London School of Economics and Political Science

Troubling Men: Interrogating masculinities and sexual and reproductive health in Accra, Ghana

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Declaration

I certify that the thesis I have presented for examination for the PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

I declare that my thesis consists of **62,161** words.

Statement of co-authored work

I confirm that Chapter 4 was jointly co-authored with Samuel Lamptey, Nii Kwartelai Quartey, and Nii Kwartei Owoo and I contributed 95% of this work.

Abstract

Men are critical stakeholders in sexual and reproductive health (SRH); alongside their own needs and experiences, they can shape the choices and decisions that other people are able to make. However, men remain minimised and marginalised as a key population in SRH policies and there is a paucity of demographic research focused on men in SRH. Examining how masculinities and gendered power are embedded in men's roles in SRH is essential for uncovering the mechanisms that drive ongoing SRH injustice and inequality.

This thesis by papers demonstrates the significant role that masculine norms have in shaping men's SRH attitudes and behaviours, including their involvement in women's decision-making. I developed a conceptual framework that operationalised feminist approaches to research through the interlinking of the key tenets of Reproductive Justice and Critical Studies on Men and Masculinities. Using co-produced, methodologically innovative instruments, men aged eighteen and over in James Town, Accra, participated in a survey (n=306) and a nested sample participated in interviews (n=37).

The findings in this thesis highlighted how a constructed masculine ideal rooted in (hetero)sexuality, reproduction, and fatherhood, was deeply embedded in men's SRH attitudes and behaviours. Men constructed notions of needing to be 'ready' to meet expectations of fatherhood. This notion of 'readiness' was particularly constructed around the capacity of men to be financial providers, and a concern that failure to meet these expectations could led to public derision. Whether a man felt 'ready' directly linked to their non-/consensual involvement in abortion-related care as well as uses of other fertility regulation methods. The survey innovation allowed for critical insights into the role of relationality in SRH; men's SRH attitudes and behaviours were not singular or static, but deeply rooted in the kind of relationship men have with a person and how a pregnancy or abortion would reflect on their masculine sense of self.

Moreover, by interrogating the role of men in SRH this thesis troubles existing assumptions in demographic research and Global Health. Open text survey responses allowed men to locate their condom non-/use within a more holistic and broader conceptualisation of their sexual lives that went beyond reproduction and incorporated the importance of pleasure,

intimacy, and trust. Examining the role of men in emergency contraceptive pills (ECPs) emphasised the plural, varied, and nuanced meanings that they ascribed to these pills that went beyond the narrow framing of 'appropriate' use set out in Global Health policy recommendations. The framework and approach of the thesis allowed for the uncovering of how men operationalised gendered power, alongside conceptualising the usefulness of the observable nature of ECPs, to pressure their partner to use. These findings expose critical factors that shape SRH, including the significant role of men and the motivations behind these, that are frequently uncaptured and under acknowledged in demographic research and Global Health.

Examining masculinities in this thesis provides essential evidence for understanding men's own SRH behaviours. This includes how men shape and influence the decisions of others and create conditions of injustice and inequality. This thesis emphasises how men construct and operationalise masculine norms in relation to SRH and uses this evidence to trouble and critically engage with demographic research and Global Health policies. It highlights the need for greater attention to masculinities within SRH to better understand the mechanisms that drive ongoing SRH inequalities and injustices.

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Abbreviations

aWGQ – abridged Washington Group Questions
CIP – Costed Implementation Plan
CSM – Critical Studies of Men and Masculinities
DHS – Demographic and health Survey
ERC – Ethics review committee
ESRC – Economic and Social Research Council
FDGs – focus group discussions
FP2020 – Family Planning 2020
FP2030 – Family Planning 2030
GHC – Ghanaian Cedi (currency)
GHS – Ghana Health service
HIC – High Income Country
HIV – human immunodeficiency virus
ICPD – International Conference on Population and Development
IDIs – in-depth interviews
IMAGES – International Men and Gender Equality Survey
INED – Institute National d'Études Démographiques
LGBTQ+ – lesbian, gay, bi, trans, queer, questioning or ace
LMIC – Low- and Middle-Income Country
LSE – London school of economics and political science
PCA - Principal Components Analysis
PMA – Performance Monitoring for Action
RDS – Respondent-driven sampling
REC – Research Ethics Committee
RIPS – Regional Institute for Population Studies
SDGs – Sustainable Development Goals
SRH – sexual and reproductive health
SRHR – sexual and reproductive health and rights
STI – Sexually Transmitted Infection
TIAB – Titles and Abstracts
UN – United Nations
UNDESA – United Nations Department of Economic and Social Affairs
UNFPA – United Nations Population Fund
WHO – World Health Organization

Chapter 1: Introduction

It is imperative for SRHR champions to fully integrate involvement of men in advancing the agenda on SRHR as their role must not be ignored. Gender equality is pivotal to successful implementation of SRHR services – (Adewole and Gavira 2018, p. 2586)

Sexual and reproductive health and rights (SRHR) are an essential component of human rights (Starrs et al. 2018). They incorporate critical notions of bodily autonomy, choice, and decision-making regarding sex, sexuality, and reproduction. SRHR are also inherently political. They require a resistance of hetero-patriarchal norms that have created systems and structures that perpetuate reproductive injustices, by limiting the sexual and reproductive health (SRH) choices and decisions available to individuals and communities.

For decades, there have been ongoing global commitments and goals that are aimed to ensure progress towards universal SRHR. These include the International Conference on Population and Development (1994), the Millennium Development Goals (2000), the Sustainable Development Goals (2015), and the Family Planning 2020 (FP2020) and 2030 (FP2030) commitments. Consistently, however, policy and programming have focused on interventions to improve the SRHR of women (Porche 2012). This emphasis reflects the significance and importance of women's SRHR, but also places the burden on women to be accountable and responsible for improving and maintaining their SRHR whilst simultaneously invisibilising men.

Fundamental to the fulfilment of universal SRHR is a need to understand and transform the roles of men (Starrs et al. 2018). This includes men as users of SRH services, having their own SRHR needs, and their roles in shaping the SRHR of others. Men remain on the periphery of policy and programmes, despite the growing awareness of their importance within SRHR (Sonfield 2004). Ignoring men does not mean that men's roles in sexual and reproductive health and rights disappear. Rather, invisibilising men, and by extension the gendered power dynamics that can shape people's lives, serves to limit the likelihood of achieving universal rights (Ruane-McAteer et al. 2019).

This thesis grapples with the missingness of men in demographic research, Global Health, and international development policy through feminist-informed, mixed methods research. It uses a conceptual framework that centres and visibilises men in SRHR, considering how evidence on masculinities, gender, and power can be captured in data collection tools. It provides empirical evidence that advances and expands understandings of men's roles in SRHR, contributing to knowledge on how these might shape the conditions under which other people navigate their own SRHR. It critically engages with evidence use within the design and implementation of SRHR policies and programmes.

Why are sexual and reproductive health and rights important?

Sexual and reproductive health and rights (SRHR) relate to the fundamental rights of a person to control their body and achieve the outcomes they want regarding their sexual and reproductive lives. Under the scope of SRHR, all people have the right to access information, services, and technologies that allow them to navigate their sexual and reproductive health (World Health Organization 2005). This includes the centring of bodily autonomy, choice, and full, legal, and easy access to care (UNFPA 2014, United Nations Population Fund 2004, Starrs et al. 2018). It brings together the intersections of sex, sexuality, and reproduction that are necessary for the health and wellbeing of an individual.

Critical to the achievement of SRHR is the individual's right to control their fertility and reproduction. Contraception and abortion are the predominant ways in which people avoid a pregnancy or its continuation. Non-biomedical behavioural methods (such as abstinence, withdrawal, and rhythm methods) are important means of pregnancy avoidance for many people (Altshuler and Blumenthal 2020). However, biomedical methods of fertility regulation are more effective and prioritised by governments, funders, and health systems and services (World Health Organization, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), and Knowledge SUCCESS 2022). Understanding access, choice, and decision-making around these methods is, therefore, of paramount importance.

Biomedical methods of temporary fertility regulation have existed in different ways for centuries but became more widely available and more innovative in the Nineteenth and Twentieth Centuries (Quarini 2005, Christin-Maitre 2013). This includes the invention of the

oral contraceptive pill, the intra-uterine device, the implant, the diaphragm, and more recently the emergency contraceptive pill. All these technologies were developed to be used by women. For men, the only contraceptive developed has been the male condom. Permanent sterilisation methods have also been developed for both women and men.

Abortions provide a means for people to not continue their pregnancy and are essential healthcare. Methods for abortions have also existed for centuries, including the use of botanicals with abortifacient properties (Joffe 2009). Medicalisation generated clinical methods for abortion, including surgical or procedural abortion[1] (Shepherd and Turner 2018, Upadhyay, Leah Coplon, and Atrio 2023). More recently, medical abortion (a combination of mifepristone and misoprostol or misoprostol only) was discovered by women in Brazil in the 1980s (Arilha and Barbosa 1993). It has revolutionised abortion care, providing a mechanism for people to self-manage safely and without medical intervention (Berro Pizzarossa and Nandagiri 2021, Berer and Hoggart 2018).

Overall, these methods of contraception and abortion are some of the most effective ways for a person to not become or not continue to be pregnant. The ability to meet desires to use or to not use these methods is a critical marker of a person's capacity to exercise their rights. Access to these methods is shaped by obstacles which intersect to contribute to conditions of reproductive injustice. These are the contextual conditions that people navigate when seeking to exercise their rights, which determine the extent to which a person can choose and access the reproductive health care they want, when they want, and how they want (Davis 2019, Ross 2017).

