are driven in part by Sierra Leone's rate of teenage pregnancy, which is among the highest in the world at 21% (Stats SL and ICF 2019). High

rates of mistimed and/or teenage pregnancy undoubtedly contribute to Sierra Leone's extremely high rate of maternal mortality, which is 1120 deaths per 100,000 live births (WHO 2019).

Researchers find that unintended pregnancies present a number of social and economic challenges for men and women in Sierra Leone, including unforeseen costs, stigma related to extra-marital pregnancy, and the interruption of one's schooling (McLean Under Review). Following the Ebola epidemic in 2015, and until just recently, pregnant girls were formally banned from school and sitting for exams (which enable individuals to progress in their schooling). Men are also generally expected to sit out of school during a partner's pregnancy and many feel compelled to drop-out permanently in order to find work (McLean Under Review). Given this situation it is perhaps not surprising that many inidividuals initially react to unplanned pregnancies with fear and disappointment, although they often eventually come around to the prospect of parenthood given its salience in this context (McLean Under Review).

High rates of unplanned pregnancies can be traced in large part to Sierra Leone's lack of reproductive health services and overall weak healthcare system, which was highly impacted by the country's civil war (1991-2002). The situation was exacerbated by recent health crises, including the 2014-2016 Ebola epidemic. While the Government of Sierra Leone recognizes the importance of scaling up family planning services, the contraceptive prevalence rate (CPR) for married women remains low at 21% (though it increases to 53% for sexually active unmarried women) (Stats SL and ICF 2019). The proportion of women of reproductive age who have their need for family planning satisfied by modern contraceptive methods is 45% (Stats SL and ICF 2019), falling considerably short of the Sustainable Development Goal target of ensuring universal access to family planning services, with a benchmark of at least 75% of demand for family planning satisfied with modern methods (UN DESA 2020). Further, these rates do not account for inequities in access, driven by factors such as cost, distance to health facilities, lack of knowledge, or poor treatment by healthcare providers. For instance, among married women, those residing in urban areas are more likely to use contraception

compared to women in rural areas (26% versus 18%, respectively) and use of contraception increases with education, from 17% among women with no education to 29% among those with a secondary education (Stats SL and ICF 2019). Age is another important variable to consider, with researchers of one study finding that 40% of young people in Sierra Leone had not used contraception (including condoms) during their last sexual encounter (Labat et al. 2018). Finally, the cost of services can sometimes be prohibitive for low-income households. Research indicates that most women pay between Le 5,000 and Le 20,000 (USD $1 - $5) for contraception, an amount that surpasses many people's daily income (UNFPA 2016). Even in instances where family planning services are theoretically free, such as in the public sector, it is not uncommon for women to both pay for commodities and provide monetary gifts to healthcare staff as a form of gratification that incentivizes quality care in a context of resource scarcity (Pieterse and Lodge 2015; UNFPA 2016).

Despite Sierra Leone's comparatively low indicators of contraception usage, the country has made substantial strides in improving access to family planning services in recent years. According to the 2019 Demographic and Health Survey (DHS), met need for family planning increased from 8% to 21% over the past decade, and demand satisfied by modern contraceptive methods also increased substantially from 18% to 45% (Stats SL and ICF 2019). The government implemented the Free Health Care Initiative in 2010 for pregnant women, lactating mothers, and children under five years of age, which included efforts to improve access to quality family planning commodities and the training of healthcare workers to provide related services. That said, such initiatives have suffered from limited budget allocations. Other research points to the challenges imposed by recent disease outbreaks, with several studies suggesting contraceptive use declined during the recent Ebola epidemic (Bietsch et al. 2020; Inter-Agency Standing Committee 2014). While Bietsch and colleagues (2020) found that Sierra Leone's family planning sector was able to recover from Ebola, the current Covid-19 pandemic poses similar challenges, including staffing shortages, quarantines, interruptions

to supply chain, and fear of health facilities that may continue to impact access to family planning services (Srivatsa 2020).

