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What About Methods for Men? A Qualitative Analysis of Attitudes Toward Male Contraception in Burkina Faso and Uganda

CONTEXT: *Male contraceptive options are limited; however, product development efforts tend to focus on female methods. Research on attitudes toward methods for men—particularly in regions of low contraceptive prevalence, such as Sub-Saharan Africa—could inform the development of new male methods.*

METHODS: *Qualitative data were taken from focus group discussions with 80 men aged 23–67 and 398 women aged 15–50 conducted in Burkina Faso and Uganda in 2016. Transcripts were analyzed thematically to explore support among men and women for male contraceptive methods, and to extract suggestions about ideal method characteristics.*

RESULTS: *Male and female participants in both countries expressed support for new male contraceptive options; more positive attitudes were expressed in Uganda than in Burkina Faso. Participants of both sexes recognized that male methods could reduce the family planning burden on women and offer men greater control over their fertility; however, some had concerns about side effects and thought that men would not use contraceptives. Relationship characteristics, such as polygamous unions, were cited as possible challenges. In both countries, various delivery methods (e.g., creams or jellies, injections and implants) and durations (from short-acting to permanent) were proposed.*

CONCLUSIONS: *The acceptability of new male methods among most participants in the two countries indicates a potential demand for male contraceptives. Options should include a variety of method characteristics to maximize choice, engage men, and support men and women's contraceptive needs.*
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Male-directed contraceptive methods are currently limited to condoms, vasectomy and withdrawal;[1] in addition, such fertility awareness-based methods as rhythm and the Standard Days Method require male participation. While male-directed methods and methods requiring male participation account for 31% of contraceptive prevalence among married or in-union women worldwide (21% for male condoms, 5% for withdrawal, 3% for rhythm and 2% for vasectomy), their use varies substantially by region and method.[2] For example, a high prevalence of vasectomy is found in Bhutan (19% of reproductive-age women using contraception), South Korea (17%), the United Kingdom (15%) and, Australia (13%);[2] however, the method accounts for less than 0.1% of contraceptive use in Sub-Saharan Africa.[2]

Across all regions, condom use is more prevalent than rhythm, withdrawal or vasectomy, except in North Africa, where rhythm is more common, and in the Middle East and Southeast Asia, where withdrawal is more prevalent.[2,3] Lower rates of male method use are generally found in areas with higher unmet need for contraception overall.[4] In addition, certain male methods tend to be more acceptable to and used more frequently by specific groups: Condoms are more commonly used by young, unmarried people, while fertility awareness-based methods and vasectomy are more likely to be used by older people and married couples;[2,5–8] before using vasectomy, couples have likely decided to end childbearing. While a few pilot studies have noted an increase in couples' communication and male involvement in family planning with the introduction and use of the Standard Days Method,[9] fertility awareness-based methods may not appeal to men and couples because of their lower effectiveness compared with other methods.[10] Other barriers to the use of these methods include men's and women's perceptions that condoms reduce sexual pleasure or indicate infidelity, and men's concerns that vasectomy will affect them physiologically or signify to others that they have lost their "masculinity."[1,8,11]

Investment in the development of new contraceptive methods has largely been focused on female rather than male methods. Yet data from surveys of potential new method users across such diverse country settings as Brazil, Indonesia, Mexico, Spain and the United Kingdom–as well as assessments of acceptability conducted in clinical trials of novel products in China,

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Italy and the United States—indicate that both men and women would accept or even welcome new male methods of contraception.[1,12,13] In addition, increasing the variety of method choice has been shown to increase method use overall.[14] A recent modeling study found that a male contraceptive pill or reversible method to block sperm transmission through the vas deferens could reduce unintended pregnancy by up to 5% in the United States and South Africa, and up to 38% in Nigeria.[15]

Few studies, however, have examined the product characteristics that would facilitate or hinder male contraceptive use. Furthermore, most studies that have assessed potential interest in male contraception have been conducted in more developed countries.[1,12,13,16] One of the few studies conducted in Sub-Saharan Africa found that while 71% of men surveyed in Mozambique would be willing to use a contraceptive pill, acceptability was largely predicated on the condition that use would not cause any side effects.[17] Similarly, among men participating in a Nigerian survey, the majority (69%) stated that they would be interested in new reversible male contraceptives; most of those who were not interested cited fear of side effects as their reason.[18]

This article presents a secondary analysis of qualitative data from a larger study conducted in 2016 of user preferences for new contraceptive methods in Burkina Faso and Uganda. These countries were chosen for their geographic locations—in Western and Eastern Africa, respectively—and because the original research team included an additional module of questions on new contraceptive method acceptability in the Performance Monitoring and Accountability 2020 country surveys.[19,20] Qualitative research was conducted in the same two countries. The larger research was focused on collecting attitudes on specific contraceptive method attributes; reactions to six new contraceptive methods in development; and reasons for method preference among women, men, and family planning providers and program staff.[19,20] Married women in both Burkina Faso and Uganda had rates of modern contraceptive use close to the average rates in Western and Eastern Africa at the time of the original study (25% and 32%, respectively);[21,22] some 3% used male condoms in Burkina Faso and 6% used them in Uganda. In this article, we analyzed the data gathered through focus groups to explore support among men and women for male-directed contraceptive methods, to identify potential facilitators and barriers to using new male methods, and to gain insight into desirable characteristics of these methods.