Sexual and Reproductive Health and Rights in Global Health and International Development

The landmark 1994 International Conference on Population and Development (ICPD), Cairo, established a rights-based approach to SRH in its Programme of Action, alongside a commitment for the reduction of SRH-related mortality and morbidity (United Nations Population Fund 2004). The ICPD Programme of Action outlined that women had a right to

[1] Language around abortion remains contested and evolving. While 'surgical abortion' is common parlance in health lexicon, there have been ongoing discussions over the use of 'procedural abortion' as a more appropriate term. See (Upadhyay, Leah Coplon, and Atrio 2023) for more details.

control their fertility and that states should facilitate full access to reproductive health care, including family planning and sexual health, without coercion or obstacle (United Nations Population Fund 2004).

Over the last three decades there has been increased recognition of the need for a broader and more holistic understanding of SRHR. SRHR is nested in human rights and includes the right to safe, effective, affordable, and acceptable reproductive health services, including contraception and abortion (Starrs et al. 2018, Hardee et al. 2014, Hook et al. 2018, Marston and Tabot 2023). The 'rights' in SRHR emphasise the intersections between systems and structures of inequality and discrimination. Recent advocacy has increased the demand for pleasure and well-being to be recognised as critical and fundamental to SRHR (Gruskin et al. 2019, Philpott et al. 2021).

SRHR is included in numerous international development and global health commitments. As well as the ICPD Programme of Action and subsequent programmes (e.g., ICPD+25), the Sustainable Development Goals (SDGs) Target 3.7 calls for universal access to sexual and reproductive health-care services by 2030 and Target 5.6 for full SRHR in alignment to the ICPD Programme of Action (UNDESA). The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) was ratified by the African Union in 2003, went into effect in 2005, and incorporated a commitment to SRHR including access to abortion (African Union 2019). The FP2020 and FP2030 commitments are a global partnership that centres on improving access to contraceptives with a goal of improving gender equality (FP2030 n.d., Scoggins, Bremner, and FP2020/2030 team 2020).

Within global health and international development policies and programmes, fertility regulation methods are framed as important in relation to specific outcomes. The SDGs reference the need for family planning and a reduction in adolescent birth rates as the key indicators of Target 3.7 (UNDESA). There is little reference to sexual health and rights, nor any reference to abortion. More generally, 'modern' [i.e., biomedical] contraceptives are the focus of most global health policies and programmes towards SRHR, such as FP2020 and FP2030 (Cahill et al. 2018). Abortion-care is often neglected in global health SRHR commitments; ICPD recommended safe abortions only in countries where it was legally

permitted (United Nations Population Fund 2004), while the Maputo Protocol recommends abortion exemptions but not the full decriminalisation of abortion (African Union 2019).

Much of the global commitments to improving SRHR are focused on the Global South, reflecting the colonial histories of global health and international development (Themrise et al. 2022, Alberto and Seye 2021). ICPD was characterised by a number of compromises (Hodgson and Watkins 1997), which have come to define how SRHR is framed within global health and international development. Central to this was a concord between feminist activists and population control advocates to promote SRHR without challenging ideologies of population control (Senderowicz 2020, Hendrixson 2019). This compromise between neo-Malthusians who advocated population control and feminists who advocated reproductive rights meant that programmes and policies remained grounded in assumptions that 'good' SRHR outcomes were measured in increased contraceptive prevalence rates and decreased total fertility rates (Hodgson and Watkins 1997).

Production of SRHR Evidence: The Role of Demography

Demography focuses on factors considered critical to population changes and dynamics: fertility (births), mortality (deaths), and migration (Williams 2010). These remain the foundational areas of interest for demographers (Desai 2000). As an academic discipline, Demography seeks to understand the world empirically, and was a historically positivist discipline, aiming to make populations legible through quantitative data (Caldwell 1996). It has been critical in contributing to global health evidence, and in particular the creation, iteration, and implementation of nationally representative, harmonised surveys, focused on countries in the Global South. The Demographic and Health Survey (DHS) is exemplary of demographic research's contribution to understanding SRHR in global health and international development (Barot et al. 2015), as the data produced are critical for evidencing health outcomes (Short Fabic, Choi, and Bird 2012). Demographic research has prioritised categorical thinking through a combination of a positivist approach, the focus on harmonised survey data, and intention to produce data for measurements and indicators (Coast, Randall, and Leone 2009, Storeng and Béhague 2017).

Demography's roots are entangled in the same colonial histories as global health and international development and continue to perpetuate global power hegemonies that determine what is considered 'important' for populations (Strong et al. 2023, Senderowicz 2020, Nandagiri 2021). It is characterised by the prevalence of assumptions about the Global South, gender, and SRHR, as well as critical conversations and contestations around how power can be reformulated, restructured, or these fields deconstructed to create new research agendas (Strong et al. 2023, Senderowicz 2020, Nandagiri 2021).

From the mid-Twentieth Century, demographers largely positioned the discipline as a 'policy science' (Hodgson 1983) to produce evidence to inform policies aimed at influencing population change, including contraceptive use and fertility regulation (Hodgson and Watkins 1997). This has tied the discipline to fertility and family planning, mirroring the contemporaneous pre-eminence of population control advocacy (Greenhalgh 1996). Its positivist and policy-orientated approaches, rooted in efforts to be considered the most scientific of the social sciences, have meant the objective and empirical framing of the discipline (Greenhalgh 1996, Caldwell 1996), distancing itself from critical theories associated with political movements and ideologies (Williams 2010). This distancing from critical theories included feminist theories that sought a grounded analysis of the cultural and contextual roles of gendered power in research (Riley 1998).

Demography was critically different from related social sciences, particularly anthropological and sociological fields, which increasingly forwarded research agendas that incorporate feminist theories and gender (Greene and Biddlecom 2000, Riley 1998). The positivist, policy science of Demography reduces the capacity for demographic research to capture complex social phenomena that can be significant for understanding populations and their behaviours (Erikson 2012, Storeng and Béhague 2017, Tichenor 2017, Sochas 2021).

What about men?

An individual's access to and use of contraception and abortion does not occur in a vacuum. The contexts of SRHR are often shaped by men; as policymakers, healthcare providers, community leaders, partners, and more (Chiweshe 2018). SRHR service accessibility can be strongly determined by men's decision-making control within a partnership (Blanc 2001). Community norms can play a significant role in shaping decision-making around

contraceptive use and are often deeply gendered (Dynes et al. 2012). Men directly and indirectly shape the conditions under which people have to navigate their sexual and reproductive health decision-making (Dudgeon and Inhorn 2009b, Hook et al. 2018). The trajectories of a person's abortion-related care, the decisions they can make, and the services they can access are shaped by their individual, interpersonal, community, and structural contexts (Coast et al. 2018, Nandagiri, Coast, and Strong 2020).

Men have their own sexual and reproductive health needs (Sonfield 2004), which are consistently under-acknowledged in policy and programming (Porche 2012). This includes men's perceptions and conceptualisations of the meanings of sex and reproduction, which vary across context and over time, and shape their engagement with and decisions around reproduction (Mohr and Almeling 2020). As reproductive beings (Maharaj 2000, Daniels 2006, Lohan 2015), men use SRH services, informed by their own gendered understandings of un/acceptable pregnancies, of contraception and its use, and fatherhood (Culley, Hudson, and Lohan 2013, Hardee, Croce-Galis, and Gay 2017, Kane, Lohan, and Kelly 2019, Starrs et al. 2018, Smith 2020).

Men and SRHR

Men are SRH users with their own needs and desires, and simultaneously gendered actors able to shape the SRH decision-making ability, choice, and access of other people. Men can have a significant impact on the conditions under which women make their SRH decisions. This includes the ways in which men's behaviours and attitudes towards SRH impact the decisions that other people, especially their partners, can make. Men can operationalise gendered norms that privilege decision-making to meet their own SRH behaviours and preferences, even when this impedes the sexual and reproductive rights of others (Dudgeon and Inhorn 2009b).

Men can use their gendered power to control decisions on reproduction while simultaneously expecting that women are responsible for meeting these decisions. They can exert influence over women's contraceptive decisions, without women having the same influence in return (Ezeh 1993, Bankole 1995), including making the final decision regarding contraceptive use (Kabagenyi et al. 2014, Mbizvo and Adamchak 1991, Hartmann et al. 2016). Men might

view the decision on which contraceptive to use as theirs to make, while considering women responsible for contraceptive use (Hook et al. 2018, Hamm et al. 2019, Kabagenyi et al. 2014, Mbizvo and Adamchak 1991, Dral et al. 2018). Men's decisions over whether to use condoms can result in their partner being burdened with using alternative contraceptive or fertility regulation methods (Dudgeon and Inhorn 2009b, Tschann et al. 2002, Harvey, Henderson, and Casillas 2006). In Nigeria, a study found that less than half of men would allow their partners to use contraception, despite over 56% of men theoretically approving women's contraceptive use (Adelekan, Omoregie, and Edoni 2014). These perceptions maintain norms around the burden of contraceptive decisions and use falling on women (Kimport 2018). This means that SRHR decision-making for women is often determined by navigating conditions that their partner can create, as opposed to centring their own choices and preferences.