The 2019 DHS indicates that women have access to and utilize a variety of modern and traditional contraceptive methods. The most popular methods include injectables and implants, which have increased in recent decades reflecting a global trend toward longer-lasting reversible options, followed by the pill (MOHS 2017; Stats SL and ICF 2019). Condom use is low for both married and sexually active unmarried women. As for men, the DHS indicates that knowledge of contraception is high. Among currently married men the most well-known contraceptive method is the male condom (99%), followed by implants (94%) (Stats SL and ICF 2019).

The predominant source of modern contraception is the public sector, which covers 80% of all users (Stats SL and ICF 2019). Within the public sector, government health centers are the most common source for modern contraception (41%), followed by government hospitals (25%) and family planning clinics (10%) (Stats SL and ICF 2019). Only 18% of users of modern methods receive coverage from the private sector, of which the most common sources are pharmacies (12%) and private hospitals or clinics (4%) (Stats SL and ICF 2019). The main nongovernment service providers for family planning are Marie Stopes Sierra Leone and Planned Parenthood Sierra Leone, which provide services through established centers, within existing government facilities, and via outreach in the community (MOHS 2017). Over 90% of primary facilities offer at least three different contraceptive methods, with the highest provision in the Eastern region of the country (UNFPA 2018).

The Government of Sierra Leone has highlighted a number of factors contributing to the country's low contraceptive prevalence rate, including poverty, school drop-out, and a lack of knowledge on sexual and reproductive health (MOHS 2017). There appears to be growing interest in assessing the role that gender plays in influencing contraception usage as well. For instance, one study of youth in Sierra Leone found that while women were overwhelmingly more likely to report a desire

to become pregnant, both genders were equally unlikely to utilize modern contraception methods (Labat et al. 2018). However, the behavioral determinants of contraceptive use differed between men and women, suggesting a need to further understand the ways in which gender norms constrain and/or facilitate contraception access and usage. This study seeks to learn more about young men who have become fathers unexpectedly. In what follows we explore men's exposure to and perception of contraception relative to their unplanned pregnancy experiences.

METHODS AND SETTING

The data used in this study are the result of 15 months of qualitative research with fathers between 2015 and 2016 in the Kono District of eastern Sierra Leone. Situated alongside the border with Guinea, Kono is well-known for its lucrative diamond mines. Due to its wealth in minerals, the district was severely impacted by the country's decade-long civil war (1991-2002), which has left it lacking in health and other social services. With a population of roughly 500,000, Kono remains one of the least-developed districts of the country, with high rates of maternal and child mortality (Stats SL and ICF 2019). These challenges were worsened by the 2014-2016 Ebola epidemic, which further strained the country's public sector services. Study sites included Koidu, Kono's largest urban center, in addition to several nearby towns and villages.

The findings presented below are part of a larger study of fatherhood and masculinity among young men in Sierra Leone. As part of this study, the first author conducted in-depth, semi-structured interviews with 106 fathers in the area, who were between the ages of 18 and 39 years of age. Participants were selected purposively, to comprise a heterogeneous group, ranging in ethnicity, religious background, education level, and employment status. Interviewees were also recruited via convenience and snowball sampling techniques. This study focuses on those participants who reported having impregnated their female partners unintentionally, or "by accident" (at least on one

occasion). This was the case for approximately 65% of the original sample, or 69 men. Of this subsample, approximately 80% remained unmarried at the time of the interview, although 29% of these men were "engaged to be married" (via *tying kola,* when a man presents a kola nut to the woman's family indicating his intention to marry her).

Interviews were conducted in Krio, Sierra Leone's lingua franca, by the first author, who is fluent in the language. They ranged between 45 minutes and two hours in duration. An interview guide was used that included questions related to men's romantic, sexual, and reproductive life histories prior to becoming fathers, including their experiences with dating and sexual relationships, family planning, pregnancy, and childbirth. Interviews were conducted in a private location determined by each participant and were audio-recorded, with permission. All interviews were later translated and transcribed into English by the first author, with assistance from Krio-and English-speaking research assistants. Data were then analyzed using an inductive, grounded theory approach (Corbin and Strauss 2014), by which themes emerged from participants' own words. These themes were then used to produce a codebook, which was applied to the coding of all interviews. For the purposes of this paper, we focus here on themes specifically related to family planning and men's experiences with pregnancy prevention.