METHODS

Data

We used cross-sectional, qualitative data from focus group discussions (FGDs) conducted with women and men between February and December 2016 in Burkina Faso and Uganda. The methodology for this study has been described in detail elsewhere.[19,20] To be eligible to participate, women had to be aged 15–17 and married or aged 18–49, while men had to be 18 or older. One woman aged 50 participated in the study; no man younger than 23 did so. Participants were recruited by health care workers (providers at health centers in Burkina Faso and village health teams in Uganda); however, men in Burkina Faso were primarily identified by their female partners who were participants, and some men in both countries were identified through snowball sampling through other male participants. Informed written consent (or assent if participants were younger than 18) was given by all participants. Parental consent was obtained for nonmarried minors in Uganda, but not required for those who were married. Participants received refreshments during the focus groups, as well as soap in Burkina Faso and the equivalent of USD$5.40 in Uganda.

In total, 60 FGDs were conducted with 478 participants. In Burkina Faso, there were 20 discussions with a total of 160 women; separate groups were formed for users and nonusers of modern contraceptive methods. In Uganda, there were 30 FGDs with 238 women; separate groups were formed for users of the implant or IUD, users of other modern methods and nonusers. In addition, in each country, five FGDs were held with a total of 40 men, not all of whom were contraceptive users. There were more female than male participants to meet the original study objectives.

FGDs were conducted in private inside rooms within the communities, or less often, in quiet and private outside locations. On average, women's FGDs lasted 118 minutes and the men's 89 minutes. Master's-level, trained research assistants who were native speakers conducted the FGDs in five local languages in Burkina Faso and four in Uganda. The FGD participants were taken through pretested topic guides of questions, which included perspectives on long-active reversible contraceptive methods, the advantages and disadvantages of six new methods described, and preferences regarding the development of new methods. The discussions were audio recorded, transcribed into French (Burkina Faso) or English (Uganda), and then coded using a codebook developed for the original study objectives.

The study received ethical approval from the FHI 360 Protection of Human Subjects Committee in the United States, the Comité d'Ethique pour la Recherche en Santé in Burkina Faso, and the Makerere University's School of Public Health Higher Degrees, Research and Ethics Committee and the Uganda National Council for Science and Technology in Uganda.

Analysis

For our analysis, we focused on two areas of discussion. The first included a series of questions designed to assess attitudes toward male contraceptive methods and reasons participants liked or did not like the idea of male contraception, as well as whether

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TABLE 1. Selected characteristics of focus group discussion participants, by gender, Burkina Faso and Uganda, 2016

Characteristic	Burkina Faso		Uganda	
	Men (N=40)	Women (N=160)	Men (N=40)	Women (N=238)
Mean age (range)	39.3 (24–67)	29.2 (15–49)	37.7 (23–65)	31.2 (18–50)
Education				
None	50.0	77.5	2.5	16.8
Some primary	30.0	16.9	65.0	55.5
Some secondary	20.0	5.6	32.5	27.7
Marital status				
Single*	2.5	3.1	0.0	8.0
Married/in-union	97.5	96.9	100.0	92.0
Mean parity (range)†	4.9 (0–18)	3.8 (0–10)	4.5 (1–11)	4.2 (0–13)
Current method use				
None	32.5	50.6	12.5	34.5
Condom	10.0	0.6	20.0	0.0
Pill	7.5	7.5	7.5	6.3
Injectable	15.0	22.5	47.5	30.3
Implant	20.0	18.8	5.0	17.2
IUD	2.5	0.0	2.5	11.3
Other/unsure	12.5	0.0	5.0	0.4
Expressed any opinion on male contraception				
Yes	75.0	36.3	45.0	40.8
No	25.0	63.7	55.0	59.2

*Includes individuals who were never married, divorced, separated or widowed. †Parity data were missing for one Ugandan woman.

researchers should focus on developing new male or female methods. The second included an activity in which participants formed pairs and were asked to brainstorm their ideal contraceptive method. Participants were prompted to think about specific characteristics: whether their ideal method would be used by men, women or both; what form of delivery it would have; how often it would be taken or obtained from a provider; where it would be available; how long it would protect against pregnancy; and whether there would be any other important characteristics. Pairs reported their method back to the larger group, and moderators probed for the rationale behind their suggested method characteristics. Participants then discussed the methods presented and voted on their favorite method among those described in the larger group.