Men's attitudes are intrinsically tied to their SRH behaviours, both personal and interpersonal. The International Men and Gender Equality Survey (IMAGES), conducted in eight countries, found that men's attitudes were explicitly tied to their subsequent SRH behaviours (Levtov et al. 2014). This includes men's more equitable attitudes being associated to more equitable behaviours and practices, such as being more involved in childcare and less likely to commit acts of violence, as well as being more satisfied in their primary intimate / sexual relationship. Studies highlight how men desire to be involved in contraception services (Sternberg and Hubley 2004, Blanc 2001, Nkwonta and Messias 2019). Men who view pregnancies as shared responsibility were found in a US study to have higher willingness of using novel male contraceptives (Nguyen and Jacobsohn 2022). Men's involvement in SRHR can help their partners navigate structural barriers to care without diminishing women's decision-making (Fefferman and Upadhyay 2018). This includes 'positive' outcomes for women's contraceptive use, where outcomes are measured as rates of continuation versus discontinuation (Kerns et al. 2003)

However, men's involvement in women's SRH decisions can reinforce or exacerbate gendered power dynamics. Men's involvement in reproductive health services can be coercive and violent, intersecting with other rights-based violations such as intimate partner violence (Watts and Mayhew 2004). This includes through reproductive coercion, in which men might pressure for a pregnancy against a woman's desires, for example through birth control sabotage or forced pregnancy continuation (Miller et al. 2010, Miller et al. 2007).

This can be expressed through verbal threats and forced unprotected sex (Moore, Frohwirth, and Miller 2010). While men can help women navigate structural barriers to services (Fefferman and Upadhyay 2018), women in the US who experienced partner interference in their contraceptive use were twice as likely to report their partner attended SRH services with them compared to women who did not experience interference (Kavanaugh, Lindberg, and Frost 2012). To navigate environments of gendered power around condom use, evidence illustrates that women might have to use contraception covertly (Adongo et al. 2013, Biddlecom and Fapohunda 1998). This can lead to what Chikovore et al. describe as 'the hide-and-seek game', where men in a study in Zimbabwe sought evidence of their partner's covert contraceptive use linked to beliefs that women's contraceptive use diminished men's control in a relationship and was indicative of a partner's extramarital sex (Chikovore et al. 2002).

Men's roles in SRH at individual and interpersonal levels are embedded in gendered community norms that determine the boundaries of acceptable and unacceptable sexual and reproductive decisions, attitudes, and behaviours (Malhotra and Schuler 2005, Izugbara, Otsola, and Ezeh 2009, Paek et al. 2006). While the manifestations of these gendered norms are contextually located and heterogenous, global comparative evidence highlights that SRHR is consistently tied to community norms (Namasivayam et al. 2012). Gendered norms around acceptable behaviours and expectations are tied to men's desires to meet masculine expectations (Marston and King 2006), which in turn shapes their SRH attitudes and behaviours (Kabagenyi et al. 2014). For example, men in Uganda reported being concerned about what other men would say about them if they were to openly support contraceptive use (Withers et al. 2015). Evidence in Mexico highlighted how gendered community norms and expectations can impact interpersonal relationships and sexual behaviours (Marston 2004).

Community norms and broader assumptions around SRHR also limit men's engagement. Men's SRHR is frequently placed as secondary to women's by scientists, policymakers, and sometimes men themselves (Daniels 2006). SRH services often prioritise provision of care to women (Porche 2012). Assumptions around men's disinterest in SRHR can mean that men are less likely to access services (Greene 2000, Sternberg and Hubley 2004, Fennell 2011). This includes health systems that do not accommodate men's accompaniment or focus their reproductive health services specifically on women (Kaye et al. 2014, Altshuler et al. 2021). Where men are able to be more open to being responsible for using contraceptives, norms

that link contraception and fertility regulation primarily to women can impede men's access to SRH services (Fennell 2011). These norms limit men's potential engagement with SRH services and provision, exacerbating the burden placed on women to be 'responsible' for sexual and reproductive health outcomes (Hardee, Croce-Galis, and Gay 2017, Basu 1996).

Men's SRHR involvement, therefore, is complex and its intersections with gendered power, inequality, misogyny, and violence can mean it is detrimental to women's sexual and reproductive health and rights. Men's privileged gendered power across almost all contexts allows them to exert power over SRHR decisions. As gendered, sexual, and reproductive beings, men's attitudes and behaviours impact and influence their own SRH and that of others. Norms shape the extent to which men might feel able to share the burden of SRH with a sexual partner or access services. Examining men's roles at the interpersonal and community level is, therefore, important for interrogating both their own perceptions, attitudes, and behaviours, and their roles in shaping the lives of others around them (Lohan 2015).

Men in Global Health, International Development, and Demography

Global health and international development establish policy, provision, and funding priorities, while demography produces the critical evidence that both informs these as well as tracks progress for global targets and goals. Examining men's place within policies and priority-setting agendas and how research includes men is necessary for considering the critical evidence gaps that this thesis contributes to filling.

The International Conference on Population and Development (ICPD) marked a milestone in efforts to mainstream sexual and reproductive health and rights in international development (Reddy and Sen 2013, Ruane-McAteer et al. 2019). It sought to specifically disentangle SRH from other population-based development targets and make it a right in itself (Farah 2005, World Health Organization 2005). ICPD also acknowledged the role of men as critical actors in the achievement of SRHR:

> *Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life… it is essential to improve communication between men and women on issues of sexuality and reproductive*

> *health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life – (United Nations Population Fund 2004, p. 28)*

However, persistent ideologies of population control and focus on women's uptake of modern contraceptives within these SRHR commitments ultimately minimises men and their roles and involvement. As SRH outcomes continued to be focused on reducing total fertility rates and 'unmet need', women and girls remained the central focus of the ICPD Programme of Action (Basu 1996). The Programme of Action focused primarily on women's rights but men's 'responsibilities', limiting objectives and actions that grappled with men's own SRH (Basu 1996). The focus ignores the pluralities and complexities of men's roles in their own and other's SRH, and men as gendered and reproductive beings (Dudgeon and Inhorn 2009a). Men became characterised in global health and international development in their role as 'partners' (Hook et al. 2018).

Furthermore, SRHR remained marginal in global health and international development; no reference was made to it in the initial Millennium Development Goals (Yamin and Boulanger 2013). 'Reproductive health' was included in an amended version in 2007 (MDG5.B) (Reddy and Sen 2013, Brolan and Hill 2014), while reference to sex and sexuality were not included (Tamale 2011, Starrs et al. 2018). The Sustainable Development Goals have since referenced universal access to sexual and reproductive healthcare, though with a continued focus on contraceptive uptake and fertility reduction. This overlooks fundamental components of SRHR that include pleasure, well-being, and justice. It also fails to consider how engaging men and boys is essential for achieving the goals of the Sustainable Development Goals of universal sexual and reproductive health and rights (Ruane-McAteer et al. 2020).

The complex relationship between global health and international development and sexual and reproductive health and rights has led to policy and programmatic objectives that focus on fertility-related areas of SRHR and a preoccupation with interventions that control women's bodies. Within this environment, men are minimised, despite their role being acknowledged and re-iterated, for example, in the 2013 High-Level Task Force for ICPD (High-Level Task Force for ICPD 2013). With little meaningful engagement of men as having SRHR needs themselves and as having an effect on the SRHR of others, gendered power dynamics are invisibilised (Ratcliffe et al. 2001). This is a critical barrier to the gender

transformative policies that are necessary for achieving universal SRHR; men need to be understood as being sexual and reproductive in their own right (Marsiglio, Lohan, and Culley 2013, Lohan 2015).

Research that centres men as gendered and reproductive beings is missing in demography. This includes men as the primary respondents in quantitative surveys and qualitative research. Demography's focus on fertility has continued to centre research on women (Riley 1998). The failure to incorporate critical feminist theories has meant that studies with women frequently do not grapple with the constructed and contextual nature of gender (Presser 1997, Williams 2010, Sigle 2016), and men remain a minimised population within demographic enquiry (Greene and Biddlecom 2000). Where men are included in demographic research, it is predominantly in their role as a husband, with little analysis of gendered power (Watkins 1993, Sigle 2016). Men's roles in reproduction are frequently made marginal and invisibilised (Greene and Biddlecom 2000, Watkins 1993). In relation to fertility and contraception, men have been characterised as neither reliable sources for information nor as being themselves interested in fertility-related issues (Greene and Biddlecom 2000).

The nature of the demographic data commodity chain, need for harmonisation, and uses of these data have prioritised categorical thinking (Coast, Randall, and Leone 2009, Storeng and Béhague 2017). Whilst beneficial in streamlining data processing, categorical questions frequently flatten realities, create confusion, and provide weaker understandings of complex social phenomenon such as race, gender, and sexualities (Erikson 2012, Storeng and Béhague 2017, Tichenor 2017, Sochas 2021). Many demographic surveys focus exclusively on women, although the Demographic and Health Surveys includes men, most commonly aged 15-59 (Greene and Biddlecom 2000, Schoumaker 2017, Corsi et al. 2012). This sample is either identified through a household listing or as a sub-sample of households already selected for the women's survey (Corsi et al. 2012). Men are asked an abridged volume of questions, including relating to the contraceptive behaviours. Gender, power, and masculinities are not captured well within the confines of major demographic data (Levtov et al. 2014), and a dearth of data on men's sexual and reproductive health remains (Sonfield 2004, Corsi et al. 2012).

Aims and Objectives: Missing pieces of the puzzle

Locating men within demography, global health and international development illustrates the ways in which men have systemically been made peripheral within SRHR. This is reflected in discourses that maintain a focus on population control that is centred on women's bodies, rather than a more considered and holistic approach to SRHR.