The study protocol was approved by the Sierra Leone Ethics and Scientific Review Committee in addition to the Human Subjects Committee of the Yale University Human Research Protection Program. Permissions were sought from local town and village chiefs prior to commencing data collection in any of the research sites. A thorough process of written, informed consent took place before each interview. To protect participants' confidentiality, pseudonyms are used in the following text.

FINDINGS

Male Involvement in Family Planning

The men in our sample reported varying degrees of involvement in family planning. While some recounted using condoms, in general condoms were not a popular method of contraception. Men viewed pregnancy prevention as a woman's responsibility and female contraceptives predominated. While limited, most men did play some role in relation to family planning however, with participation ranging from financial support, to advisement, to accompanying women as they accessed services.

The most commonly reported manner of involvement in family planning was financial in nature. When asked about their role in pregnancy prevention, many men responded with something to the effect of, "I was giving her money for prevention." This might include covering the costs of reproductive services or transportation to access care. Others reported playing a more advisory role, recounting times when they encouraged their partners to take birth control or instructed them regarding which type to take. By advising women in this way, they often saw themselves as safeguarding their future and that of their partners. As a 26-year-old teacher-in-training named Aiah explained:

> I told her [his girlfriend] to go prevent because we had been together for a while, and I was worried a little bit because she was going to school and I also was going to school… I had taken her one time to Marie Stopes to do the prevention, but the precaution that they gave her, I think she failed to go and buy it.

Another individual, a 25-year-old miner, displayed strong feelings as to which type of birth control his partner used:

> I said instead of captain band [implant] take PPA [Planned Parenthood, referring to the pill]. I told her to take it, and she said no problem. PPA is better than captain band because if she takes the captain band it will stay there for a long time and get melted into her system. And when it gets into your system it will be difficult to give birth. After such you'll become fat. When you take the tablet it will develop the womb. It will clean the womb, your body will become fresh. So when you stop taking that tablet and want to get pregnant it's easy to give birth.

Other men, though in the minority, reported playing an even more active role in their partners' contraceptive usage. For example, one man reported that he kept the birth control pills for his girlfriend, while others, as in the case of Aiah above, described instances where they had accompanied women to family planning service providers, such as Marie Stopes or Planned Parenthood.

However, for most men, even when they did participate in these more direct ways, they often stopped short of knowing if their partner was able to fully access contraception. In Aiah's situation, for instance, we see that though he escorted his girlfriend to Marie Stopes, he seems unclear as to the type of contraception provided or whether his partner even bought or used it appropriately. In most cases, regardless of the type and extent of their involvement, men had limited knowledge about contraception and considered it to be a women's issue. It was not uncommon for them to be uninformed about the details of their sexual partners' contraceptive usage. In response to questions about prevention, some men revealed their lack of engagement with comments such as, "the woman was doing it," or, in the case of a 24-year-old trader, "I was not doing that. I was expecting that the girl was preventing." When asked what type of contraceptive this woman was taking, the man responded: "She used to do something," demonstrating his lack of detailed knowledge.

Importantly, family planning services in this setting are oriented towards empowering and serving women. As a result, some men felt excluded from spaces catering to pregnancy prevention and were uncertain of how to engage their partners or providers in communication and joint decision-making. Consider the case of Ibrahim, an 18-year-old *okadaman* (commercial motorbike rider) whose girlfriend requested Le 10,000 (approximately $2) for contraception. As he recounted:

> I gave her the Le 10,000, and she told me she is going to prevent for the period of three years. Then I said no problem, but by that time I used to be ashamed to follow behind a woman to go and do preventives. I asked her to go alone. Behold…she did not go. Instead she ate [spent] the money.

