

Global Knowledge Project

Title: A study to Explore how Males at the University College View Male Involvement In Contraceptive Use.

Subtitle: Views of men on male involvement in contraceptive use.

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ABSTRACT

The purpose of the study was “To Explore the Views of Male Students and Male Lecturers at the University College in the Western Part of Norway on Male Involvement in Contraceptive use”. Therefore, the statement of the problem was; “How do male students and male lecturers view male involvement in contraceptive use such as condoms, pills and sterilization according to gender equality in Norway?”

Background: Gender based power relations have a direct effect on the ability of partners to acquire information, make decisions and take actions related to their reproductive health, safety and wellbeing, for example, a woman and her partner may not agree on the desirability of pregnancy or the use of contraception. Giving men information about contraceptive use can influence their participation in contraception. Male involvement in contraceptive use may help not only in the acceptance of a contraceptive method but also in its effective use and continuation. Involving men in contraceptive use mainly require their direct participation by using methods that directly involve them like condom use, vasectomy, and withdrawal or period abstinence (Outlook, 1997). It may also mean having the contraceptive counselling together with their partners in order to make a joint decision about which contraceptive method to use, being supportive to their partners’ contraceptive use (K4Health, 2012) for instance, escorting partner to access the method or reminding her to take a pill or have an injection to prevent pregnancy.

Literature review: It should be noted that it was very difficult to find literature on previous researches done on male involvement in contraceptive use in Norway.

Methodology: A qualitative study design that was explorative, descriptive and contextual was used with a purposeful convenience sample of three (3) male students and three (3) male lecturers because of differences in age and experiences. However, an inclusion criteria was used to include an assistant principal at a high school in the same area of Norway. This was in order to have views of men on the topic at different levels. Data collection was done through a semi structured interview schedule and analyzed using content analysis. The data was later divided into meaning units which were condensed, coded and colored. It was then categorized into three (3) themes which were; Knowledge about contraceptives, Male involvement in contraceptive use and Gender equality in contraceptive use.

Results: The findings of the study showed that the respondents viewed male involvement as a good thing but doubted if gender equality extended in contraceptive use, because they said, women take more responsibility when it comes to contraceptive use. It also revealed that the

reason why women may take more responsibility maybe, because women are the ones that carry the pregnancy and undergo the abortion procedure. The study also revealed that the respondents had more knowledge on condoms, the pill for women and sterilization, while a few of them had knowledge on Intra uterine device/spiral, injectable contraceptives, and periodic abstinence and withdrawal methods. The respondents further revealed that most men may enjoy sex more without a condom and for this reason women may take responsibility by taking the pill. In view of our findings, it was difficult to make a conclusion because only six (6) males were interviewed in the study which will not reflect a true picture of the views of men on male involvement in contraceptive use, but we recommend that the men should be fully involved in contraceptive use, as this also promotes gender equality.

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ABBREVIATIONS

HBM – Health Belief Model

ICPD -International conference on population and development

ReCAPP- Resource Centre for Adolescent Pregnancy Prevention

UN – United Nations

UNDP – United Nations Development Programme

UNPF – United Nations Population Fund

USAID - United States Agency for International Development

WHO – World Health Organization

1.0 INTRODUCTION

In this paper, the readers will find different parts and in the first part, there is the background, statement of the problem and purpose of the study. In the second part, there is Literature review which comprises the theoretical background, male involvement in contraceptive use, contraceptive methods and gender. It should be noted that it was very difficult to find literature on previous researches done on male involvement in contraceptive use in Norway for the literature review. The third part talks about the research design and methodology. The fourth part includes data analysis and presentation of results, and the fifth part talks about discussion of results, conclusion and recommendations.

1.1 BACKGROUND

Male involvement in contraceptive use is very important because not only do men have reproductive health concerns of their own but their health status also affect women's reproductive health (Outlook, 1997). This was highlighted by both the International conference on population and development (ICPD) held at Cairo in 1994 and the World Conference on women at Beijing in 1995, that Male involvement in family planning and reproductive health in the context of Gender equality and responsible sexual behaviour was highly neglected (Jayalakshmi et al, 2002). Male involvement in contraceptive use remain largely invisible despite them having advantageous position in sexual, family and reproductive health matters (Akindele and Adebimpe, 2013). In order to make the correct decision on time, men should have awareness and knowledge about the contraceptive use (Jayalakshmi et al, 2002). The key ways to directly involve men in women's reproductive health may include, using contraceptive methods that require their direct participation such as condoms, withdrawal, natural family planning and vasectomy. It may also mean supporting their partners' use of contraception, through joint decision making about contraceptive method use and also preventing the spread of sexually transmitted infections, by using condoms and limiting their sexual activity to one partner (Outlook, 1997).

Norway is a modern society that has gender equality and from the time we arrived in Norway as students, we were told there is gender equality in Norway and it affects almost all aspects of life, it made us wonder whether this gender equality also influences contraceptive use. Coming from Zambia, a traditional society which views contraception as a woman's issue, where more females are seen to access contraception with minimal male involvement (Abt Associates, 2013). How is the situation in Norway? Is there adequate male involvement in contraceptive use?

Therefore, keeping this background in view, the present study was done with the following specific objectives:

1. To assess the knowledge of some male students and male lecturers on contraceptives.
2. To find out the views of males on male involvement in contraceptive use
3. To explore the extent of gender equality in contraceptive use.

Because of this background, our statement of the problem has been as below:

1.2 STATEMENT OF THE PROBLEM

How do male students and male lecturers view male involvement in contraceptive use such as condoms, pills and sterilization according to gender equality in Norway?

1.3 PURPOSE OF THE STUDY

To explore the views of male students and male lecturers at the university college in the western part of Norway on male involvement in contraceptive use.

1.4 DEFINATION OF KEY TERMS

The key terms below are defined to enable readers understand their meanings as they read this document.

Birth Control- Encyclopaedia Britannica (2015) defines birth control as “the voluntary limiting of human reproduction, using such means as sexual abstinence, contraception, induced abortion and surgical sterilization”.

Contraception is defined as “a deliberate prevention of conception or impregnation” (Encyclopaedia Britannica, 2015).

Male involvement in this study means male participation in contraceptive use.

Reproductive Health is a state of physical, mental, and social wellbeing in all matters relating to the reproductive system at all stages of life (Bio Med Central, 2015).

Sterilization is a surgical procedure for permanent prevention of conception by removing or interrupting the anatomical pathways through which gametes (ova in females and sperm cells in male) travel (Encyclopaedia Britannica, 2015).

Vasectomy is the “severing of the vas deferens in the male reproductive tract to bring about sterility” (Encyclopaedia Britannica, 2015).