Demography as a discipline has developed in ways that have reduced the capacity for data and evidence to untangle the role of power that is central to any meaningful gender analysis. As demographic research responds to data commodity chain demands from global health and international development initiatives, surveys continue the focus on women in SRHR. Men's perceptions and experiences of sexual and reproductive health are devalued and, significantly, gender power dynamics are under-interrogated.

Men's voices are necessary to understand how they experience and enact gendered expectations and norms and the relationship between these and their SRH attitudes and behaviours. Focusing on men provides critical insights into the motivations and mechanisms that drive these attitudes and behaviours, including how their interactions with their sexual partners manifest, and crucial evidence to inform future gender transformational policies and programming.

The thesis interrogates men's roles in sexual and reproductive health and rights. It advances empirical understandings of men and SRH, as well as methodological approaches to gender research in demography. It intends to trouble existing conceptualisations of SRHR within international development and global health to consider what current foci overlook. It does so through three key objectives:

(i) To develop an in-depth understanding of men's perceptions and conceptualisations of sexual and reproductive health;
(ii) To critically examine the mechanisms and motivations that drive men's behaviours and decision-making regarding sexual and reproductive health;
(iii) To analyse the ways in which men's roles in sexual and reproductive health shape the conditions and contexts that their sexual partners must navigate.

Additionally, the thesis explores novel approaches to centring gender, power, and justice in demographic research on sexual and reproductive health.

Conceptual Framework

A conceptual framework was needed that could allow for the empirical, methodological, and theoretical objectives of this thesis. It required a mode of centring gendered power, developing a constructivist and relational approach to understanding knowledge, and visibilising the links between individual, interpersonal, community, and structural systems of power and inequality. The framework draws from several disciplines, including demography, to work towards a more interdisciplinary approach within demographic research.

The conceptual framework first employs the lens of Reproductive Justice to critically engage with current conceptualisations of SRHR within international development, global health, and demography. It emphasises the need to understand rights within contexts of social injustice. Layered into this lens is an intersectional approach to understanding sex and abortion stigma, necessary for better examining people's SRHR attitudes and experiences. This approach provides a meaningful conceptual basis through which to understand men's roles in SRHR through the interlinking lenses of Reproductive Justice and stigma.

A feminist approach to research provides a mechanism through which to challenge and trouble dominant demographic thinking and centre systems and structures of power at the core of inequalities in SRHR. The final component of the conceptual framework brings in the foundational elements of Critical Studies of Men and Masculinities (CSM). Through an interdisciplinary drawing on the concept 'hegemonic masculinities', using CSM allows for an in-depth interrogation of men as gendered and reproductive beings.

This section first outlines the origins and core components of Reproductive Justice, incorporating an intersectional approach to stigma, to provide a lens through which to critically engage with sexual and reproductive health and rights. It then describes a feminist approach to research, before layering into the framework three core components of Critical Studies on Men and Masculinities: men as gendered, hegemonic masculinities, and locating masculinities in their cultural contexts. This feminist approach to research centred on masculinities provides the tools through which to interrogate men and SRHR through the critical lens of Reproductive Justice, intersectionality, and stigma. Taken together, this conceptual framework informs the entire research process, from conceptualisation, design, implementation, analysis, and knowledge exchange.

Reproductive Justice

Where SRHR is focused on the rights of an individual, Reproductive Justice necessitates moving towards a recognition of the role of community and contextual conditions in shaping these rights (SisterSong , Ross 2017). Conceptualised and developed by the Black Feminist collective Women of African Descent for Reproductive Justice in 1994 and the SisterSong Women of Color Reproductive Health Collective, Reproductive Justice is based on the intersecting rights to bodily autonomy, to have children, to not have children, and to parent in safe and sustainable communities (SisterSong , Ross 2017). In addition, it calls for sexual autonomy and gender freedom for all people (Ross and Solinger 2017b).

Reproductive Justice advances the conceptualisation of 'rights' within international and national accords, requiring that rights be understood within social contexts of injustice, discrimination, and oppression (Gurr 2015). It provides a lens through which to interrogate the 'choice'-based approaches to SRHR, seeking instead to centre rights and particularly access to SRHR related care within their political and community locations (SisterSong). Reproductive Justice challenged mainstream framings of abortion as 'pro-choice' or 'pro-life' – in the context of the United States – towards grappling with the gendered, racialised, and classed laws, policies, and environments that shape reproductive decision-making (Ross and Solinger 2017a). Reproductive Justice is:

> *…a political movement that splices reproductive rights with social justice to achieve reproductive justice – (Ross and Solinger 2017a, p. 9)*

It is through this lens that SRHR can be further situated within its political and social contexts, as a set of contested rights that are shaped by intersecting inequalities and modes of oppression. This thesis locates men within the conceptualisation of SRHR as a political battleground, in which the right to have children and raise them safely and sustainably, and to not have children, are defined by racialised, gendered, and classed systems and structures.

Stigma

Experiences of stigma are critical in shaping people's access to and choices of SRHR. Sexual stigma and abortion stigma can have a significant impact on the ability of a person to seek the care that they desire and meet their health and wellbeing needs. Such experiences intersect with the conditions of reproductive injustice and unequal power dynamics that shape access and choice (Shah, Ergler, and Hohmann-Marriott 2022). Stigma operates to 'discredit' and 'other' particular communities of people based on socially-prescribed 'markers' relating to their physical and psychological health and their behaviours and characteristics (Goffman 1963).

Stigma is both a cause and consequence of health inequality (Kumar 2013, Hatzenbuehler, Phelan, and Link 2013), and is deeply rooted in unequal power systems (Tyler 2018, Millar 2020, Link and Phelan 2001). For abortion stigma, this includes idealised notions of "womanhood" – maternal, caring, loving – being violated by people who seek abortions and resulting in stigmatisation (Kumar, Hessini, and Mitchell 2009). Abortion stigma and broader sexual stigma are linked by discourses and norms around acceptable and unacceptable pregnancies and the 'appropriate' number of children a person should have (Millar 2020). Stigma is tied to notions of stratified reproduction; the demarcation of un/acceptable pregnancies along gendered, racialised, classed, and ableist norms (Colen 1995, Harris and Wolfe 2014)

Thus, experiences of stigma are not uniform across populations and need to be conceptualised through the lens of intersectionality. Intersectionality, coined by Kimberlé Crenshaw and building on the work of Black feminist thinkers in the USA including Angela Davis and bell hooks, was conceptualised to describe how Black women's access to justice in the US was shaped by the intersecting discrimination they faced as gendered and racialised people (Crenshaw 1991). This discrimination operates within matrices of oppression that define and shape social systems and structures (Hill Collins 2019). Within SRHR, those with more structural privilege may be able to navigate stigmatising social, political, economic and health systems more easily than people who experience multiple forms of discrimination and oppression (Strong, Coast, and Nandagiri 2023).

Understanding SRHR through the lenses of stigma and intersectionality exposes the critical role of power in shaping a person's sexual and reproductive experiences. Power inequalities allow those with more structural privilege to determine the boundaries of acceptable sex and

reproduction, as well as enact stigma in ways that shapes the experiences and consequences felt by people who are stigmatised. To meaningfully engage with SRHR requires a conceptual framework that interrogates this power.

Feminist Approaches to Research

To interrogate the roles of men in sexual and reproductive health and rights, this conceptual framework must also centre the role of gendered power. This requires troubling, challenging, and critically engaging with the epistemological and colonial origins and underpinnings that maintain the dominance of positivist approaches to demographic research. Power is inherently constructed, shaped through the interactions between people as well as with the systems and structures around them (Foucault 1982). Power dynamics are experienced through the shaping, modifying, and oppressing of actions and behaviours (Foucault 1982). The reliance on positivist, categorical thinking within demographic research minimises the roles and manifestations of these power dynamics (Connell 1987).

Demographic research requires theories of gender that focus on their social construction and the importance of location and contexts (Williams 2010). The decolonial, Afro-feminist approach to research grounded in the work of Sylvia Tamale allows for engaging with socially constructed meanings within diverse and plural contexts, making it a critical component of the conceptual framework of this thesis (Tamale 2014, 2011, 2013). Tamale argues that gender plays an essential role in shaping sex, sexualities, reproduction, and relationships, and that sexuality is intrinsically embedded in gendered systems and structures that tie to community contexts and links to conditions of reproductive injustice (Tamale 2014). Understanding these systems requires challenging and reconceptualising the ways in which Eurocentric, positivist approaches have reduced sex to being synonymous with reproduction / reproductive sex (Tamale 2011).

A feminist approach specifically challenges assumptions around how sexuality has come to assume a singular definition, one which is homogenous and transferrable across contexts (Adomako Ampofo, Beoku-Betts, and Osirim 2008). Intersectional feminist scholarship specifically critiques the homogenisation of the category ‘woman’, emphasising the different experiences people have within gendered, racialised, classed, and ableist systems (Crenshaw 1991, Hill Collins 2019). African feminist scholars including Tamale and Stella Nynazi

challenge demographic thinking by researchers who flatten African sexualities through an ideologically colonial demographic gaze (Tamale 2011, Nyanzi 2011). Histories of gendered power dynamics, particularly the formalisation of gendered roles during colonial oppression, created notions of 'good' and 'bad' sex (Nyanzi 2011). Contextual gendered systems continue to shape notions of 'repronormativity' – the un/acceptability sex, sexuality, relationships, and reproduction (Tamale 2014). To deconstruct colonial assumptions and norms, sex, sexualities, reproduction, and gender must all be understood as containing pluralities and multitudes and not determined by one singular notion (Tamale 2011).