Given men's lack of knowledge regarding female partners' birth control practices, it was not unusual for them to be surprised when a partner became pregnant. In fact, in several cases, it was only after learning of a pregnancy that a man thought to inquire about prevention at all.

Men's Explanations for Unplanned Pregnancy

Similar to the varied forms of male involvement in family planning described above, men's explanations for unplanned pregnancies were diverse, ranging from justifications for why prevention was not used to contraceptive failure. Many reported being shocked by the news of a pregnancy, often despite any effort on their part to engage in pregnancy prevention. As a 21-year-old IT specialist recalled, upon hearing that his girlfriend was pregnant:

> It was really difficult! It was a shock to me, because I was not expecting it. It was not in my plan; she too did not plan for it. At first she just told me briefly, and I thought it was a joke. I took it as a joke and told her that, maybe you want to kill me or you want to create something that can stress me.

While some men cited contraceptive failure as the reason for a pregnancy (for instance, in the case of the man who daily administered the pill to his partner), most reflected on the reasons why they or their partner failed to effectively use contraception. In a small number of cases, men claimed ignorance—that they were simply unaware that sexual intercourse would lead to pregnancy. As one man, who was 17 at the time of conception, recalled:

> I did not have the idea that if I have sex with this woman she will get pregnant. Maturity was not there by then. It was just the sex that was much in us, so to speak. We were just going with the idea that when someone likes me and I also like her so…you would not think about the outcome. We have that love influence… I didn't have that idea that being with a woman, she could get pregnant by me without marriage.

More common was to claim ignorance regarding the existence of family planning services. Although this response was most commonly observed among slightly older men (e.g. those in their 30s) for whom it had been many years since their first child, or those from rural areas, who had less access to family planning services prior to coming to Koidu. As one participant, a 36-year-old petty trader, explained, "During those times, it was not common as compared to now when there is awareness about prevention. It was not there…especially for those of us living in the bush [rural areas]." As another recalled:

> That time Marie Stopes was not yet established here. It is just now that Marie Stopes has been opened. That was the time they began to go from school to school to give injections to the girls, to tell them what to do and what not to do, this recent time now.

Despite some reported ignorance, however, most men acknowledged awareness about the benefits of pregnancy prevention and knew where to access it. They cited numerous reasons for failing to or choosing not to utilize it. One Muslim man, for instance, explained that his religion was unaccepting of contraception. A 21-year-old man, speaking about condoms, claimed discomfort: "these things have to do with fitting, you can only use something that can fit you. If it does not fit you, you can't use it. One man's choice is another man's poison."

More commonly men spoke to issues of availability, access, and convenience. They reported not having used contraception either because services were out of reach or because they lacked the funds to pay for them. As one man explained, "We were thinking about planning how she can join Marie Stopes, but there was no money." For many men, however, the failure to use prevention had more to do with timing and convenience, as illustrated in the following quotations:

> But like that time I didn't use it [prevention]. I knew about it. I was quite aware about it but it was like… most times, there are times when you and the woman meet if there is feeling and there is no condom, there is no option, except you make love. (29-year-old electrician)

> We were actually doing unprotected sex. Sometimes you want to use it [contraception] but it's not available, but just because you want to do it… something like that. (26-year-old NGO employee)

In the case of the second respondent, who worked for an NGO that provided healthcare, including family planning services, to local residents, he further admitted that his failure to use contraceptives had been "stupid" because he had been so young at the time and was unable to support a family.

Finally, men were also influenced by their own insecurities around masculinity and sexuality. A few men, for instance, reported choosing "not to prevent their women" out of fear that it would encourage promiscuity—in other words, that it would free them to pursue other men. This fear was at times associated with financial insecurity, as demonstrated by one man who said, "Sierra Leonean women like money too much. If you and her are in a relationship, if you don't spend on her she will leave you and go behind someone who can spend on her." Another man named T-boy, a 24-year-old *okadaman*, explained his own reasoning for not using— or rather, not permitting his partner to use—contraception: "She told me that we should prevent but I said no. I said because if I prevent you, you will go to another man." When pressed as to what caused him to think this way, he recounted his prior experience with women:

> Because of the way that other one treated me. I was preventing her… and she was going around dating other men. So that was what made me to be afraid to prevent this one… Just because she [referring to his current partner] loved me, she said, 'Ok, I am there for you, I will agree.'