Gender- World Health Organization defines” Gender as the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women” (WHO, 2015, *online*).

Gender equality- Gender equality means “the absence of discrimination on the basis of the person’s sex in opportunities, allocations of resources and access to services” (WHO, 2001, *online*).

2.0 LITERATURE REVIEW

2.1 THEORETICAL BACKGROUND

In this study, the writers are Nurses, hence decided to use the Health Belief Model, because it is a Nursing Model that deals with issues of behaviour. Behavioural change is expected to take place when someone has perceived some benefits from the actions one takes. Therefore, male involvement in contraceptive use is very important because it may need change of behaviour for men to be wholly involved.

The Health Belief Model (HBM) was originally developed in the 1950s by social psychologists Godfrey Hochbaum, Irwin Rosenstock, and Stephen Kegels who were working in the United States Public Services. The model was developed to explain why medical screening programmes particularly for Tuberculosis, were not very successful (ReCAPP, 2015).

The screening for Tuberculosis programme provided adults with free Tuberculosis screening X-ray from mobile units which were placed in various neighbourhoods. However, few adults turned for the programme services and this prompted the organizers like Hochbaum to investigate why few people turned up for the services. He therefore, conducted a study and found that people's perceived risk of disease including perceived benefits of action were crucial factors in their motivation. Firstly, the model was presented with only four concepts which are perceived susceptibility (meaning person's subjective assessment of their risk of getting the condition), perceived severity (the consequences and seriousness of the condition), perceived benefits (the person's opinion of value or usefulness of new behaviour in disease reduction), and perceived barriers (which includes those that facilitate adoption and interfere with the adoption of behaviour such as time, side effects and inconvenience). Later the concept of cues for action was added to stimulate behaviour. In addition, Self- efficacy was also added to the model (ReCAPP, 2015).

The model is an expectancy-value approach of decisions that are specifically related to an individual's health, and assumes that one's willingness to engage in preventive health behaviour depends on a two-step appraisal process which is the perceived threat of the situation under consideration, and the result of the cost-benefit analysis of the preventive behaviour. The model in this study was also used to see how men can have a healthier behaviour by seeing the importance of contraceptive use to prevent unplanned pregnancies (Bakkar, A. B. et al, 1997). The above mentioned concepts are now going to be discussed in detail on the next page.

2.1.1 Perceived Susceptibility

In order for people to adopt healthier behaviour, the most powerful perception is susceptibility or personal risks. The greater the risks, the greater the likelihood of engaging in behaviours to reduce the risks. For example, men who have a sexual partner with unknown HIV status, are most likely to use condoms in order to reduce susceptibility to HIV infection. Furthermore, it is logical that when people believe they are at risk of disease they will prevent themselves from getting infected. Although at times the opposite may happen, where unhealthy behaviours occur because people believe they have a low risk of susceptibility to infection. At times even when the perception of risk is high people usually don't adopt healthier behaviours. It is believed that when perception of susceptibility is combined with seriousness, the perceived threat is the result. Therefore, if the perception of the risk is to a serious disease for which there is real risk, there is often change of behaviour (Hayden, 2009).

2.1.2 Perceived Severity

The concept of perceived severity points to an individual's beliefs about seriousness or severity of the disease. On the other hand, perception of severity may be based on medical information and knowledge, and it may also come from beliefs a person has about the difficulties the disease may create on them or the complications. For instance, flu is viewed as a relatively minor ailment, where if one gets it would stay home for a few days but this might not be so for someone who has asthma, because it could land the asthmatic person in hospital (Hayden, 2009).

2.1.3 Perceived Benefits

The construct of perceived benefits is a person's opinion of value or usefulness of a new behaviour in reducing the risk of disease development. Therefore, people might adopt healthier behaviours when they think the new behaviour will reduce their chances of disease development. Perceived benefits play a critical role in adoption of secondary preventive behaviours such as condom use in the prevention of sexually transmitted infections and pregnancy (Hayden, 2009).

2.1.4 Perceived Barriers

Since behavioural change is difficult to attain to most people, the last construct of Health belief Model addresses the issue of perceived barriers to change. "This is the individual's own evaluation of obstacles in the way of him or her adopting a new behaviour. Of all constructs, perceived barriers are the most significant in determining behaviour change" (Hayden, 2009,

p.33). For a new behaviour to be adopted, a person needs to believe the benefits of new behaviour, which must outweigh the consequences of continuing the old behaviour. This eventually enable adoption of new behaviour after overcoming the barriers (Hayden, 2009).