Operationalising a feminist approach to research also necessitates understanding, acknowledging, and reflexively negotiating power in the research process itself. Language, interaction, and modes of communication are integral mechanisms in shaping discursive power dynamics (Foucault 1982). This is especially true for international development and global health policies, rooted in their colonial origins (Saha, Kavattur, and Goheer 2019). The ability to meaningfully understand and research sex, sexuality, reproduction, and relationships is shaped by language (Ahlberg and Kulane 2011). This includes critically engaging with the role of language within research and the academy, and how the institutionalisation of language (re)shapes key contextual meanings and nuances that can become lost in the analysis of research data (Tamale 2011). Dispelling essentialism within research and the homogenisation of populations is essential for grappling with power. It requires critical engagement with how academic and institutional language conflicts with regional and local languages (Tamale 2011).

Central to the conceptual framework of this thesis is the feminist imperative to interrogate power dynamics across the entire research process and the role of the research. As Leung et al. write:

> *A feminist perspective demands that researchers consider how various components of the research process are themselves gendered, and that the gendered nature of research can perpetuate existing power imbalances…A feminist approach requires the researcher to consider biases that may be present at all stages of the research process and how these biases may shape the conclusions drawn from the work and the way the research findings are utilised – (Leung et al. 2019, p. 431-432)*

Queer and feminist African scholars advance the importance of embedding a decolonial feminist approach to the entire research process. Masculinities scholar Isaac Dery emphasises the need for research to be grounded in "the complexity of African realities" with a focus on "African men as gendered subjects" (Dery and Apusigah 2020, p. 7). Nyanzi points to the need for localised approaches to research to generate meaningful evidence for policy and programming:

> *Failure to comprehend local meanings, nuances and enactments of local sexualities results in irrelevant, inappropriate, meaningless and time-wasting interventions that are bound to be oppressive to target communities or individuals – (Nyanzi 2011, p. 479)*

Thus, a feminist approach to research also requires a broader grappling with the entire research process – from conception to analysis to knowledge exchange. Chapter 2 describes the methodological considerations and choices within this thesis, that were driven by a desire to gathering complex and nuanced data in ways that challenged epistemological hegemonies. Chapter 7 outlines how the co-production and partnerships that were central to this thesis and informed knowledge exchange plans and activities, both by and for men within the community where the research took place.

Masculinities

This thesis interrogates men's roles in SRHR. Through the lens of Reproductive Justice and stigma, the thesis understands men as both people who experience injustice and stigma as well as create the conditions that exacerbate and enact these. A feminist approach to research requires examining gendered power dynamics as central to sexual and reproductive experiences, while African feminist scholars emphasise the need to situate these within their local contexts.

To meaningfully bring together these different components of the conceptual framework this thesis incorporates sociological work on hegemonic masculinity as a key and novel approach for demographic research. Examining, interrogating, and understanding men through the lens of masculinities allows for the centring of power and gender. As Levtov et al. write:

> *The field of men and masculinities studies emphasizes an understanding of gender as relational and structural, and highlights the multiplicity, hierarchy, and changing nature of masculinities in the context of historical, social, and material realities – (Levtov et al. 2014, p. 468)*

Drawing from Critical Studies of Men and Masculinities (CSM), this thesis incorporates three intersecting, feminist-informed conceptual components to develop the analysis: (i) that men are gendered; (ii) the theory of hegemonic masculinity; (iii) the locating of gendered relations within cultural contexts (Lohan 2015, Lohan 2007). CSM also offers a framework through which to consider how existing norms, expectations, and ideals can impact men as reproductive beings. Cynthia Daniels conceptualises reproductive masculinities as those which assume men as secondary in biological reproduction, invulnerable to external harm, illness, and injury, virile and able to biologically reproduce, and as distanced from children and care (Daniels 2006). This provides productive and generative thinking for the ways in which masculinities are constructed and their interaction with men's roles and involvement in sexual and reproductive health.

Men as gendered

This thesis understands men as gendered beings, embedded in contextual constructions of gender (Chant and Gutmann 2002). It moves beyond positivist social science approaches to gender, which describe what people 'are' through a binary categorisation of woman/man (Connell 2005). Rather, it understands gender as a socially constructed phenomena, (re)shaped through interactions between people, communities, and systems and structures. Gender is linked but distinct to sex, which describes the series of biological traits that have been combined and constructed over the years to determine – usually at birth – if someone is male, female, or intersex (Hines 2019).

Rather than binary and fixed, gender has plural, socially constructed expressions and, therefore, elicits plural and intersecting constructions of masculinities and femininities (Annandale and Riska 2009). Such a conceptualisation allows for a constructionist understanding of how gender is not simply fixed to biological bodies but rather rooted in the social and cultural context in which bodies act (Hines 2019, Mfecane 2018). As Connell writes:

> *Gender is a social practice that constantly refers to bodies and what bodies do, it is not social practice reduced to the body – (Connell 2005, p. 71)*

Gender is frequently tied to expressions of masculinities and femininities. These are the constructions, expressions, and interactions most often (though not exclusively) associated with men (masculinities) and women (femininities) within their social context (Butler 1988). Constructions of masculinities and femininities have been increasingly interrogated, starting with gay and queer liberation movements in the 1970s (Connell 2005), and gaining scholarly prominence in the 1980s and 90s (Bird 1996). The analysis of masculinities and femininities presents a mechanism to go beyond exploring the interactions between genders towards understanding internalised and externalised constructs that shape behaviours (Dudgeon and Inhorn 2009a).

Hegemonic Masculinities

The concept of 'hegemonic masculinities' is a critical and central component of this conceptual framework. Principally developed in Raewyn Connell's germinal *Masculinities*, it makes visible the mechanisms that develop the social ordering of gender in a given context:

> *Hegemonic masculinity can be defined as the configuration of gender practice which embodies the currently accepted answer to the problem of legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women – (Connell 2005, p. 77)*

Hegemonic masculinities are a set of ideals that gain cultural acceptance and are embedded in structures and systems of power. It is this embeddedness that legitimises the hegemonic masculine ideal in a given context, ensuring it privileges from the greatest share of the patriarchal dividend (Connell 2005). It is against this hegemonic masculinity that other masculinities and femininities are ordered; the hegemony only exists through its relationality to other masculinities and femininities (Connell 2005). Thus, the concept of hegemonic masculinities requires us to acknowledge that masculinities are plural and that multiple masculinities complement, contest, and interrelate (Beasley 2008). It provides a mechanism through which to conceptualise how a dominant masculine construction in a given context is

able to access power and privilege through its proximity to the hegemonic ideal (Connell and Messerschmidt 2005). This allows for an understanding of the ways in which masculine constructions link to systems and structures of power, and the deeply relational nature of power.

Locating masculinities in their cultural contexts

The concept of hegemonic masculinities has been critiqued for its inability to conceptualise Black masculinities as anything other than marginal (Ratele 2014). This is because at the macro and global levels, the power structures that hegemonic masculinities are tied to colonial white supremacy. Gender and masculinities in Africa have been shaped by these colonial regimes and their supremacist ideologies (Bhana 2016, Pasura and Christou 2017). Drawing on queer and decolonial scholars, this thesis considers masculinities in their plural sense, not essentialised to homogenic Euro-American constructs (Chiweshe 2018, Ahlberg and Kulane 2011, Tamale 2011, Mfecane 2018). The concept of masculinities remains salient, however, as a lens through which to recognise the power inequalities between gendered communities (Manuh 2007, Lohan 2007). Rather than reject the concept of hegemonic masculinities, it becomes necessary to (re)conceptualise it within localised contexts and associated social, economic, and political systems and structures (Tamale 2011)

This thesis understands hegemonic masculinities in the plural sense and is focused on understanding dominant masculinities in their localised contexts. To do so, it recognises how masculinities are constructed through social processes and are constantly shaped and reshaped by evolving and contested norms (Connell 2005). They are tied to the social, cultural, political, economic, and historical contexts within which they located. Cultural constructions and the operationalisation of traditions build constructions of gendered ideals (Ampofo and Boateng 2011, Ratele 2014). Histories of colonialism include the direct and indirect implementation of particularly European gender norms across contexts by colonial regimes (Hanh 2009, Bhana 2016, Ratele 2017, Pasura and Christou 2017). Religion and religious organisations can shape masculine ideals around fatherhood, partnering, and values of religiosity through teachings as well as through the ability to shape privilege and power structures (Van Klinken 2016, Tamale 2011).

Operationalising the conceptual framework

The conceptual framework developed for this thesis is designed to meet the needs of the aims and objectives, maximising the nuance, complexity, and relevance of the data collected. It informs the conceptualisation, design, implementation, and analysis of the thesis. Rather than prescriptive, the conceptual framework reflects the exploratory approach to this research, which seeks to understand under-interrogated and minimised areas of sexual and reproductive health.

Using a lens that draws on the intersections between Reproductive Justice, intersectionality, and stigma means the research is sensitive to the role of context and the interpersonal, community, and structural conditions that shape SRHR. This is essential for understanding both men's own perceptions and conceptualisations (Objective 1), including their framing of un/acceptable sex, sexuality, and reproduction, as well as understanding the roles men can have in shaping the SRH conditions and contexts of their partners (Objective 3).