The second author reviewed previously coded qualitative transcripts and coding reports to generate a thematic matrix summarizing participants' reasons in favor of and arguments against male contraception. The first and second authors then separately reviewed the qualitative transcripts for Burkina Faso and Uganda, respectively, for the section related to attitudes toward male methods. Individual responses were coded as "supportive" of male methods if participants said that they felt positively about the idea of male contraceptives or if they believed that researchers should focus on developing new methods for men. Responses were coded as "unsupportive" if participants expressed negative attitudes toward male contraception in general. The detailed reasons participants gave for supporting or not supporting male contraception were counted and categorized according to their specific theme. While the first and second authors were reviewing and coding the responses, they met to discuss adding additional themes and collapsing others, until they agreed on the final list of themes. After each author completed coding, both met to identify the most commonly occurring themes and to identify how frequently the themes were cited by male and female participants in each country. The proportion of participants coded as supportive or unsupportive, and the frequency of themes mentioned, were used to summarize the respondents' overall attitudes.

Finally, the first and second authors used a summary table of all the methods generated through the ideal method ideation to determine what proportion of new methods suggested were male-directed, female-directed or intended for use by men and women. We summarized the specific characteristics of proposed male methods, including their delivery mechanisms and durations; we also extracted other important characteristics from the transcripts, such as potential side effects, accessibility and affordability. Individual responses to the proposed methods were drawn from the transcripts.

RESULTS

Participants' Characteristics

On average, male participants in Burkina Faso were 39 years old and had 4.9 children; female participants were 29 years old and had 3.8 children (Table 1). More than two-thirds of women and half of men in Burkina Faso had no education, and almost all were married or in-union. Fifty-one percent of women reported no current contraceptive use, while 23% relied on the injectable, 19% the implant, 8% the pill and about 1% condoms; among men, 33% reported no current method use, while 20% relied on the implant, 15% the injectable, 10% condoms, 8% the pill and 3% the IUD.

In Uganda, male participants were 38 years old and had 4.5 children, on average; female participants were 31 years old and had 4.2 children. The vast majority of both women and men in Uganda had at least some primary education (83% and 98%, respectively), and nearly all were married. Thirty-five percent of women reported no current contraceptive use, although this proportion was likely a result of the user targets for the FGDs in Uganda; 30% of women reported using the injectable, 17% the implant, 11% the IUD and 6% the pill. Only 13% of men reported not currently relying on a contraceptive method; nearly half (48%) relied on the injectable, 20% condoms, 8% the pill, 5% the implant and 3% the IUD.

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Support for Male Contraception

Not every participant answered the question about their attitudes regarding male contraception: In Burkina Faso, 75% of men and 36% of women expressed an opinion about male contraception, while in Uganda, the proportions were 45% and 41%, respectively (Table 1). Overall, among those who expressed an opinion, more than two-thirds of men and three-quarters of women were classified as being "supportive" of male methods (not shown). In Burkina Faso, 53% of men and 83% of women who expressed an opinion were deemed supportive. Support for male contraception was particularly strong in Uganda, where 95% of men and 77% of women who expressed an opinion were deemed supportive.

Most Ugandan participants who gave an opinion stated that researchers should focus on developing new contraceptive methods that can be used exclusively by men, or by both men and women. In Burkina Faso, more men and women said that research should focus on methods to be used by women, or by both men and women. Several men in both countries stated that new male methods should be developed—with the caveat that they be rigorously scientifically tested before introduction, and with the understanding that uptake and broad acceptance may take time. For example, one man in Burkina Faso said:

"If something is new, people can be reticent, because with the other methods too [e.g., female methods], people were wary a lot more at the beginning. It's with time that people have understood..."—*47-year-old married man with 16 children, wife currently using the implant, Burkina Faso*

Reasons Given for Support of New Male Methods

• *Share the burden and provide back-up.* In both countries, the primary argument made by both men and women in favor of increased male contraceptive options was to better support women to "rest" by sharing the responsibility or burden of preventing pregnancy. This included allowing women to take a break from contraceptive use—usually hormonal contraceptives—and any accompanying negative side effects, as well as supporting women to regain their health and strength by spacing births. As one man in Uganda said:

"If you look at the load of work women do compared to men, [it] is heavier so they need a break from family planning methods.... These methods for men will relieve our women of having to hassle with the side effects associated with family planning."—*27-year-old married man with one child, wife currently using the pill, Uganda*

A woman in Burkina Faso expressed a similar sentiment:

"I know that if the man uses the method, we too will have peace. This permits spacing births especially, and the children will all be healthy."—*26-year-old married woman with five children, currently using the injectable, Burkina Faso*

A subtheme cited by several women in both countries and a few men in Uganda was that male methods could serve as back-up options when women are unable to use a method because of medical reasons or side effects. As one woman in Uganda put it:

"Why I want the methods used by men to be made is because I started with the injection, and I could not continue with it because of side effects. Then I decided to use the implant. I also could not continue with it. Now I am using IUD. Now if it so happens, that it also does not treat me well, don't you see that I will have no other method to use?"—*25-year-old in-union woman with two children, currently using an IUD, Uganda*

A few women in both countries also indicated that having methods for both men and women could prevent births for extended periods of time and improve family life. A woman in Burkina Faso expressed it this way:

"If there is a method for men too, it will help us all. If men and women all use a method, they are sure not to have a child for a long time, this allows a good cohabitation." —*30-year-old married woman with six children, not currently practicing contraception, Burkina Faso*

• *Deter extramarital pregnancies.* Many participants said that effective and acceptable male methods would help deter extramarital pregnancies; this was the second most mentioned reason for supporting male methods in Uganda and a close third in Burkina Faso. Several men and women noted that children born from extramarital affairs often become the responsibility of the man's wife—or among young men, his mother. As one woman in Uganda explained:

"I think if men can also be on family planning, it would be okay. Sometimes you agree with him that you should stop producing more children...but later you realize that he is going behind your back producing kids out there from other women. So if he is on family planning...he will not bring to you children from out there."—*28-year-old in-union woman with two children, currently using the injectable, Uganda*

Several men in Burkina Faso suggested male methods would help deter female promiscuity: If a man used contraceptives, then his wife or partner would refrain from an extramarital affair out of fear of becoming pregnant and having to reveal the affair.

• *Lack of options and poor choices.* In Burkina Faso, almost equal numbers of men and women noted the lack of contraceptive options available to men, which were considered insufficient, unacceptable and, in the case of condoms, unreliable. One man in Burkina Faso reported that there is only "one" type of male contraceptive, suggesting that men may not know of additional methods beyond condoms. He also suggested that there is a systemic reproductive health bias in favor of women and that research has focused on female methods to the detriment of men. As he put it:

"All this is the fault of the government...because we care more about women than about us [men]. As for female contraception, there are several types of methods but for men there is only one.... I think if we could find a new method for [men], it would be good because frankly, I'm not fond of condoms."—*33-year-old married man with two children, wife currently using the injectable, Burkina Faso*

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Several women also mentioned the need for an expanded method mix for men. For example, one in Uganda said:

"Yes, methods for men are very few, they need to make more provisions for men. [With] the number of [female] methods available, no woman can fail to get one method that works for her, which is not the case for men...." *–30-year-old married woman with three children, currently using the implant, Uganda*

• ***Empower men and increase their acceptance of family planning.*** A related subtheme was the belief that increasing the number of male methods would empower men to make their own contraceptive choices. Several men and women in Burkina Faso felt that having increased options and agency would allow men to use contraceptives even if their fertility desires differed from their partner's desires. As one man in Burkina Faso put it:

"Our wives sometimes trap us because they may want a child while we don't, so if we had the opportunity, we would close our tap."*–39-year-old married man with five children, not currently practicing contraception, Burkina Faso*

In Uganda, however, this theme was exclusively mentioned by men. For example, one said:

"...if they put emphasis on women, then it means that the men are on holiday, and from experience in our community the women are very promiscuous so that means that as a man, if I don't want a child I just take my pill and protect myself without being worried whether she is using something or not."*–34-year-old married man with two children, not currently practicing contraception, Uganda*

Several women in Burkina Faso and one in Uganda said that expanding the range of male methods would encourage empathy among men for women's contraceptive use and increase their acceptance of family planning–including among men who refuse to let their own partners practice contraception. This would provide both men and couples with more contraceptive options and potentially increase overall support. As one woman in Burkina Faso said:

"Often, some men don't accept that their wife use methods, so if there are methods for men, and they can be sensitized as much as women, they will eventually have the same ideas. If only women are sensitized...the men won't be able to understand."*–33-year-old married woman with six children, not currently practicing contraception, Burkina Faso*

She added that increased male contraceptive use could be used to "teach children, if the boy and the girl grow up with this teaching, they will understand."