Clearly, for some men, ensuring a female partner's fidelity may outweigh the risks of unwanted pregnancy.

"If the Woman Doesn't Prevent, You Will Become Pregnant"

While the reasons listed above were often espoused by men as contributing to unplanned pregnancies, the most common reaction by men was to blame women for failing to use contraceptives

or for using them incorrectly. Men blamed not only their sexual partners, but also female relatives and healthcare workers, as family planning efforts were considered to be the purview of all women. Women were blamed for various reasons, from unknowingly misusing contraceptives, to fearing side effects, to secretly not using them to become pregnant.

In some instances, men gave their female partners the benefit of the doubt that contraceptive failure was indeed responsible for an unplanned pregnancy, particularly in the case that women were also visibly disappointed by a pregnancy. However, it was more common to assume that women were somehow at fault, for instance, by forgetting to adhere to their contraception (i.e., efficacious use) or misunderstanding how to take it. As one young man explained, referring to his partner, "Yes, she used to use it [contraception], but the time got expired and she refused to tell me." Another, a 22-year-old security guard, rationalized the "mistake" by saying, "she went to Marie Stopes to prevent but she missed how to use the medicines." Some men blamed women's young age for their lack of knowledge, as in the case of Samuel, a 28-year-old petty trader:

> Well, I asked her if she was doing prevention, but it was an injection by then since she was a little girl. She was 18 so she was not too mature. It was an injection she was taking by then, but I think the date passed her.

Other men attributed unplanned pregnancies to women's aversion to using contraception. They acknowledged that some women feared unpleasant side effects or were swayed by stories they had heard regarding the dangers of contraception. As one man explained, referring to his girlfriend, "she says she cannot use this implant because it has an infection." Another added, "she said it will get stuck in her [referring to a condom]." Acknowledging the power of stories around contraception, one man, a 26-year-old trader, said, "sometimes it is the aftereffect people talk about—that it [contraception] will cause your body to enlarge, or you will become thin and die. That people talk about them cause them [women] to be afraid." Another elaborated further, demonstrating his knowledge of possible side effects:

> No, we didn't use prevention really, because…most of the preventives now you will find out that they have after effects on women. They do grumble about it. Some explain that if they are using it during their menstrual period they can bleed so much indeed. There are a lot of talks that they can talk. So most of them do not like to use it or most of them can like to look for the right one, which they can use. But like mostly it cannot fit them.

Finally, the most common justification men provided for an unexpected pregnancy was the belief that women were deliberately forgoing contraception in order to become pregnant. Many men conveyed feeling deceived by women who they perceived as wanting to become pregnant to secure the longevity of their relationship. As one man explained, "Some women will not adhere to their [man's] advice, because she needs the man or has love for the man, and she will think that if she gets pregnant for the man he will marry her." Another man, who was 21 at the time his girlfriend became pregnant, rationalized:

> I used to give her money every month for her to go and prevent but it is like the girl was having the passion to bear a child for me…. So she did not take the preventives so unfortunately she came and told me that she is pregnant…yea, so she decided to skip the prevention. She said 'let me give birth for him so that I can get him!' Yea, so that I will not be able to leave her, so that she can have total control over me. So that was her intention.

Aiah, mentioned above, who had accompanied his girlfriend to Marie Stopes, speculated that she wanted to have a baby for fear that he would leave her if he achieved an advanced education. As he recounted:

> I really knew she wanted to have a baby, because she told me when we were younger, like when we were growing up, she said that maybe sometime I would disappoint her. Like, if I went far in my education, I would not want her. So I sat down and thought, I said maybe something bad made her get pregnant, so if she bore my child I wouldn't be able to leave her.