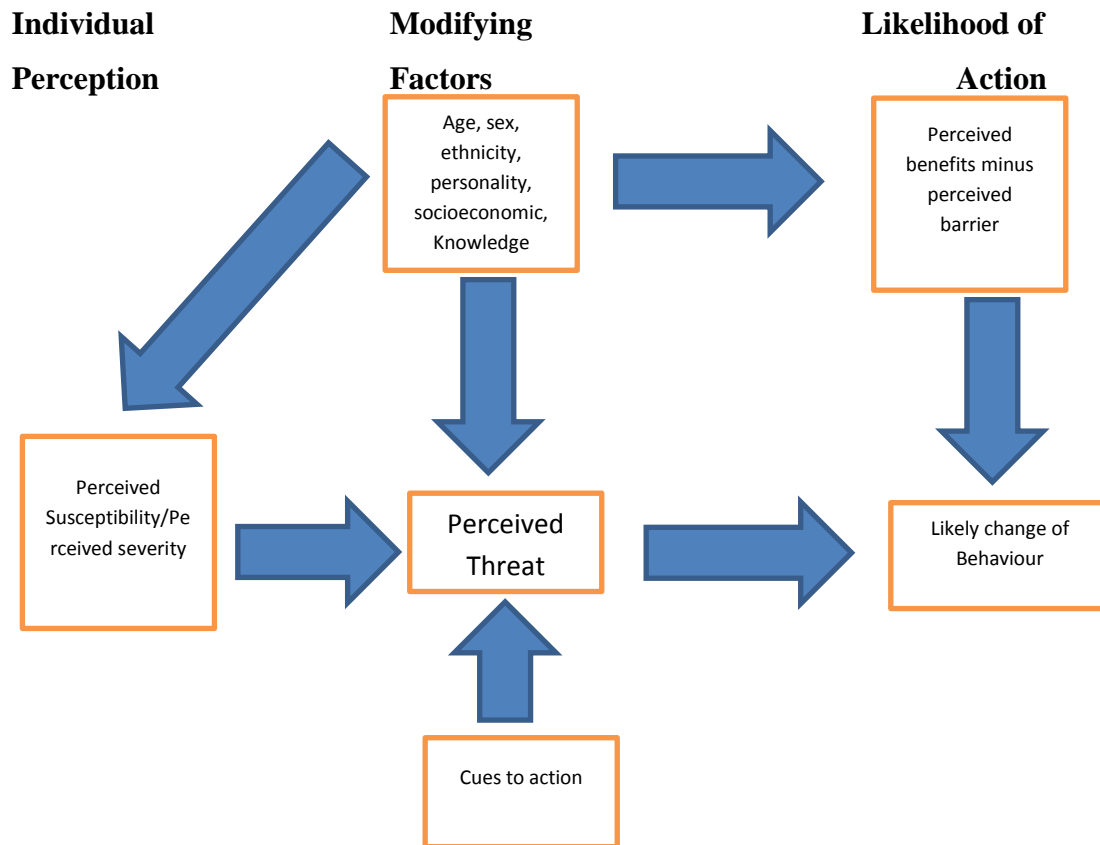
2.1.5 Cues to Actions

In addition to the four beliefs and modifying valuables, the health belief model suggest that behaviour is also influences by cues to action. The cues to action are events, people, or things that move people to change their behaviour (Hayden, 2009).

2.1.6 Self- Efficacy

Self- efficacy was added to the model in 1988 and it focuses on one's own ability to do something. It emphasises that people generally can only do something new when they believe they can do it. It further says that in situations where someone believes a new behaviour is useful (perceived benefit) but doubts his or her capability of doing it (perceived barrier), chances are that it will not be tried (Hayden, 2009)

The model explained above is on the next page.

HEALTH BELIEF MODEL by Hochbaum, Rosenstock & Kegels

(Hayden, 2009).

APPLICATION OF THE THEORY

In the Health Belief Model above, Perceived susceptibility is an individual's assessment of getting the disease and in our study, it is the individual's assessment of his chances of impregnating the partner by not getting involved in contraceptive use, while his perceived benefits could be his conclusion as to whether getting involved in contraceptive use is better or not. Then, perceived barriers would be his opinion on what would stop him from adopting the new behaviour. The perceived seriousness or severity could be his judgement of the seriousness of not getting involved while his modifying variables are his personal factors that affect him whether he gets involved or not. His cues to action are those factors that will cause him to start to be involved in contraceptive use as a way to support his partner. In addition, the self-efficacy would be his personal belief in himself to do something new, for instance, by supporting his partner in contraceptive use like reminding her to take the pill or himself getting involved directly by using condoms to prevent pregnancy or doing sterilization when he feels his family size has been attained.

When individuals think that they are old enough or they are sexually active, and they have the knowledge that getting involved in contraceptive use is an important thing, not only to prevent pregnancy but also to have a health family, they are likely to develop behaviour that will be helpful to them. This will result into taking an action, when they know there are more benefits of those actions without looking at the barriers, which is then likely to bring about change of behaviour. On the other hand, an individual's knowledge of being susceptible to sexually transmitted infections will make them use a condom every time they have sex, because getting an infection is their perceived threat and this brings about behavioural change. Furthermore, when a men believe that they can impregnant their partners, they may opt to use condoms or tell their partners to be on contraceptives, in order to prevent pregnancy. So, in this case, impregnating a partner is the perceived threat and the cue of action is the move one takes to use a condom or reminding a partner to take for instance, a pill and this eventually brings change of behaviour.

Moreover, partners' social economic status can influence them to make a plan on number of children they want to have, which can be achieved by using contraceptives like condoms and sterilization for men. Pills, injections, as well as intrauterine devices for women can also be used in order to prevent pregnancy.

2.2 REVIEW OF LITERATURE

Literature review is defined as a written synthesis of information about a topic that comprises of a discussion on previous research done and evidence gathered including methodologies, strengths and weaknesses of findings and the gaps that require more knowledge (Boswell and Cannon, 2008).

In order to understand male involvement in contraceptive use, it is important to view a brief history of birth control. The literature review also discusses male involvement in contraception, the types of contraceptives in general, Gender and Gender Equality in Norway.

Birth control practice is as old as human existence. For centuries humans have attempted to avoid pregnancy. For instance, dating back from 1850BC, Egyptian ancient writings refer to techniques of family planning using device placed in the woman's vagina, which was made of crocodile dung and fermented dough, which created a hostile environment for sperm (Samra, 2014). Other items placed in the vagina included plugs of gum, honey and acacia. Furthermore, a highly acidic concoction of fruits, nuts and wool was placed on the cervix as a type of spermicidal barrier in the early second century in Rome (Samra, 2014).

2.2.1 Male Involvement in Contraception

The recognition of male involvement in contraceptive use came about as a result of the 1994 international conference on population and development (ICPD) and the 1995 world women conference which made key declarations for the need of male involvement in reproductive health issues. It stated that harmonious partnership of both men and women, can be achieved through changes of their knowledge, attitudes and behaviour. Men play a key role in gender equality because men have an upper hand in decision making, ranging from personal decision regarding size of family to policy making and all decision taken at all government levels (UNPF, 2004). It also tackled the issue of improved communication between men and women on issues of sexuality and reproductive health, and the understanding of joint responsibility which results in men and women being equal partners in public and private life. The main objective of male involvement was to promote gender equality in all aspects of life including family and community life, as well as to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles (UNPF, 2004). It further stated that "special efforts should be made to emphasize men's shared responsibility and promote active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning, prenatal, maternal and child health, prevention of

sexually transmitted infections, prevention of unwanted, unplanned and high risk pregnancies”(UNPF, 2004, p. 29).

Men have an important role in decision making about contraception, family planning and use of health services (WHO, 2015). Male involvement has a very important part to play on the shift from family to the broader reproductive health Agenda. Men constitute an important asset in efforts to improve women’s health. Therefore, an effort to involve them in ways that transform gender relations and promote gender equity, contribute to a broader development (Greene et al, 2004). The use of male contraceptive methods such as condoms, withdrawal and vasectomy has for a while been considered as an indicator to describe “male involvement” in contraception (Ashraf, et al. 1999). However, none of these methods account for more than 7% of contraceptive use worldwide (Glasier, 2010).

In 2003, the condom use accounted for 5.7% of worldwide use of contraception, withdrawal 6.8% and vasectomy 4.5%. These percentages has a wide variation between countries. In the northern part of Europe 10% to 22% of married couples were using condoms while 1.2% was recorded in East Africa and below 1% was recorded in most countries in that region (Glasier,2010). About 26% of couples in Turkey depended on withdrawal method while at the time, no one used withdrawal method in Ethiopia and South Africa. In addition to the above information, in the year 2005 to 2006, couples in the UK who chose sterilization were more likely to choose vasectomy than female sterilization (Glasier, 2010).