Reasons for Not Supporting Male Contraception

• ***Men will not accept new methods and existing methods are sufficient.*** The strongest concern voiced by many women in both countries was that men would simply not accept new male methods; these women noted that many men already refuse to use the methods available to them or fear reactions such as ridicule from other men for using contraceptives. As one woman in Uganda said:

"...men are hard to convince if they are not the one who have decided on their own.... You tell him [I] am tired of the implant when I remove it, you also use a condom for a year, it is very hard unless if he is the one who has decided himself."*–30-year-old married woman with three children, currently using the implant, Uganda*

Many women in Burkina Faso and one in Uganda noted that the men would not use contraceptives, in part because they do not bear the burden of pregnancy and child-rearing. One woman in Burkina Faso put it this way:

"Even if you bring out a method for men today, you must know that they will not accept taking it. In any case, they are not the ones who suffer. Once they have finished [having sex] and [having] fun, the rest is no longer their problem. The rest of the suffering is up to the woman..." *–39-year-old married woman with four children, currently using the implant, Burkina Faso*

A few men in Burkina Faso said they were less interested in new methods because they perceive contraception to be a woman's responsibility and believe that condoms are sufficient for when they want to prevent pregnancy or protect themselves from STIs. As one man in Burkina Faso said:

"The condom is enough for men right now, where it constitutes double protection against illness and undesired pregnancies, so that's good.... With the condom, we have already resolved the problem for men, so it's not worth finding other things."*–51-year-old married man with four children, unsure of current partner's contraceptive use, Burkina Faso*

• ***Negative impact on sexual desire, performance or fertility.*** The top concern among men in both countries–as well as among many women in Uganda–was the possibility of side effects. Participants repeatedly mentioned the negative impact of male contraceptives on sexual desire and performance, loss of libido, delayed return of fertility or possible infertility. As one man in Uganda put it:

"I repeat: It should not contain an ingredient that denies me or drains us of our sexual prowess. It should not give me headache, dizziness, fever or any other side effect that can deny me the strength to do my work...."*–Man, full demographic information not recorded, Uganda*

• ***Female methods are the norm, and women wish to retain control over family planning.*** Some women in Burkina Faso argued that only men who already support family planning would be receptive to new male methods; therefore, the introduction of new male methods would do little to increase acceptance on a broad scale. For example, one woman in Burkina Faso said:

"A man who knows that it's not good for his wife to get pregnant before the child is big enough will accept this method. But those that don't seek to understand the wife will refuse and will want her to get pregnant as soon as she can...men around here will not accept using that."*–33-year-old married woman with five children, not currently practicing contraception, Burkina Faso*

A second argument made by a smaller number of men and women in Burkina Faso was that both men and women are accustomed to women being responsible for family planning, contraceptive use and, in some cases,

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experiencing side effects, thus diminishing the need to explore more options for men. As one 49-year-old married man in Burkina Faso with seven children, who was not currently practicing contraception, explained: "If we want women to use family planning...it's their affair, they're used to it."

In both countries, several women said that men would lie about their contraceptive use, which could lead to unintended pregnancies:

"He will flatter you, saying he's using a method, while really he's not using anything, that can lead to problems. He can even make you pregnant and say it wasn't him." *–26-year-old married woman with three children, not currently practicing contraception, Burkina Faso*

As a result, some women reported wanting to maintain control of family planning, whether they disclosed their contraceptive use to their partner or kept it secret.

• *Polygamy and differing fertility desires.* Many men and women in Burkina Faso expressed concerns about the difficulties polygamy poses for contraceptive use by men. Such use in polygamous contexts was perceived as "complicated" and likely unacceptable, given the differing fertility desires of multiple wives. One woman in Burkina Faso said:

"...if the man uses a method and then takes a new wife, that wife can't have a child. And so, she will leave the husband to go and see another man. That's why we think it's up to the woman who doesn't want to have any more children or who wants to rest to find the solution."*–44-year-old married woman with five children, currently using the implant, Burkina Faso*

Ideal Method Ideation

In Burkina Faso, most proposals during the ideal method ideation activity—in which the participants brainstormed in pairs and then discussed their ideas with the larger group—were for female-directed methods (85% and 81% of those proposed by men and women, respectively; Table 2). In Uganda, however, more than half (56%) of new methods proposed by men and one-third of those proposed by women were male-directed. The few male methods suggested in Burkina Faso, which were mostly proposed by women, included injectable delivery mechanisms and a long duration of effectiveness. Men in Burkina Faso suggested only one type of male method: a more resilient condom. In Uganda, delivery forms for male methods were more varied: Men most frequently suggested a cream, foam or jelly to rub on the penis or arm (44%), and women most frequently suggested an injection (38%). Ugandan men were split on whether their ideal method would be short-, medium- or long-acting, whereas a majority of women (59%) proposed methods lasting longer than one year.

• *Factors influencing preferred method characteristics.* Some of the suggested method characteristics suggested by Ugandan men related to lifestyle and context-specific concerns. For example, men might forget to take pills, as described by a member of one pair:

"We would like to have an injectable that will be given after every five months.... It is because we cannot handle the daily pills by virtue of our work, which is hard work; we can forget to take and end up failing to control births."