Moreover, recognising men as gendered and reproductive beings is key to understanding how their internalisation of masculine norms and expectations might shape their views (Objective 1). In particular, it enables the research to examine how men's experiences of masculinities, their constructions of masculine ideals, and the role of gendered interactions and normative environments are potentially critical to their behaviours and decision-making (Objective 2). Finally, the overall conceptual framework centres a constructivist understanding of SRH behaviours and ensures that the research design is focused on interrogating how gendered power is constructed and manifests.

Country Context: Ghana

Ghana was chosen as a case study for this research for four main reasons. Three of these related to conditions that provided the necessary foundations for the research in this thesis, and one related to personal and existing connections. First, Ghana has a long history of committing to global health and international development goals, including those around SRHR, such as the Sustainable Development Goals and the Maputo Protocol. These have informed the population policies that have been produced by successive governments and make researching SRHR contextually relevant. Second, sexual and reproductive health

services are part of the provision from the Ghana Health Service, including contraception, emergency contraception, and abortion under certain exemptions. While this does not preclude structural barriers to SRHR services, it does mean that this thesis was conducted in a context where most SRHR care is part of health policy.[2] Third, existing evidence highlights the significant role that gendered norms have in shaping interpersonal and community-level health access. This includes evidence indicating that men can shape the SRHR decision-making of other people. This provides useful foundational evidence for this research to develop and advance. The final reason for Ghana as a case study relates to personal connections through familial and friend networks and relations, as well as previous research trips and visits.

In combination, these reasons made Ghana not only a useful case study, but also a study location that would facilitate the aims and objectives of this thesis. Time, budget, and resource limitations meant that conducting this research in a context where there was little or no existing information, or where SRHR was an especially socially and politically fraught topic, would be unfeasible. Furthermore, the aim of this thesis is to provide useful and relevant empirical data that would be able to contribute to ongoing community and national level policies, programmes, and interventions. Thus, a case study where there was evidence of existing commitments to universal SRHR was important.

Population and SRHR policies in Ghana

In the decades following liberation from the British colonial regime in 1957, sexual and reproductive health services, including contraception and abortion provision, have been progressively included in Ghana's health and legal policies. Ghana developed its first population policy in 1969 (Kwankye and Cofie 2015), creating a precedent for population policies to the present (Robinson 2007). This was followed by the National Family Planning Programme (NFPP) in 1970, which operationalised the rhetoric of 'modernisation' to encourage primarily women to adopt family planning (Ashford 2020). In 1985, the abortion laws were updated to legalise abortions under three conditions: (i) health of the pregnant woman; (ii) foetal indication; (iii) rape, incest, defilement. Among the more recent policies to impact SRH provision was the inclusion of emergency contraception in the health service in

[2] With the exception of abortions, which remain criminalised except for the three exemptions outlined in the thesis.

1996 (Baiden, Awini, and Clerk 2002). Levonorgestrel-based emergency contraceptive pills became available in 2000 and is available without prescription (Mayhew, Osei, and Bajos 2013, Teixeira et al. 2012). Overall, Ghana is ranked as having among best policies, funding, and access to contraceptives compared to other countries within the West African region (European Parliamentary Forum for Sexual and Reproductive Rights 2020).

To facilitate SRH access, the National Health Insurance Act (Government of Ghana 2003) created the groundwork for the National Health Insurance Scheme (Wedam and Sanyare 2017). The scheme aimed to reduce financial barriers to healthcare, including free maternal and child healthcare (World Health Organization 2021b). By the end of 2014, it was reported that 80% of Ghanaians had ever been registered under the National Health Insurance Scheme, though only 38% of the population were active card holders (Andoh-Adjei et al. 2018), and barriers, such as cost of renewal, remain (Lattof 2018b). Moreover, despite the National Reproductive Health Service Policy and Standards being updated in 2003 to include a section on 'Prevention and management of unsafe abortion and post abortion care', access and coverage of abortion care remains limited (Aniteye and Mayhew 2019, Lithur 2004).

In the most recent publicly available health policy (2020), sexual and reproductive health was only mentioned as a 'strategy' to "Encourage and promote safe and responsible sexual behaviour" (p.13), within the objective to "Encourage the adoption of healthy lifestyle" (Ministry of Health 2020, p. 11). Moreover, Ghana hosted the Accra Declaration on Universal Health (2022), signed by health Ministers from across the Economic Community of West African States. It included a commitment to:

> *Ensure that health services cover the whole spectrum of promotive, preventive, curative, rehabilitative and palliative care and ensure the package include mental health, Sexual and Reproductive Health (including family planning) and emergency services; ensure no one is left behind (especially the youth, women, children, the aged and persons with disabilities) for better health outcomes – (ECOWAS 2022, p. 2)*

Despite this, sexual and reproductive health and rights are frequently minimised in health policy in Ghana. The recent political and social conflict over comprehensive sexuality education, tied to anti-LGBTQ+ transnational movements, highlights the fraught and political nature of some components of SRHR (Peyton 2019).

Sexual and Reproductive Health Trends and Access in Ghana

Ghana has experienced a decline in fertility rate over the last four decades, though the rate varies across socio-economic inequalities and urban/rural populations (Blanc and Grey 2002, Agbaglo et al. 2022). The total fertility rate is estimated to have decreased from 6.4 children per woman in 1988 to 4.2 in 2014 (Ghana Statistical Service, Ghana Health Service, and International 2015). This has been associated with an uptake in modern contraceptives. However, only 25% of women aged 15-49 are estimated to be using a modern contraceptive method (Ghana Statistical Service, Ghana Health Service, and Icf 2018). This is indicative of women's use of a mix of different fertility regulation methods, including those less counted in demographic surveys (Marston et al. 2017). Methods include male condom use (sporadically) and withdrawal, both of which involve men.

Sexual and reproductive health service provision in Ghana has improved since the 1970s, though critical obstacles and limitations remain. SRH services are provided by a network of public, private, and non-profit providers, and often advertising and information dissemination is through private and non-profit organisations (Clements and Madise 2004, Baiden, Awini, and Clerk 2002). Contraceptive services are regionally inconsistent, with access often hampered by poor infrastructure and stock outs (Lebetkin et al. 2014). Political, economic, and social barriers, including stigma, also contribute to ongoing obstacles to accessing services (Jones 2015, Hall et al. 2018, Crissman, Adanu, and Harlow 2012, Eliason et al. 2014, Hindin, McGough, and Adanu 2014). Knowledge of available services and how to access these remains mixed, limiting the effectiveness of service provision (Rondini and Krugu 2009).

Abortion provision through the public health system remains limited. Despite lobbying and support from Ipas and MSI Choices leading to the development of the 'Standards and Protocols for the Prevention and Management of Unsafe Abortion' in 2006, Ghana Health Service (GHS) coverage of abortion through services and insurance provision remains weak (Aniteye and Mayhew 2019). In 2017, it was estimated that 4% of all maternal deaths in Ghana were caused by less or least safe abortions (Ghana Statistical Service, Ghana Health Service, and Icf 2018). Whilst this is a decrease from the 11% reported in 2010 it remains a leading cause of maternal deaths in the country (Sedgh 2010). Health care facilities that do

offer abortions rarely advertise these services publicly, limiting public awareness (Schwandt et al. 2013), and conscientious obstruction remains a critical provider-based barrier (Lithur 2004).

Gender, Power, and Sex in Ghana

Gender in Ghana has a complex history. Pre-colonial notions of gender in Akan societies constructed gendered power in association to age, with people of older ages being more powerful irrespective of their gender (Miescher 2007). Colonialism – primarily British invasion and occupation – reconstructed these gender norms to be more reflective of Anglo-European standards of gender (Miescher 2007). Although the notion of 'gender' as it is understood in research emanates from the Global North (Dery and Apusigah 2020), it has relevance when understood in its pluralistic sense and located in the cultural context of Ghana (Manuh 2007).

Gender is structured and regulated by dominant masculine norms which silence and stigmatise other masculinities (Ampofo and Boateng 2011). Over the course of history, masculine constructions came to centre men's roles as providers and 'breadwinners' (Dery and Apusigah 2020). As part of the process of transitioning to adulthood, men are typically expected to be able to provide as part of their fulfilment of their gender role (Atobrah 2017, Ampim, Haukenes, and Blystad 2020). This construction of men's gender roles as tied to financial dominancy can be complicated by the reality that many women assume the role of provider as wage earners themselves (Atobrah and Ampofo 2016). However, women are frequently made marginal, both publicly and privately (Awumbila 2006), and masculinities are often shaped on dominance over women (Dery and Apusigah 2020).

Sex, sexuality, and reproduction are all deeply tied to constructions of gender (Ampofo and Boateng 2011, Fiaveh et al. 2015). Being able to have children is important for both genders (Ampim, Haukenes, and Blystad 2020), and men are typically expected to take financial responsibility for the family as part of their fulfilment of their gender role (Atobrah 2017). Sexuality is embedded in heteronormative notions of sex, and men's virility is an important component of gendered norms (Fiaveh 2020). Men who are unable to fulfil masculine norms are often labelled with derogatory terms such as *kojo besia*, which connotates a gay/queer man (Ampofo and Boateng 2011). Sex is gendered, and norms mean that women are

expected to abstain from sex until they meet a more formal (e.g., marital), socially acceptable partner, whereas sex with casual or non-formal partners is more permissible for men (Atobrah 2017). Gendered norms and power inequalities create complex and negative conditions in which women both fear their husband's reactions and feel they need to seek their husband's approval before using contraceptives (Eliason et al. 2014, Bawah et al. 1999). This emphasises the relevance of critically examining the relationship between masculinities and SRHR in this thesis.