In another study that was done by Tuloro et al (2006) entitled “the role of men in Contraceptive use and fertility preference, in Hossana Town, Southern Ethiopia”, reported that most contraceptive programmes favoured women in contraceptive use such as pills and injections, although their effectiveness and continuous use usually remained unsuccessful due to lack of approval from partners. Most family planning programmes rendered less attention to the understanding of men’s roles in the effective and consistent utilization of contraceptives. Methods that required direct involvement of men like condom use, periodic abstinence, withdrawal and vasectomy were used less.

According to a study done in India Delhi by Jayalakshmi et al (2002) entitled “A study of male involvement in family planning” reviewed that there was low knowledge level of various contraceptive methods like vasectomy and emergency contraceptives among respondents. In addition, despite having three (3) or more living children, only half of men had the intention to have a permanent family planning method immediately or in future. It was also found that the desire to have vasectomy done was low among men. Furthermore, it

was found that, in most of the families, men were the main decision makers regarding the number of children.

In addition, according to the United Nations department of economic and social affairs population division, contraceptive prevalence by method, estimated that in 2005 in Norway only, between the age group of 20 to 44years, condom use was 12.8%, natural method 6.3% and there was no statistics on vasectomy and withdrawal method (UNPD- WCU, 2009).

According to a report done by K4Health (2013) which was done in Jordan by USAID on male involvement on family planning and reproductive Health programme, found that a good number of men were more informed about different contraceptive methods and were more likely to include their wives in decision making concerning contraceptive use. In addition, it was also reported that apart from men using the male contraceptive methods, they should also be included in contraception discussions and counselling, so that they could encourage or facilitate women's contraceptive choice (K4Health, 2013). Moreover, involving men in contraceptive discussions and counselling removes a barrier to women's contraceptive use, in turn, this empowers women and girls in all aspects of their lives. It is said that "in many parts of the world gender equality was still in the beginning phase and using men as allies in the struggle for gender equality advances progress and increase the likelihood of success for women's rights and empowerment" (K4Health, 2013). The report stated that the United Nations population Fund (UNFPA) has programmes which encourage male involvement in family planning and joint decision making with the partners on contraceptive choices. Many men do not consider themselves in need of contraception because most prescription contraceptives are designed for use by women (K4Health, 2013). Darney (2012) said in his research entitled "California women's perception about their male partner's involvement in contraceptive decision making and use, 2008 - 2010" that when there is men shared responsibility in contraceptive decision making and use, it has advantages beyond receiving direct services. He found out that when men make decisions about contraceptive methods with their partners, it increases the use of other contraceptives such as condoms. Thus, involving men in contraception use may lead to effective and consistent use of contraception which may result into the prevention of unintended pregnancies (Darney, 2012). As much as women have a critical role in their own reproductive health, involving men in contraceptive use can facilitate the effective use of contraception (Darney, 2012).

Talking about male involvement in contraception will not be complete without mentioning contraceptive methods even those used by females to prevent pregnancy. Therefore, the writers of this paper thought it wise to include various types of contraceptives, in order for the

readers to have an insight on how different methods work, their effectiveness and their precautions. Out of the contraceptive methods mentioned below, men are only able to use male condoms, vasectomy, withdrawal method and periodic abstinence. We will now shortly go through the contraceptive methods that we asked the respondents.

2.2.2 CONTRACEPTION METHODS

Combined Oral Contraception or the Pill

The pill contains two hormones that is progestogen and oestrogen. It works by preventing ovulation and is said to be more than 99% effective if used correctly and consistently. It is also believed to reduce the risk of endometrial and ovarian cancer and it should not be used by breastfeeding mothers because it reduces production of breast milk (WHO, 2015).

Progestogen only Pills or the Mini Pill

The mini pill contains only one hormone which is progestogen and works by thickening cervical mucus, which blocks the sperm from fertilizing an ovum. It is also believed to suppress ovulation. It is said to be 99% effective when used correctly and consistently when taken at the same time each day and can be used by breastfeeding mothers, because it does not contain oestrogen hormone which suppresses the production of breast milk (WHO, 2015).

Progestogen only Injectable

These contain progestogen hormone only and has the same mechanism of action as the mini pill. It is said to be more than 99% effective if used correctly and consistently. The progestogen only injectable are given intramuscularly every 2 to 3 months depending on the product and may delay return to fertility for about 1 to 4 months and there is normally a common side effect of irregular vaginal bleeding (WHO, 2015).

Intrauterine Device (IUD): Copper T

These are small and flexible device made of plastic with copper sleeves or wire, which are inserted into the uterus to prevent fertilization from taking place and the copper works by damaging the sperms. It is said to be more than 99% effective and can also be used as emergency contraceptive. Its side effects are believed to be longer and heavier menstrual periods during the first months of use (WHO, 2015).

Intrauterine Device (IUD) Levonorgestrel

It is a T-shaped device made of plastic which is inserted in the uterus, which steadily release small amounts of levonorgestrel each day. It is believed to work by suppressing the growth of endometrium and it is said to be more than 99% effective. The advantage is that it tends to reduce the menstrual cramps as well as symptoms of endometriosis. Some women may experience some side effects like amenorrhea (WHO, 2015)

Male Condoms

These are sheath or coverings that are placed on erected penis of a man and acts as a barrier to prevent sperm from meeting an egg and it is believed to be 98% effective in preventing pregnancy when used correctly and consistently, and the advantages are that it protects against sexually transmitted infections including HIV (WHO, 2015).

Female Condoms

These are sheath made of thin transparent soft plastic film, which are loosely inserted in woman's vagina and act as barriers to prevent sperm from meeting an ovum. It is said to be 99% effective when used correctly and consistently. The advantages are that it protects against sexually transmitted infections including HIV (WHO, 2015)

Male Sterilization (Vasectomy)

It is a permanent method of contraception where the vas deferens (tubes that carry sperms from the testicles to the ejaculatory duct) is cut or blocked. It works by keeping sperms out of the ejaculated semen, and is more than 99% effective after three months semen evaluation (WHO, 2015). The advantages of vasectomy are that it does not affect sexual performance (WHO, 2015), no hormones are used, it is permanent, the procedure is quick with few risks, and can be performed as an outpatient procedure in a clinic or doctor's office (Samra, 2014). However, the disadvantages are that, it may take three months to be effective as stored sperms may still be present (WHO, 2015), men may regret the decision later in life, and it does not prevent a man from getting sexually transmitted infections (Samra, 2014).