Nor did men perceive that women were necessarily conspiring alone, or that their sexual partners were always at fault. Several men, for instance, blamed their partners' mothers (the expectant grandmother) as playing an assisting role. As one man recounted, "the woman was protecting herself, but without knowing… her mother was a nurse, so her plan was to have a granddaughter. So, without me knowing, she had stopped her daughter from taking the preventives. Yea! That was the mistake—and her daughter agreed with her." In other instances, men blamed the organizations that provided the contraceptives (and their female staff) for conspiring with their partners. This was the case for one 19-year-old student:

> Because at one time I took her to Marie Stopes so they would do an implant on her, but behold they lied to me. So that is the reason I doubted over this pregnancy, because I took her to Marie Stopes and they told me they have used the contraceptive on her, but they lied to me. The lady refused to accept the preventive but they lied to me that they have done the prevention.

Such experiences served to further cement men's distrust and distaste of such places, which they perceived as existing solely for women.

DISCUSSION

Improving access to and utilization of family planning services is key to reducing unintended pregnancies, and by extension, a range of negative social, economic, and health outcomes. In this paper, we explored contraceptive knowledge, attitudes, and behaviors among a sample of Sierra Leonean men who experienced an unplanned pregnancy to gain a better understanding of why these pregnancies occurred and the role men played (if any) in family planning. As our findings demonstrate, while male involvement in pregnancy prevention varied, it was generally limited to indirect measures such as financing contraceptives, providing instruction, or in some instances, accompanying women as they sought services. While these findings counter assumptions that men are

inherently barriers to, or completely uninterested in family planning, they do suggest that their roles are restricted. As we found, men displayed limited knowledge about pregnancy prevention in general and were often unaware of the details of their sexual partners' contraceptive use, themes that have been found elsewhere (Kabagenyi et al. 2014; Kassa et al. 2014; Kriel et al. 2019). While some, particularly younger, men demonstrated awareness of the benefits of contraception, the various types available on the market, and/or potential side effects, others were largely uninformed about such issues. Especially concerning were the minority of men who were unaware that sexual intercourse could result in pregnancy. Promising, however, were indications that awareness of contraception and where to access family planning services was on the rise. These findings resonate with those of the Sierra Leone DHS (Stats SL and ICF 2019) and suggest that recent government efforts to improve access to services are creating positive change. The narratives provided by these men additionally imply that the expansion of family planning services was considered to be a benefit not just for women, but also men.

That said, a number of substantial barriers continue to limit men's involvement in pregnancy prevention. Among our sample, some men reported that the cost of family planning services was prohibitive, an issue that is global in scope but most critical among poor households in low-income countries (Singh et al. 2014). In addition to cost constraints, men also spoke to perceived discomfort or inconvenience as reasons for not using contraception. This was even the case for men employed in the health sector who are most likely to understand the benefits of contraception relative to unplanned pregnancies. The importance of discomfort or decreased male sexual pleasure on contraceptive use, particularly male condoms, has been discussed elsewhere in the literature (Govender et al. 2020; Higgins and Smith 2016; Kriel et al. 2019) and may speak to local perceptions that the physical burdens of pregnancy prevention should not apply to men, emphasizing the existence of male sexual entitlement in this setting (Scorgie et al. 2009). This entitlement is reflected in the acknowledgement

by multiple men in this study that certain types of contraception can have negative physical side effects for women.

Our study indicates that culturally mediated gender dynamics played a major role in informing men's understanding of and engagement in family planning. According to our study, a critical factor impacting male involvement is the normative belief that family planning is a women's issue, a finding that has been mirrored in other countries, including Nigeria (Adelekan et al. 2014), Ethiopia (Kassa et al. 2014), and Uganda (Kabagenyi et al. 2014). In Sierra Leone, gender is constructed along a strict binary where men and women are considered to have different roles and responsibilities (Coulter 2009), and nearly all men viewed pregnancy prevention as a woman's responsibility. It is perhaps no surprise then that men reported feeling excluded from spaces providing family planning services. Marie Stopes, which sits along Koidu's main thoroughfare and is a popular provider of contraceptive services, is known locally as *di mami fo welbodi* (literally, "the mother of health"). Feelings of exclusion from such spaces may help to explain the results of a recent survey, which found that lack of access to contraception was an important determinant of non-use among boys, but not girls in Sierra Leone (Labat et al. 2018).