Thesis structure

Following this introductory chapter, this thesis is comprised of one methodological chapter, one scoping review of evidence on men and abortion, and three empirical chapters, which are either published or will be published as journal articles. Chapter 2 describes the methodological decisions and methods used to collect primary data for analysis, drawing on a published protocol (Strong 2021a) (see Appendix A for the full protocol). Reflecting the evolution of this thesis over time, the protocol's initial focus was on emergency contraception and abortion. The richness and detail of data that were captured on condom-use resulted in a thesis that was able to expand its analytical scope more broadly to focus on this third component of SRH.

Chapter 2 discusses the key concepts that inform the research design, instrument development, and approach to data collection. It outlines the development and testing of the quantitative survey instrument and qualitative interview guides, which were used to collect data for analysis. In response to the COVID-19 pandemic and the necessity to ensure that the research project eliminated any potential physical harm to researchers and participants, the chapter then outlines the changes to remote methods and the implications for the research.

Chapter 3 and 4 are linked and examine men's roles in abortion-related care. Chapter 3 is a scoping review, published in *Sexual and Reproductive Health Matters* (Strong 2022), which maps current evidence of men's involvement in abortion-related care. Chapter 4 explores the mechanisms that drive men's involvement through empirical data collected as part of this thesis. The chapter, published in *Social Science and Medicine* (Strong et al. 2022), uses qualitative and quantitative data to interrogate how men's constructions of masculinities tie to their attitudes, behaviours, and involvement in abortions.

Chapter 5[3] analyses men's involvement in emergency contraception, and the drivers and manifestations of this involvement. It examines qualitative data gathered in both interviews and through open ended questions in the survey to critically explore men's knowledge and conceptualisations of emergency contraception and how this connects to their involvement in its use. It interrogates how current biomedical and health-based framings of the 'emergency' nature of the emergency contraception pill misaligns with conceptualisations of its uses among men.

The final empirical chapter, Chapter 6[4], explores men's motivations to use (male) condoms. It seeks to trouble demographic work on condom-use that focuses primarily on the biomedical role of condoms within assumed reproductive sex. The chapter situates men's condom non-/use within a more holistic understanding of sex, critically interrogating how desires and different meanings around sex are essential motivators. The results offer insights into how contraceptive development in the future might better meet the desires, needs, and motivations to use among men.

The conclusion, Chapter 7, reflects on the theoretical, methodological, and empirical implications of this thesis. It offers recommendations for how future research might engage with men, masculinities, and SRHR based on the findings, as well as for policies, programmes, and interventions in both Ghana and more broadly in global health and international development. The chapter includes considerations on how the work might be developed to produce further analysis, before offering insights into the possible research futures that will be built from this thesis.

A note on terminology

This thesis uses the gendered language of 'man/men' and 'woman/women' throughout. This reflects the language that was used by respondents in this survey, who regarded themselves as men. It focuses on their normative experiences of masculine expectations and environments. The language in this thesis is not used to exclude the reality that people of any gender can

[3] Currently under R&R in a journal
[4] Currently submitted in a journal

and do have specific sexual and reproductive health needs and desires (Riggs et al. 2020, Riggs et al. 2021). Non-binary, gender-queer, and trans* folks all deserve the same universal SRHR, and grappling with this in a meaningful way is beyond the scope of this thesis.

Chapter 2: Methodology

*This chapter draws on a published research protocol in BMJ Open: Strong, J. (2021). "Exploring the roles of men and masculinities in abortion and emergency contraception pathways, Ghana: a mobile phone-based mixed method study protocol." BMJ Open **11**(2): e042649 (Strong 2021a). The original protocol can be found in Appendix A.*

The protocol focuses on abortion and emergency contraception (the original focus of the thesis). Data collection and subsequent analysis meant that the research scope was broadened to respond to the findings and the voices and foci of the respondents themselves. Thus, condom use became included in the final thesis.

This chapter describes the methodological decisions and methods used for the collection of empirical data for this thesis. It outlines the justifications for these, the strengths and limitations, as well as the hiring processes and training for the research team and the gathered outputs. In addition, it describes the impact of the SARS-CoV-2 pandemic (hereafter referred to as COVID-19) on the overall research design and implementation, as well as reflexively examining the positionality of the author.

The methodology chapter is divided into four parts. The first describes the original research instruments developed for this thesis. The second outlines the preparation work and research instrument piloting in Ghana. This includes the process of building a collaborative partnership with a community-based organisation and hiring a research team. The third describes the methodological responses necessary as a result of COVID-19 and the process of collecting the data. Retaining the work done prior to the COVID-19 pandemic within this thesis is important for understanding the application of the conceptual framework. The fourth and final section provides critical reflections on the methodology and methods in this thesis.

The original research project intended to use three methods of data collection: a household survey, focus group discussions, and in-depth interviews. Table 1 outlines the original

research design and the final data collection due to adaptations to COVID-19. This is further elaborated on throughout the thesis.

Table 1: Original research methods and COVID-19 adapted methods

Research method	Original plan	COVID-19 final data collection
Survey	Randomly selected household survey of men and boys over the age of 16	Respondent-drive sample survey of men over the age of 18, administered using mobile phones
Focus Group Discussions	A minimum of seven age segregated focus group discussions using vignettes, from a nested sample of men who took part in the survey	Unable to implement with COVID-19 appropriate remote methods
In-depth Interviews	In-depth interviews with a nested sample of men who took part in the focus group discussions, purposively sampled for breadth of experiences and demographic characteristics	In-depth interviews with a nested sample of men who took part in the survey, purposively sampled for breadth of experiences and demographic characteristics, administered using mobile phones

Embedding the conceptual framework into the methodology

The methodological approach in this thesis is informed by the conceptual framework, which explicitly focuses on gender, power, and sex, alongside troubling the dominance of positivist thinking within demographic research. This requires methods that centre a constructivist approach and can meaningfully capture contextual realities, the role of interactions in shaping masculine norms and expectations, and the social meanings of gender, power, and sex. The framework necessitates engaging with the role of power within the research process itself, including between the research team, between researchers and the community, and reflexively engaging with positionality within the research design, implementation, and data

analysis. The below outlines the ways in which this framework is embedded in various aspects of the methodology, which is then expanded on through the remainder of this chapter.

Research design

A mixed method approach most effectively meets the aims and objectives of this thesis and the critical components of the conceptual framework. Mixed methods are particularly helpful for research on masculinities, in which a single method approach can be limited in the capacity to capture critical complexities and nuances around social constructions, meanings, and gendered experiences (Culley, Hudson, and Lohan 2013). Through a survey and interviews, quantitative data can provide critical, broader evidence on patterns of behaviours across a community-wide sample, while qualitative data can be collected that examines men's attitudes, perceptions, and conceptualisations of sexual and reproductive health. This allows for an analysis of the complementarities, contestations, similarities, differences, and tensions between the data collected, which provide essential complexity and nuance to the thesis evidence (Onwuegbuzie and Collins 2007, Onwuegbuzie and DaRos-Voseles 2001).

The research was developed as a nested, concurrent research design, which meant that the interview sample came from the same sample as the survey respondents, and that data collection and analysis would occur concurrently and not be developed sequentially. The design maximises the effectiveness of the different modes of data collection, providing a more grounded approach to data collection that is receptive to respondents' voices (Onwuegbuzie and Collins 2007, Onwuegbuzie and DaRos-Voseles 2001). Moreover, it is more responsive to novel and unexpected data emerging. This design is the most appropriate mechanism for capturing data on the ways in which perceptions and conceptualisations around sexual and reproductive health relate to behaviours and attitudes.

The operationalisation of the conceptual framework in the preparation, design, and implementation of the research instruments is elaborated further in this chapter.

Ethical Approval

Consent was sought from both the Research Ethics Committee (REC) at the London School of Economics and Political Science (ref. 000802c) and the Ghana Health Service Ethics

Review Committee (GHS-ERC) (ref. 0104/10/19). Assent from local stakeholders in James Town, the final study site (selection described in *Part II: Preparation Work and Piloting*), including the Secretary to the Paramount[5] and from community based SRHR organisations, was also obtained.

Submissions to each ethical board included a data management plan in order to make sure that data were transferred securely and stored safely during and after data collection.

Amendments were submitted to the LSE-REC and GHS-ERC in March 2020 in light of the COVID-19 epidemic, specifically pertaining to the method of gathering consent. Approval was given 17th March 2020 (LSE ref. 000802c) and 8th May 2020 (GHS-ERC ref. 008/11/19).

Informed consent and information sheets can be found in Appendix B. The survey was administered by a team trained in research ethics and included additional information on SRHR services available in the community and on COVID-19 for any respondents who were interested. Checks between myself and each team member each day allowed for any ethical issues to be raised (none were).

[5] The Paramount was the name used to describe the community figurehead / leader. At the time of research, there was no person in this position and there was a contest for who would succeed the previous Paramount. Thus, the Secretary acted as the proxy for any approval.