Female Sterilization (Tubal Ligation)

It is a permanent method of contraception where fallopian tube are cut or blocked to prevent ovum from meeting a sperm. It is said to be more than 99% effective (WHO, 2015). The advantages of tubal ligation are that it does not involve hormones, there are no changes in

sexual desires, menstrual cycle or breastfeeding ability(Samra,2014).However, it has some disadvantages because it involves general or regional anaesthesia, does not protect a woman from getting sexually transmitted infections and some women may regret the decision later in life which may be due to young age and unpredictable life events such as change in marital status, death of a child and pressure from spouse and relatives(Samra,2014).

Withdrawal method (coitus interruptus)

This is the method in which a man withdraws his penis from the partners' vagina and ejaculates outside to keep semen away from external genitalia. It is said to be 96% effective when used consistently and correctly, although it may require discipline and proper timing of withdrawal which may often be difficult to determine (WHO, 2015).

Fertility awareness methods (natural family planning/periodic abstinence)

These are calendar based methods which are done by monitoring fertile day in a menstrual cycle, they also use symptom based methods which are monitoring of cervical mucus and body temperature. In this method, the couple may prevent pregnancy by avoiding unprotected vaginal sex when a woman is in her fertile day, usually by using condoms or abstaining from sex and is said to be 95-97% effective when used correctly and consistently although it may require partner cooperation (WHO, 2015).

Since the project is talking about male involvement in contraceptive use, the writers found it significant to talk about gender and gender equality which follows below.

2.2.3 GENDER

Gender concerns the psychological, social and cultural differences between males and females. It is linked to “socially constructed notions of masculinity and femininity, and it is not necessarily a direct product of an individual’s biological sex” (Giddens, 2001, p.107). The distinction between sex and gender is an important one, since many differences between males and female are not biological in origin. Sometimes people may find it difficult to distinguish gender from sex. Sex refers to the biological and physiological characteristics that define men and women (WHO, 2015). “Sociologists use the term sex to refer to the anatomical and physiological differences that define male and female bodies” (Giddens, 2001, p.107).

According to Giddens (2001), we all do gender ourselves in our daily social interactions and all aspects of our existence are gendered. Gender is a pattern in our social arrangement and in everyday activities or practices which those arrangement govern (Belmonte 2012). Gender differences are culturally produced and not biologically determined, hence, gender inequalities are reviewed because men and women are socialised into different roles (Giddens, 2001).

Gender equality

Gender is said to interact with social factors and biological differences. The roles that women and men play are different and valued differently in different social contexts, and usually those associated with men are valued more highly. This therefore, is believed to affect the degree to which women and men have access to and control over, the resources and decision making needed to protect their health. “This results in inequitable patterns of health risks, use of health services and health outcomes. There are different factors that determine health and ill health for men and women. Mainstreaming gender in health is recognized as the most effective strategy to achieve gender equity. It is the strategy that promotes the integration of gender concerns in the formulation, monitoring and analysis of policies, programmes and projects, with the objective of ensuring that women and men achieve the highest health status” (WHO,2001, *online*).

According to the mission statement of the 1995 Beijing conference for women, “the platform for action emphasises that women share common concerns that can be addressed only by working together and in partnership with men towards the common goal of gender equality around the world. It respects and values the full diversity of women’s situations and conditions and recognises that some women face particular barriers to their empowerment” (UN, 1996, P.7).

Gender Equality in Norway

“Norway is considered to be one of the most gender equal countries in the world, although a number of challenges to gender equality remain and new gender issues keep surfacing” (Gender in Norway, 2006, *online*). The gender equality act in Norway was adopted in 1978 by Parliament and was put in place to promote gender equality and aims in particular at improving the position of women. It further stated that men and women shall be given opportunities in education, employment and cultural and professional advancements. The law

is based on principle of non-discrimination, which is the cornerstone and basis for promoting gender equality (Gender equality Act, 1978).

Gender equality policies have been more or less successfully integrated into many areas while others lag behind like families and relationships, welfare, work and the economy. The official Norwegian strategy to achieve equality between men and women include both gender mainstreaming and gender specific actions .In order to make these strategies work, it demands knowledge of gender perspectives as well as an intersectional approach, seeing how gender intersects with race, age as well as sexuality (Gender in Norway, 2006).

Gender perspective looks at the impact of gender on people's opportunities, social roles and interactions. A gender perspective recognizes potential gender differences of the nature of relationships between women and men and of their different social situations, life expectations and economic circumstances. The easiest way to discover a gender perspective is to look at numbers like how many women and men, girls and boys are included in a policy. Many gender specific actions are a result of gender imbalances in representation as shown by gender segregated statistics (Gender in Norway, 2006).

In Norway, a woman has a right to make decisions concerning her own body which is seen through the Abortion on Demand Act, easy access to contraception and the right to free health services during pregnancy and childbirth (Gender in Norway, 2014). This has been made possible because of human rights, the universal declaration of human rights stipulates that human rights apply to all people equally, "without distinction of any kind as race, sex, colour, language or any other status"(Gender in Norway, 2010, *online*). Norway ratified all international agreements on human rights and equal rights of women and men (Gender in Norway, 2010).

3.0 RESEARCH DESIGN AND METHODOLOGY

Research design is defined as a frame work for collecting and analysing data (Bryman, 2008). Qualitative research method was used for this study. A qualitative research is a method of inquiry which are used in many different academic disciplines, traditionally in social sciences and also in market research and further context (Denzin, et al. 2005). Qualitative researchers aim to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour (Denzin, et al. 2005). In this study, the writers want to find out how male students and male lecturers at a University College in the Western part of Norway, view male involvement in contraceptive use, because the writers come from Zambia were contraceptive use is seen by most men as a woman's issue.

This study was conducted from April 1 to May 14, 2015, at the University College in the western part of Norway. The questionnaire was used as an interview tool for collection of data. Six (6) respondents were purposively selected for the interview, because they were able to understand and speak English, as well as that, they were representative of different age groups and different professions.

All the respondents agreed to be interviewed and signed the consent form. They were told that they had the right to withdraw from the interview if they wished to. They were comfortable and interviewed in conducive and different environments. The researchers shared roles, one was interviewing while the other one was taking notes. Voice notes were also taken after getting permission from the respondents. Open ended questions were asked according to the interview schedule and the respondents gave their views freely. This made it easier to probe further on their responses. The interview took an average of 19 minutes for each respondent.

3.1 QUALITATIVE RESEARCH

Qualitative Research is defined as “a method of inquiry employed in many different disciplines, traditionally in the social sciences, but also in market research and further context” (Denzin, et al. 2005). Qualitative research aims at gathering the subjective meaning of issues from the perspective of participants. It also focuses on concealed meaning of a situation (Flick, 2011).