Men in Uganda were also concerned that they might fear needles or lack drinking water to help them take pills. One male participant put it this way:

"We want a method where they apply creams on the body, reason being it is much easier to use than any other method.... I particularly have a fear for the injectable, for instance in the process of injecting me, the needle can break, and I can get into trouble. The creams are much easier to use compared to the pills because the hassle involved in taking tablets; one must have boiled water, something rare in our village..."

Three male pairs in Uganda reported that their ideal method would have no side effects, which influenced the delivery mechanism or the duration of the male methods they suggested: As a member of one pair said:

"We also suggest that they can develop a jelly which we can smear on the penis and prevent pregnancy. Because if it's a jelly then it will not affect you because the pills can affect our liver, so since we men always want to be in control, it should work during that moment. After it, I get back to [my] initial state. Otherwise, if it's three months, then men may not like it...."

Two pairs reported that the method should not affect sexual desire or functioning, and three that their method should not cause "weakness." Members of one male pair in Uganda expressed both of these sentiments:

"We have thought of the pill to take us for about five years, for us the men.... It should not give us any side effects, and in case it does, they should be able to help and change us to another type.... Things like taking away my sexual potency, loss of sexual urge, so that I am able to satisfy my wife's sexual desires [uses a polite phrase directly translatable as 'handling the machine effectively'] and giving me body weakness that I cannot do my daily chores."

Many women in Burkina Faso and Uganda suggested that male methods should have longer durations, so that men do not have to remember to take pills daily. Some women in Uganda also felt that men may refuse pills because they might associate taking them with being sick. As a member of one female pair in Uganda said:

"I was also suggesting that there should be a method for men, say an injection.... The method should be for two years, because men won't allow a method of five years...."

After pairs presented their ideal methods, the larger groups discussed these methods. Some women suggested that longer-lasting methods should be marketed to men who already have many children; in doing so, they were implying that male contraceptives should be used for limiting the number of children, rather than delaying a first birth. In addition, longer contraceptive durations that do not require daily use could prevent out-of-wedlock births. A woman in Uganda said:

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"I have liked the one for men where sperms are disabled for about five years before the woman can become pregnant.... Because when the woman gets a method for several years, the man goes out and produces children and brings them home. Then you do not see what that family planning you are suffering with is helping you."–*29-year-old in-union woman with four children, not practicing contraception, Uganda*

Like their male counterparts, women in Uganda highlighted the importance of having methods that do not have side effects; although, unlike the men, these women focused on sexual side effects for both men and women. As one woman in Uganda put it:

"...they usually say that when you use family planning, it impacts and reduces sexual functionality and interest. So our method will be safe and will not interfere with our marital relationship, and we shall be able to look after our children."–*Woman not practicing contraception, full demographic information not recorded, Uganda*

Women also mentioned that a new male method would allow couples to share the burden of side effects. As one woman in Uganda, describing a hypothetical situation, said:

"...I have explained to [my husband] all the problems [I] am having in all this, so that he also gets to make a decision and he says that now my dear, you have been on contraception for a long time, let me be the one to go this time; I hear that there is a new method that is now available. So let me go and start with that method...."–*45-year-old in-union woman with seven children, currently using the injectable, Uganda*

TABLE 2. Percentage distribution of pairs of ideal method exercise participants, by suggested characteristics of male contraceptives, according to country and gender

User/Characteristic	Burkina Faso		Uganda	
	Men	Women	Men	Women
INTENDED USER	(n=20)	(n=74)	(n=16)	(n=89)
Suggested male-directed methods	5	9	56	33
Suggested male- and female-directed methods	10	8	31	8
Suggested female-directed methods	85	81	6	60
Not specified	0	1	6	0
CHARACTERISTICS OF MALE METHODS	(n=1)	(n=7)	(n=9)	(n=29)
Delivery mechanism				
Cream, foam or jelly to apply to penis or arm	0	0	44	3
Injection	0	57	22	38
Single pill	0	0	11	7
Pill (repeat or not specified)	0	14	11	10
Oral drops/liquid to drink	0	0	11	10
Implant	0	14	0	14
Permanent method	0	0	0	7
Other/not specified	100*	14†	0	10‡
Duration				
Single-use	100	0	22	7
Short-acting (≤3 mos.)	0	29	22	7
Mid-range (>3 mos. to <1 year)	0	0	22	10
Long-acting (≥1 year) or permanent	0	71	33	59
Not specified	0	0	0	17
Total	100	100	100	100

*More-resistant male condom. †Finger ring. ‡Something to secretly give men when they have sex—for example, a pill or drink; or something to tie around the waist or wrist.
Notes: Percentages may not add to 100 because of rounding.