It is also imperative to mention the impact of gender inequality upon family planning in this context, where men tend to wield significant power over women, including with respect to their bodies and sexualities (Schneider 2019). While contraception was generally deemed the purview of women, we found that many men were involved—at least indirectly—when it came to choice of method or accessing services. Some men went even further, providing direct instruction, or in the case of one man, distributing birth control pills to his partner. While on one hand this may have indicated an exercise in joint decision-making, or even care on the part of the male partner, it could also be taken as a form of gendered surveillance, reflecting men's desires to exert control over women. Their positions of power certainly allowed them to deflect fault in the case that an unwanted pregnancy did

occur, as we found a strong tendency to blame women (girlfriends, mothers, and even female nurses) in the case of contraceptive failure.

In some instances, men even refused to allow their partners "to prevent" out of fear that it would encourage promiscuity, only to claim they had been deceived when a pregnancy ensued. That men at times felt deliberately tricked by women wanting to ensure the longevity of a relationship, discounting their own role in pregnancy prevention, points to a lack of trust and communication among sexual partnerships with the end result of victim-blaming. This finding also points to the financial precarity faced by many women in this setting and mirrors other instances where women's sexual behaviors (e.g. in the case of vaginal practices to stimulate "dry sex") have been reported as attempts to secure more stable and economically rewarding relationships (Scorgie et al. 2009). While in some circumstances women may indeed be intentionally becoming pregnant, such narratives can also be harmful by disregarding instances when women themselves lack the know-how or agency to adequality prevent unwanted pregnancies.

While patriarchal gender norms can certainly discourage men from engaging in family planning, encouragingly, the literature points to signs of heterogeneity in men's behaviors. In the study referenced above from Nigeria, researchers found that while some men held negative perceptions about male involvement in pregnancy prevention, others were of the perception that male engagement was a way of showing love to one's wife (Adelekan et al. 2014). Another study conducted in South Africa indicated how cultural practices relating to men's involvement in family planning are changing, particularly in urban areas, resulting in men and women renegotiating reproductive roles and behaviors (Kriel et al. 2019). While not specific to family planning, research from Sierra Leone suggests an interest among many men to participate in pregnancy and childbirth (McLean 2020). Although noted shifts are certainly promising for improving gender equality in this context, our revelations speak to continued patterns that border on coercion, indicating a man's ability to dictate decisions even when they fall within socially constructed female domains (Kabagenyi et al.

2014; UNFPA 2016). The complex relationship between men's involvement in family planning in light of shifting perceptions of gendered roles and privileges thus requires further investigation.

Our findings have a number of implications for global health policy and practice. First, given the limited nature of men's knowledge of and perceived access to family planning services, it is imperative that programming be expanded to engage men (Dalaba et al. 2016; Duze and Mohammed 2006; Kassa et al. 2014). As demonstrated, in the face of inadequate knowledge, gossip or rumors may fuel people's behaviors, leading to low uptake of contraception and other unintended outcomes (Labat et al. 2018; UNFPA 2016), for instance by stoking men's concerns that their partners' use of contraceptives will encourage sexual promiscuity (Kabagenyi et al. 2014). While recent interventions targeting women have helped to curb rates of unintended pregnancies in Sierra Leone, by focusing exclusively on women they may inadvertently marginalize men's roles and potential responsibility in family planning. Rather, engaging men, by leveraging existing forms of involvement, may provide space in which to broaden the scope of male partner support that could have positive impacts even beyond reproductive outcomes.