3.2 METHODS OF COLLECTING DATA

A semi structured interview was used in this study. A number of questions were formulated in advance, in order for the respondents to give their views on the subject. In other words, a questionnaire was used to collect data and information was based on responses from respondents.

3.3 POPULATION AND SAMPLE

Population is an entire set of individuals that have the same characteristics (Polit and Beck, 2010). The population in this study were male students and male lecturers at a University College, who provided information on how they viewed male involvement in contraceptive use.

SAMPLE

A sample is defined as a subset of a population selected for measurement, observation or questioning, to provide statistical information about the population (Boundles, 2015).

A purposeful convenient sample of six (6) people was included in the study. These included three (3) male students, two (2) male lecturers at the University College and one (1) Assistant Principal at a high.

3.4 DATA ANALYSIS PROCEDURES

Data was sequenced and coded based on the recorded responses. It was later recorded into themes and the results were finally analyzed under each theme.

3.5 ETHICAL CONSIDERATIONS

According to Creswell (2009), it is useful to consider the ethical issues that can be anticipated and described in the research proposal. The ethical issues are considered in all phases of research process (Creswell, 2009).

The letter requesting for permission was written to relevant authorities in order for the students to carry out the study. After giving clear information to the participants about the research, a written informed consent was obtained. Participants were informed that the research was voluntary and that they could discontinue from participating if they wished to. The anonymity of the participants was respected and the confidentiality maintained. The literature used in this study was cited correctly in order to give recognition to the authors.

3.6 PILOT STUDY

A pilot study is defined as a small version of the main study (Polit and Beck, 2010). This helps to test the instrument of data collection and see whether it is feasible and realistic. Furthermore, if any information would be missing in the pilot study, it could be added to the full scale study to improve the chances of a clear outcome. It also helps researchers to be able to remove irrelevant questions from the questionnaire.

A pilot study was done to test the interview schedule and four (4) male international students were purposefully picked for the study. It was found that some questions were very difficult to answer and hence, adjustments were made to the interview schedule. The questions were simplified and others were removed.

3.7 METHODOLOGICAL STRENGTHS AND WEAKNESSES

The writers of this project used qualitative research which had its strengths and weaknesses. The strengths were that the researchers were able to collect detailed information as they were able to probe further on the views of the respondents on the topic. The other strength was that when collecting data, the tool used (questionnaire), helped the researchers to collect in-depth information as it had open ended questions making respondents to express themselves fully. The other strength was that the respondents allowed the researchers to get voice notes as well, which made it possible to listen to the interview through and through when analysing data. Moreover, the respondents were able to understand and responded well in English, which made communication easier.

However, the main weakness was that only a few students and lectures were interviewed which will not represent the true picture about the views of men on male involvement in contraceptive use at the university college in the western part of Norway.

4.0 DATA ANALYSIS AND PRESENTATION OF RESULTS

4.1 Data analysis

Data analysis in qualitative research is the process to interpret and structure the meaning of data and this involves inductive reasoning processes. The inductive reasoning uses the data to generate ideas (EBN notebook, 2000). The qualitative content analysis involves breaking down data into smaller units, coding and naming the units according to the represented content, and grouping coded material based on common concepts (Polit and Beck, 2012).

The researchers did the analysis of data together and discussed the information given in this document, the respondents were interviewed separately on different days and in different conducive environments. Six (6) male respondents were interviewed. Three (3) of the respondents were male students and three (3) male lecturers. The age range of the respondents was from 21 years to 63 years. Of the three (3) male students, two (2) were single and one (1) was living together with the girlfriend. All the lecturers were married. The respondents were from different fields of study and professions namely economics, landscape architecture, real estate broker, clinical psychology, sports, and a high school administrator.

In this study an interview schedule was used to collect data in which the notes were taken in the field. When analysing data the voice notes were compared to the written notes several times to ensure accurate interpretation of data. Later, data was divided into meaning units that were condensed. The condensed meaning units were then coded and coloured. Thereafter, the coded data was compared based on differences and similarities and sorted in various categories which contained the main content. The data was later interpreted into meaning which was categorised into themes in order to explain the relationship and to answer our objectives.

The following themes were identified during the analysis which are Knowledge about contraceptives, male involvement in contraceptive use and gender equality and these themes are discussed in the presentation of results.

4.2 PRESENTATION OF RESULTS

Knowledge about contraceptives

When the respondents were asked about various methods of contraceptives they know, all were able to mention the condom, pill, and sterilization.

One of the elderly respondents said that the contraceptive methods he knew were “*condom, and also can take surgery, that’s quite common among my friends, then we have several for*

women like spiral, and something like a spiral but It's different, female condom, pills which I think most young women prefer and also women can take surgery", while one of the young respondents said "condom, pills, condom for girls, also something in the pipeline on development is pill for men and surgery".

When asked how the condom works, one of the elderly respondents said "it Prevents seed to float freely, taken on before intercourse, and for the second intercourse after ejaculation, one should change and have a new condom. Be sure the condom is not perforated and expired". The other respondent said, "They stop the semen from entering the reproductive area of a woman". When asked the same question, the response from one of the young respondents was, "the condom captures the semen so that nothing comes into the woman", while the other one said, "The condom is safe, it also prevents both of them to not get sexual diseases".

The respondents were further asked what they knew about the pill, one of the respondents said "I think the pill is the most the used contraceptive in Norway, women take it and it's something about the hormones, it prohibits fertilization and there some risk factors maybe, but as I know it, there is not so many problems like thirty years ago", while the other one said that the pill is "problematic for some women because it's for the hormones, they might have some issues with the use p.pill but again some women think it's okay to use the pill to control not only the menopause but also the period to control the blood flow. Then again it might cause some symptoms and might cause long term problems for some women. So we should really discuss and take up the pros and cons".

When asked what they knew about the injectable contraceptives, three (3) of the respondents had some knowledge on the injections used for contraception while three (3) had no knowledge at all on the same. The ones who had an idea said;

"I know a little about that, it probably lasts for a long period of time and you don't have to take a jab everyday". While the other one said; "yes I know about the injection but I have no experience and knowledge about it, but I suppose it works in the same way as the pill".

Furthermore, when asked about the intra uterine device/spiral, four (4) of the respondents explained how it works, while 2 had no knowledge about it. One respondent said;

"I have very little knowledge, but it is something that is put inside the part of the vagina so that the seed could not enter in to the uterus". The other respondent said; "women put it in the vagina, it stops egg from getting fertilized".