DISCUSSION

Our results add to a growing literature on the potential acceptability of male contraceptive methods in low- and middle-income countries, specifically in Sub-Saharan Africa. A majority of FGD participants in both countries who expressed an opinion on male contraception supported new male methods, in part because many believed that existing male methods are insufficient and have unacceptable characteristics. Interestingly, side effects from contraceptive use were some of the most common reasons both for and against the development of male methods. Participants felt that new methods would allow men to help women take a break from side effects associated with their contraceptive use; however, side effects that could affect men's sexual desire, sexual performance and fertility were mentioned as potential deterrents. Previous studies of hypothetical male methods in Sub-Saharan Africa have focused on men's unwillingness to use contraceptives if there are side effects; however, these studies did not explicitly mention sexual function.[17,18] In a U.S.-based clinical study of a male contraceptive gel, self-reported declines in sexual satisfaction were not associated with overall acceptability.[23] Future research on new male contraception should measure any real or perceived effects on sexual functioning to determine whether these impact acceptability.

While we found support for new male methods in both countries, it was greater among both men and women in Uganda than among their counterparts in Burkina Faso; participants in Uganda also suggested a greater number and variety of new male methods during the brainstorming exercise. These differences may be the result of greater familiarity with contraceptives in Uganda, which has had a higher contraceptive prevalence over the past decade and a more diverse method mix than Burkina Faso.[24,25] The overall greater support for male contraception in Uganda, however, may reflect some underlying cultural differences, which deserve more study.

Our results indicate that potential demand for new methods of male contraception will depend on individual motivations and desired product characteristics. Motivations and decision-making criteria for men will likely differ depending on cultural norms, as well as relationship context, such as a polygamous household or a monogamous couple with a shared decision to use contraceptives. Women in both countries said that they wanted to retain control of contraceptive use, both because of divergent fertility desires and the belief that men might lie about their use; men also expressed that they wanted to control their own fertility. Some male and female participants also mentioned the impact of multiple partners and promiscuity on male agency and motivation to use contraceptives. Male contraception was seen, alternately, as tacit approval for men to be promiscuous without consequence, a way to deter extramarital pregnancies and discourage female promiscuity. However, participants, especially women, also recognized that the availability of

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new contraceptive options for men could increase overall acceptance of family planning by making it more than just a woman's issue.

Consistent with previous cross-national studies that found that preferences for delivery mechanism vary by context,[13,26] our research found that men and women—particularly in Uganda—suggested a variety of preferred delivery methods. These results indicate that a new method with a single delivery system (such as an injection) is likely to meet only a portion of potential demand. In addition, concern over possible side effects of new methods demonstrates that a negative impact on men's sexual desire, performance or fertility would likely be unacceptable. Some participants said that an absence of side effects would result in a position switch from unsupportive to supportive. Furthermore, potential enhancements to sexual pleasure or virility, for example, may prove to be an incentive.

Strengths and Limitations

There are several strengths to our study. While the data were from a broader study on the acceptability of new contraceptive methods that was not specifically focused on male contraception, the ideation activity encouraged broad thinking related to future contraceptive methods, which allowed for the generation of ideal characteristics for male contraceptives, rather than merely assessing potential acceptability of existing methods. In addition, although the study was conducted in two countries, many similar themes emerged in both contexts, which suggests that common perceptions and concerns regarding support of male contraception may exist across Sub-Saharan Africa. Furthermore, most research on male contraceptive use has focused on either men's or women's opinions; however, this study allowed for comparisons of the reasons men and women support or oppose male contraceptives, as well as the characteristics of an ideal method that each sex supported.

Our study also has several limitations. The FGD format does not allow all voices or opinions to receive equal weight and increases "group-think," although the small-group ideation activity allowed for more ideas to be generated. In both countries, there were fewer FGDs conducted with men than with women, which makes it difficult to generalize findings to men in each country. In addition, different moderators across FGDs and countries likely led to varied facilitating styles, including how much moderators probed for more detail and ensured that every participant's voice was heard equally. Because of the FGD format, responses from each individual were not recorded for each discussion question. For that reason, we were not able to characterize all opinions related to male contraceptive methods. This may have led to conclusions that either overstate or understate support for male contraception. Future research might consider purposive sampling for individual in-depth interviews or survey questions in large-scale surveys to better understand support for male contraception at a population level. Finally, this analysis is unable to determine the extent to which new male methods might fulfill unmet need for contraception or serve as alternate methods for current users. Future research on country-level contraceptive use dynamics, registration of contraceptive products, and training and health system capacity may benefit from the inclusion of potential new methods in their analyses of unmet need.