A number of intervention studies in sub-Saharan Africa have shown an increase in the acceptability and uptake of contraception when family-planning programs were directed at men, suggesting that they can be relevant and successful (Dalaba et al. 2016; Shattuck et al. 2011; Tilahun et al. 2015). A recent intervention implemented by Restless Development in Sierra Leone points to the value of using volunteer peer educators to influence boys' negotiation and use of condoms (UNFPA 2016), indicating the potential effectiveness of community-based initiatives (Kriel et al. 2019). A community-based primary health care program in northern Ghana known as the Navrongo Project combined male mobilization and doorstep provision of family planning care with positive results for family planning knowledge and modern contraceptive usage (Dalaba et al. 2016). Our work also supports that which highlights the benefits of interventions that target men and women *together*, with the goal of improving relationship dynamics (Christofides et al. 2014). As Hartmann and colleagues

(2012) found in their Malawi Male Motivator intervention, communication was an integral component for increasing male involvement and ultimately led to greater instances of shared decision-making and increased contraceptive use.

Our findings also support Shattuck and colleagues' (2011) call for activities that challenge patriarchal gender norms more broadly, suggesting that education alone may not go far enough in fostering behavior change. Macro-level interventions that target men by normalizing their engagement, for instance, by making family planning clinics more inviting to men, may also be required. Ijadunola and colleagues (2010) note the potential for family planning clinics to hire male staff and offer hours that are more convenient to men, in addition to catering to male reproductive health services. It will also be critical to make sure, as Kabagenyi and colleagues (2014) note, that interventions incorporating men do no inadvertently reinforce gender inequities by relying on men's power, placing undue burden on women to involve their male partners, or subverting funding for initiatives to improve women's access to reproductive health services.

Finally, it is also pertinent to address the structural barriers that prevent both men and women from engaging in family planning. As McLean (2020) argues, men's involvement in women's reproductive health via indirect forms of support like financial provision or accompaniment constitute culturally meaningful forms of "involvement" and should not be dismissed. Rather, the barriers hindering men's engagement in such forms of care could be further explored. For example, researchers of a study conducted in southern Ethiopia found that male contraceptive use increased with education and employment (Tuloro et al. 2006). Given that poverty is perceived as the main social problem leading to early pregnancy in Sierra Leone (UNFPA 2016), greater opportunities for education and financial support may help to alleviate insecurities that prompt men to demonstrate controlling behaviors rather than engage in mutual decision-making with their female partners.

The findings presented in this paper should be interpreted in light of a number of limitations. First, this analysis was conducted using existing data from a larger research project on fatherhood and

masculinity in Sierra Leone. While the authors found sufficient relevant data to analyze, our guiding research questions were not specific to family planning, and as such, the data do not reflect explicit probing into this theme. Ideally future research will be undertaken with the goal of shedding further light on this topic, particularly with respect to how shifting gender norms are contributing to the renegotiation of roles and expectations concerning contraceptive use. We also note that our sample comprises a unique group of men who experienced an unplanned pregnancy and, as such, our findings are not representative of all men in Sierra Leone. Additionally, although both authors have spent substantial time in Sierra Leone, and the first author is fluent in Krio and has a robust understanding of communities in eastern Sierra Leone, both authors bring with them a set of inherent biases stemming from their American upbringing. Finally, the fact that the lead interviewer was a female may have influenced how male participants responded to questions about what were likely considered sensitive issues.

CONCLUSION

Studying men in relation to "women's issues" is critical for capturing the complexity with which individuals and communities approach reproductive health. In this paper, we assess men's perceptions and experiences with family planning in the aftermath of an unplanned pregnancy in order to better understand the role that men play in influencing contraceptive uptake. We provide one of few analyses to qualitatively assess contraceptive usage in this context as an explicitly female *and* male issue. Our findings indicate that men's knowledge of and engagement in family planning is heterogenous, but generally limited by a lack of sexual and reproductive health education, poor access to services, and gender norms that designate family planning clinics as female-only spaces. While Sierra Leone has seen an expansion of reproductive service provision over the past decade, it is our perception that more needs to be done to incorporate men as partners in family planning initiatives. Our findings can be used to develop more effective policies and interventions that both

include and attend to the specific needs of men in support of reducing the incidence and burden of unplanned pregnancies.

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