The respondents were further asked to mention the contraceptive methods available for men and all of them knew the male condom and sterilization, two (2) talked about the withdrawal method. One of the respondents said that the male methods he knew were "Condoms,

Surgery, and withhold penetration, or have sex without penetration or sex without ejaculation”, and the other respondent said, *“Condoms and sterilization”*. Three (3) of the respondents also talked about the male contraceptive pill which is still under study. One of the respondents said the contraceptives he knows for men are, *“Condoms and I have heard of the pill for men to inhibit ejaculation”*.

When asked about how men get the knowledge about contraceptives in Norway, everyone said it is normally talked about in schools through the school health system, where nurses go to conduct health talks on the topic. In addition, three (3) of the respondents said that the knowledge is gotten from talking with friends and two (2) of them talked about getting the knowledge through talks with parents, and the other one talked about getting it from the sex center. One mentioned about getting knowledge through people who talk about it, sexual partners, reading about it on the internet and media talks when new methods are available. One of the respondents said;

Men get the Knowledge *“in school (late primary school) and as parents we do talk about it”*.

When they were further asked about the age at which they felt a man or woman could start using contraceptives, everyone said they should start using contraceptives when they are sexually active. One respondent said;

“As soon as they are sexually active, because age varies from person to person”, while the other one said that *“The first time you have sex, start with a condom and when you have a permanent partner you can start using the pill”*.

Male involvement in contraceptive use

When asked about what they thought about involving men in contraceptive use, three (3) of the respondents said it was a responsibility for both men and women, and men should take part and prevent pregnancy so that no one takes a blame. One of the respondents said that male involvement *“is very important and that’s why it is part of the school curriculum”*. The other one said it was a good, natural and normal thing to do. There should be communication between partners before they can have sex and that it is easy for a man to use a condom because it is easily accessible. The other one stressed the fact that when a man gets involved by using a condom, he does not only prevent impregnation but also prevents contraction and spread of sexually transmitted infections. He said male involvement *“is a good thing because pill doesn’t protect someone against diseases, but the condom prevents pregnancy and sexually transmitted diseases”*. Moreover, when they were asked about what role men can play in the usage of contraceptives, one respondent said it was a common responsibility of

men as women do, to prevent unwanted pregnancies and that men should break the cultural that makes them think it is not their responsibility. The other respondent said;

“I wouldn’t want to be a father right now, so I would ask the girl if she is on contraceptives and if she says no, I have to use a condom but it is important to discuss with your partner about contraceptives”. Furthermore, the other one said a man should take initiative and ask a woman if she was on any form of contraceptives. On the other hand, the other one mentioned about being supportive to the partner and being open about using contraceptives, and men can be supportive by talking about what kind of contraceptives is better for the two of them. He further said that, the man can have the responsibility not to make anyone pregnant by using contraceptives because he is also part of the act. The other one said the man can use the condom and if the partner is on pill he could make sure she takes the pill. So, when they were further asked if they should recommend a male contraceptive method, which one it should be and why five (5) of them said they would recommend condoms, because they are easily accessible, cheap, and easy to use and prevent pregnancy and sexually transmitted infections. The sixth one said it *“depends on the situation, myself it would be probably surgery, but condom is an alternative because I don’t want children anymore with anyone, but I should have given you a different answer twenty (20) to thirty (30) years ago”*.

Gender Equality on Contraceptive Use

When asked whether gender equality in Norway extends to usage of contraceptives, all the respondents said it does not, because women take more responsibility in the prevention of pregnancy, as they are the ones who become pregnant or undergo abortion and that sex with a condom does not provide contact satisfaction. One of the respondents said *“I know many men do not like the condom, because in a way you have to stop, do something and put it on and so some men think there is reduced sexual contact and less natural in a way”* and he further said that *“consequences of having children is more serious for women than men, because they have to either take an abortion or carry the child and this may interfere with work and education, so I still think that women more often than men think they have to take more responsibility, and so I don’t believe there is complete equality”*. Another respondent said that one of the factors that might show that there is no gender equality is that, women buy their own contraceptives even when escorted by their partners and that the male condom is three (3) times more expensive than a pill for women. The respondents were further asked what their view was on who should make a choice for contraception in a relationship and everyone said both partners should make a decision together on which method to use and who should

be on contraception. One of the respondents said, *“I think it should be a shared decision between a man and woman, but I know that men mostly prefer that women use the pill or something that makes it unnecessary to use the condom, but I also know that some women for different reasons don’t want to use the pill, there can be some side effects and other reasons not to use it and of course you have to make the choice together”*.

5.0 DISCUSSION, «CONCLUSION», RECOMMENDATIONS

5.1 DISCUSSION OF FINDINGS

Knowledge about contraceptives

For men to be involved in contraceptive use, it may be important to have more knowledge about the contraceptive. According to our findings, the respondents said that, most men get most of their knowledge about contraceptives from school, through the school health programme, media, discussions with friends and partners as well as from parents. This is important because, according to the article by Outlook 1997 entitled Involving men in reproductive health, stated that the programmes of action of both the 1994 international conference on population and development in Cairo and the fourth world conference on women in Beijing, highlighted the need to develop more programmes that reach men with reproductive health information and services. Furthermore, one of the respondents said that men should stop the culture of thinking that contraceptives use is a responsibility for women, and according to Greene et al (2004) men usually enforce cultural practices which are detrimental to the women's reproductive health. When men have got knowledge about contraceptives, it would be easy for them to use methods that requires their direct participation like condom use, withdrawal, periodic abstinence and vasectomy (Outlook, 1997).

Even though all the respondents were knowledgeable about the condom use, most of them said that most men do not like using condoms because there is no direct contact with women, and that it causes some disturbances like stoppages during sexual act, although it prevents sexually transmitted infections. According to a Health Belief Model, when someone has knowledge about impregnation, that is a perceived threat to them, so they will be influenced to use for instance, condoms which can prevent unwanted pregnancies. And this can eventually make someone to see the benefits of using a condom.

Male involvement in contraceptive use

Male involvement in contraceptive use is very important (Toure, 1996). It means more than increasing the number of men using the male methods of contraception like condoms, withdrawal, periodic abstinence and vasectomy. This also includes encouraging and supporting women and peers to use contraception as well as influencing policies to develop male related programmes (Toure, 1996). This research reviewed that men may get involved by using condoms and vasectomy for those that do not want to have children any more. In addition, they may get involved by reminding their partners to take the pill when they need to,

and escorting their partners to access contraceptives, although most men may feel shy to escort their partners. Moreover, despite the differences in age, all the respondents said that since the act is done by two people both partners should take equal responsibility of contraceptive use. To support this statement, the 1994 United Nations International Conference on population and development stressed that “male responsibility and participation” in sexual and reproductive health is of paramount importance and it should not be overlooked (Greene et al, 2004). According to the Health Belief Model, an individual’s perception towards contraception can be influenced by his personality, which will eventually make them see the benefits of a method and have a behavioural change. In addition, personality and knowledge can influence the individual’s perception and if the perceived threat outweighs the perceived benefit then change of behaviour may not take place.