CONCLUSIONS

Our results indicate interest in new male methods in both Burkina Faso and Uganda, although there are some reservations related to such characteristics as delivery method and side effects. Future research should explore specific motivations for male contraceptive use, as well as incentives and method characteristics that will be acceptable and generate demand in different Sub-Saharan African countries. The relationship patterns in each country must also be taken into consideration, as should the cultural norms that govern pregnancy and contraceptive use behaviors. In addition, messaging that addresses shared responsibility and perceived side effects will be needed in marketing plans and demand-generation campaigns for new male methods in Sub-Saharan Africa.

Increased effort should be placed on framing family planning as both women's and men's responsibility to drive demand for new male methods. Consideration of the many characteristics of contraceptive methods that are important to both sexes will increase the chance of acceptance of new male methods in Sub-Saharan Africa.

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RESUMEN

Contexto: *Las opciones de anticonceptivos masculinos son limitadas; sin embargo, los esfuerzos de desarrollo de productos tienden a enfocarse en los métodos femeninos. La investigación sobre las actitudes hacia los métodos para hombres, –particularmente en las regiones de baja prevalencia de anticoncepción, como el África subsahariana– podría dar sustento al desarrollo de nuevos métodos masculinos.*

Métodos: *Se tomaron datos cualitativos a partir de discusiones de grupos focales que se llevaron a cabo en Burkina Faso y Uganda en 2016, con la participación de 80 hombres de 23 a 67 años y de 398 mujeres de 15 a 50 años. Las transcripciones se analizaron temáticamente para explorar el apoyo de hombres y mujeres a los métodos anticonceptivos masculinos, así como para extraer sugerencias sobre las características ideales del método.*

Resultados: *Los participantes masculinos y femeninos en ambos países expresaron su apoyo a las nuevas opciones de anticonceptivos masculinos; se expresaron más actitudes positivas en Uganda que en Burkina Faso. Los participantes de ambos sexos reconocieron que los métodos masculinos podrían reducir la carga de planificación familiar para las mujeres y ofrecer a los hombres un mayor control sobre su fecundidad; sin embargo, algunos participantes plantearon sus preocupaciones sobre los efectos secundarios y consideraron que los hombres no usarían anticonceptivos. Las características de la relación, como las uniones polígamas, se mencionaron como posibles desafíos. En ambos países, se propusieron varios tipos de métodos anticonceptivos (por ejemplo, cremas o jaleas, la inyección y el implante) y de distintas duraciones (de acción corta a permanente).*

Conclusiones: *La aceptabilidad de los nuevos métodos masculinos en la mayoría de los participantes en los dos países indica una demanda potencial de anticoncepción masculina. Las opciones deberían incluir una variedad de características del método para maximizar la elección, involucrar a los hombres y apoyar las necesidades de anticonceptivos de hombres y mujeres.*

RÉSUMÉ

Contexte: *Les options contraceptives masculines ne sont guère nombreuses. Le fait est, cependant, que les efforts de développement de produits se concentrent généralement sur les méthodes féminines. L'étude des attitudes à l'égard des*

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méthodes masculines – en particulier dans les régions à faible prévalence contraceptive telles que l'Afrique subsaharienne – permettrait d'éclairer le développement de nouvelles méthodes pour les hommes.

Méthodes: *Les données qualitatives requises ont été extraites de discussions de groupe menées en 2016 avec 80 hommes âgés de 23 à 67 ans et 398 femmes âgées de 15 à 50 ans au Burkina Faso et en Ouganda. Elles ont été transcrites et analysées thématiquement pour examiner le soutien des hommes et des femmes à l'égard des méthodes contraceptives masculines et en dégager les suggestions possibles sur les caractéristiques des méthodes idéales.*

Résultats: *Dans les deux pays, les participants et participantes ont exprimé leur appui de nouvelles options de contraception masculine; plus d'attitudes positives ont été exprimées en Ouganda qu'au Burkina Faso. Les participants des deux sexes ont reconnu que les méthodes masculines pourraient alléger la charge de la planification familiale portée par les femmes et offrir aux hommes un meilleur contrôle de leur fécondité. Certains s'inquiétaient cependant des effets secondaires et pensaient que les hommes n'utiliseraient pas les contraceptifs. Les caractéristiques de relation, telles que les unions polygames, ont été citées comme difficultés possibles. Dans les deux pays, différentes méthodes (par exemple, crèmes ou gels, injection ou implant) et durées (de courte à permanente) ont été proposées.*

Conclusions: *L'acceptabilité de nouvelles méthodes masculines aux yeux de la plupart des participants dans les deux pays révèle une demande potentielle de contraception masculine. Les options proposées doivent inclure diverses caractéristiques de méthode pour maximiser le choix, engager les hommes et soutenir les hommes et les femmes dans leurs besoins contraceptifs.*

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