Gender Equality

This research reviewed that there may not be complete gender equality in contraceptive use. This is fulfilled by responses from respondents that, more women use contraceptives than men, because sex is not enjoyable with a condom. They added that a man probably uses a male method when the woman has problems with the pill, as most of them prefer taking pills. This is also supported in the statement which says that most people believe that male methods of contraception are less widely used because they are viewed as unacceptable to men. The health Belief Model illustrates that sex and age would influence the contraceptive method a man can choose, for instance a young man who still wants children would use condoms while an elderly man may choose male sterilization because he is satisfied with the number of children he has. This is fulfilled when respondents said both man and woman can start taking contraceptives as soon as they are sexually active.

5.2 «CONCLUSION»

The purpose of the study was to explore the views of male students and male lecturers at the University College in the western part of Norway on male involvement in contraceptive use. Men influence decision making in all sectors of life. Therefore, male involvement in contraceptive use cannot be over emphasized, the main way to involve them maybe to increase their knowledge about contraceptives, by having programmes that directly need their participation, through the media and when they go to family planning clinic they should be given information material about contraceptives and health talks together with the partners. This may also be done by using contraceptive methods that require their direct involvement like condom use, withdrawal, periodic abstinence and vasectomy. From our findings it was

clear to note that the respondents thought that, women may carry most of the responsibility where contraceptive use is concerned as illustrated by one of the respondents, that may be because, its women that carry the pregnancy and they are the ones that undergo abortion procedure. In addition, most men may not be willing to use condoms because they say sex is good without a condom. This should not be the case as it should be the responsibility of both partners.

Despite all the findings, it is difficulty to make a concrete conclusion from our findings because only six (6) respondents were interviewed which may not be the true picture of the views of all male students and male lecturers on male involvement in contraceptive use at the University College. However, the writers were able to get answers according to the statement of the problem.

5.3 RECOMMENDATION

Men should be encouraged to be fully involved in contraceptive use as this also promotes gender equality in reproductive health.

5.4 CHALLENGES

The writers of this project had two challenges and the first one was that, the first title of the project which was a study to understand whether gender has a role to play for couples or partners in Norway in who chooses “Vasectomy” or “Tubal Ligation” as permanent family planning method. The project was worked on from January to March, 2015, but was later dropped because the writers were advised that it would be difficulty to get information as this was too sensitive and that people might not open up. The writers were further advised to keep the same topic and open it up a bit to include family planning methods in general but this turned out to be difficult because all the contents of the document were changing. The other challenge was that, it was difficult to find literature for previous researches done in Norway on Male involvement in contraceptive use.

6.0 FUTURE RESEARCH

This study concentrated on the views of male students and male lecturers on male involvement on contraceptive use. The future research, we think it would be interesting to look at Male Involvement in Contraceptive use in Norway on a wider scale. This could be their actual involvement in contraceptive use instead of just getting their views.

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8.0 APPENDICES

8.1 PERMISSION LETTER-MAIN STUDY

GLOBAL KNOWLEDGE NURSING STUDENTS (2014-2015)

Appendix 2: Permission Letter – Main study

Høgskulen i Sogn og Fjordane

6856, Sogndal

Norway.

11th April, 2015.

The Dean of Students

Sogn og Fjordane University college

6856, Sogndal

Norway.

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

We are nurses from Zambia on exchange programme studying global knowledge at Sogn og Fjordane university college. As part of our examination in global knowledge, we are required to carry out a research project. Our topic is “To explore views of male students and lecturers on male involvement in contraceptive use” in Norway. We therefore, write to request your office for permission to interview three (3) male students and three (3) male lecturers at your institution starting from 15th to 23rd April, 2015.

If you need further details and clarification, you can contact our project supervisor Birgit Weel Skram, at the Faculty of Health Studies on telephone number 90891210, email Birgit.Skram@staminagroup.no.

Find attached the copy of our interview schedule.

Your consideration in this regard will be highly appreciated.

Yours faithfully,

Appronia Nalishebo Sitali (RN/ RM) and Myers Libingi (RN/ ROTN) GLOBAL
KNOWLEDGE NURSING STUDENTS (2014- 2015)

8.2 CONSENT FORM

We are two (2) Nurses from Zambia doing Global Knowledge at Sogn og Fjordane University college, Faculty of Teacher Education. As part of our examination in Global Knowledge we are required to undertake a research study and our topic is: **“Exploring views of Male students and male lecturers on Male involvement in contraceptive use”**. In this study, Contraception means ways to prevent pregnancy and male involvement means male participation in contraceptive use.

CONSENT FORM

I understand that my participation in this study is entirely voluntary, and I may withdraw from the study at any time I wish. I understand that my participation in this study will not benefit me in terms of financial and material gains, and that all information provided will be kept confidential. However, this information may be used in presentations in nursing and gender issues. The study has been explained to me. I have read and understood this consent form and all questions have been clarified. I therefore, agree to participate.

.....
Signature of participant Date

.....
Signature 1 (Appronia Sitali) Date

.....
Signature 2 (Myers Libingi) Date

8.3 INTERVIEW SCHEDULE

SOGN OG FJORDANE UNIVERSITY COLLEGE

FACULTY OF TEACHER EDUCATION AND SPORT

GLOBAL KNOWLEDGE

INTERVIEW SCHEDULE

TOPIC: A STUDY TO EXPLORE VIEWS OF MALE STUDENTS AND MALE LECTURERS ON MALE INVOLVEMENT IN CONTRACEPTIVE USE.

Serial Number:

Date:

SECTION A: DEMOGRAPHIC DATA

Student / Lecturer.....
Age.....
Profession.....
Marital status:

SECTION B: REPRODUCTIVE HEALTH

What contraceptive methods do you know?

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What do you know about the following contraceptive methods?

Condom.....
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Pill.....
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Injections.....
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Spiral/Intra Uterine Device (IUD)
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Sterilization.....
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What contraceptive methods are available for use by men?
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How do men get the knowledge about contraceptive use?
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What do you think about involving men in contraceptive use?

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What role can men play in the usage of contraceptives?

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If you should recommend contraception, which male contraceptive method would it be and why?

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In your view, at what age should a man or a woman start using contraceptives?

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SECTION C: GENDER

In your own view, does gender equality extend in contraceptive use and how?

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Who do you think should make a choice for contraception in a relationship and why?

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