Part I: Original Research Instruments

Intended Sample

The intended sample for this thesis was men aged sixteen and over. The decision was made to keep the sample as unrestricted as possible, in line with recommendations for research on men and masculinities to include e.g., unpartnered men who are typically excluded from SRHR research (Law 2019). Sixteen was taken as an appropriate age for two reasons. The first is that this reflects the age of consent for sex in Ghana. Thus, the research would include all men of a legal age of consent. The second was a feasibility consideration, as 16–17-year-olds were deemed minors by the Ghana Health Service but could provide assent towards participation in this project. Whilst it can be assumed that boys aged 15 and under might be sexually active and also have important voices with regards to masculinities and SRHR, the additional safeguarding and specific training for working with children engaging in potentially illegal behaviours (based on age of consent) were beyond the scope of this project.

Household Survey

A household survey was planned for quantitative data collection. This would have required myself and a researcher to go to a randomly selected sample of households from the study site and administer a survey to any man at the household aged over sixteen. A household survey is an effective way of sampling a population that is not categorised by their (lack of) visibility (UNDESA 2005). In other words, where the sampling frame is not seeking specific communities who are made marginal and might actively seek to be less visible, a household sample is suitable. Nevertheless, household surveys do have limits when it comes to populations made marginal in research, including men with no fixed addresses, mobile populations, and men hidden by members of their household (for example, due to shame and stigma around disability). The original research plan intended to work with disability organisations to try and ensure the research was accessible where necessary, but this was not further developed due to the later changes as a result of COVID-19 (see *Part III: The COVID-19 Pandemic*).

The sample size for the household survey was determined by demographic information provided by the Ghana Statistical Service. Detailed data on the enumeration areas in James Town were obtained. The data indicated that the total population of individuals aged sixteen and over in James Town was 10,195, of which 4,536 were men. This approximates to 44% of the population aged 16 and over being male.

Using enumeration area clusters reduced the geographical space necessary to cover and reduced the costs of listing exercises (see section *Part II: Preparation Work and Piloting*), making it more feasible for this research. It does, however, increase the standard error of the survey, and the plan was that this be addressed in the survey design and through post-survey weights (Heeringa, West, and Berglund 2017). Nonresponse was also to be recorded and weighted adjustments would have been applied post-survey in order to account for this (Groves 2009, Groves and Lyberg 2010). The impact of these was accounted for in the calculation of the minimum number of households to survey, as indicated below.

To determine the household sample size, the following formula was used, as per UN guidelines (2008, 2005):

$$n_h = \frac{(z^2)(r)(1-r)(f)}{(p)(n)(e^2)(k)}$$

Where:

- n_h = the parameter to be calculated
- z = the confidence interval level desired
- r = estimate of key indicator to be measured
- f = sample design effect
- k = estimated response rate
- p = proportion of total population accounted for by target population upon which r is based
- n = average household size
- e = margin of error to be attained

The population of interest (r) were men who are involved in some way in SRHR, taken as 0.73, based on the 2014 Demographic and Health Survey which reported that 73% of men aged 15-59 believed they should have some involvement in contraceptive use decision-making (Ghana Statistical Service, Ghana Health Service, and International 2015). Household level assumptions were based on existing work in James Town and data from the 2010 Population Census. Average household size (n) was estimated as 4.5 in James Town, and the proportion of the total population (p) as 0.28, which corresponds do the estimated proportion of people in a household expected to be eligible for this study (Tutu et al. 2019, Ghana Statistical Service 2014). Based on standard household survey assumptions and to account for potential clustering and errors (UNDESA 2005), sample design effect (f) was set at 4.0, a response rate (k) at 0.85, and 95% confidence intervals were used (z = 1.96). The margin of error was 0.1r (e = 0.1r). This gave a total estimated number of households for inclusion as 530.

Household Survey Design

The survey aimed to gather data on men's sexual and reproductive health knowledge, attitudes, and behaviours, as well as key socio-demographic and household information. The survey included: socio-demographics, household, sex and relationship, emergency contraception, abortion, masculinities, dis/ability, and space at the end for respondents to ask questions or provide any further details.

The initial design was informed by existing data collection instruments, including the Demographic and Health Survey, Performance Monitoring for Accountability (PMA) surveys, and the Promundo IMAGES survey (Ghana Statistical Service, Ghana Health Service, and International 2015, Levtov et al. 2014, Performance Monitoring for Action 2020 2020). The abridged Washington Group Questions (aWGQ) were included to allow for the capture of data relating to dis/ability (Washington Group on Disability Statistics 2016). The survey was then iterated during the pilot fieldwork period following survey design recommendations (Statistics Canada 2003, Groves 2009). This included consultation with the research team and cognitive testing and piloting with a sample of men, with questions subsequently revised and refined. Particular attention was paid to the ways in which question

order and categorical options were displayed, to try and avoid assumptions on what is 'normal' or response options that might guide respondents' answers (Groves 2009).

The survey design implemented the conceptual approach described in Chapter 1. This meant that questions were designed to avoid assumptions around categories of relationships, instead privileging men's own understandings of their relationships. Space was provided for the research team to write in their own comments, for example, if a question was troubling or elicited relevant information. Binary yes/no questions were avoided where possible and responses included the option to answer "don't know", to capture critical ambiguities. Attitudinal questions related to a partner were repeated where men had multiple partners, to capture the relational nature of attitudes.

The full survey can be found in Appendix C. The following section describes and explains each survey section:

1. Socio-demographics

The age and gender of respondents was asked in order to determine whether they were eligible for the study (originally men aged 16 and over, subsequently men aged 18 and over (see *Part III: The COVID-19 Pandemic*). Ethnicity questions used categories adapted from the DHS (2015) with input from the research team for relevance, and men could answer that they belonged to multiple ethnicities. Men's religion was captured as well as whether they were practising, to allow for a measure of religiosity. Men were asked whether they worked, what this work was, and whether they received an income or some form of payment (including non-cash payments) for this work. Finally, the section asked men about income of other members of their household and who is the main source of income. This allows for an understanding of respondent's financial role within the household.

2. Household

The household section aims at understanding what working items the household contains, including livestock and transport vehicles, what the household is constructed from, and sources of water. These are adapted from the DHS (2015) and iterated based on contextual knowledge, with the sources of water being changed to reflect community water sources

commonly found in James Town. Questions in this section were used to develop a wealth index for empirical analysis (for the variables included in this wealth index, see Appendix D).

3. Relationships and Sex

This section was developed to understand men's current relationship status, their contraceptive use, and their attitudes towards condoms. It was designed to be as open as possible to men's own definitions of what constituted a relationship, with additional questions ascertaining whether the relationship was sexually active. Men were asked about their contraception use and why they used (or didn't use) contraception, as well as their partner's use (if they knew this information). Men were asked whether they were fathers or cared for anyone like a father. This was aimed at capturing both men's biological children as well as children, relatives, or other people for whom they took on a paternalistic role. This is not unusual within the context of the community and was a decision made with the research team. It reflected a desire to understand fatherhood as a constructed identity, not one that is simply tied to whether or not a man has biological children. All decision-making questions were open ended, to allow for the capturing of multiple and varied people that men felt were involved in decisions.

4. Emergency contraception

Questions on emergency contraception were aimed to understand men's knowledge, whether they had ever bought it and who they had bought it for, the costs, as well as their attitudes towards whether emergency contraception was acceptable for their partner to buy and whether the respondent themselves would ever buy it.

5. Abortion

The abortion module was aimed at understanding knowledge, attitudes, and whether men had previously been involved in an abortion (in any capacity, in their own words). Knowledge included knowledge of the law and safety. In addition to questions on abortion acceptability in relation to a man's partner(s), this module included a series of questions in a grid that were designed to elicit abortion acceptability for a range of different familial, friend, and sexual

relationships. The aim of this was to understand the relational components of abortion acceptability to allow for greater complexity than binary measures of 'pro' or 'anti' abortion.

6. Masculinity

The masculinity section was intended to explore various ways in which constructions of masculinities could be captured. The first questions sought to capture men's constructions of manhood and womanhood in their own words. To understand relational components of decision-making and power, the next set of questions aimed to understand who made individual and household decisions. These were drawn from decision-making questions in the DHS, PMA, and IMAGES surveys, and iterated during team discussions (Ghana Statistical Service, Ghana Health Service, and International 2015, Levtov et al. 2014, Performance Monitoring for Action 2020 2020). The IMAGES Gender Equitable Men scale was used as the basis for the final panel on what factors / behaviours were considered important for a man (Barker et al. 2011). This was adapted and iterated for contextual relevance, for example, the instance of a man reporting his partner for violence related to a contextually well-known incident.

The final section (section 7) comprised the abridged Washington Group Questions.

Qualitative Methods

Focus group discussions (FGDs) and in-depth interviews (IDIs) were chosen as two complementary methods with important and unique benefits to the thesis. The two methods allow for an exploration of the differences between what men say when surrounded by other men and what men say when they are in a confidential interview environment. This was illustrated in a study of young men and abortion in the Philippines, which found that the combination of FGDs and IDIs was useful in understanding the differences between men's personal views and the impact of social and group norms on their public opinions (Hirz, Avila, and Gipson 2017).

Focus Group Discussions (FGDs)

FGDs are a useful tool to explore the ways in which gendered concepts and attitudes are constructed within groups of men, and to analyse the interactions between men as well as what men say. FGDs provide useful qualitative data on normative behaviours, as well as the opportunity to look at interactions in shaping discussions and responses (Crossley 2002).

In this thesis, focus group discussions were to be segregated by age, which is a significant determinant of social interaction and behaviour in Ghana (Atobrah 2017, Manuh 2007). The intended age categories were: 16-17, 18-20, 21-30, 31-40, 41-50, 51-60, 61+. Attention was paid to younger ages, where smaller differences in age can represent more significant differences in realities. In addition, sixteen- and seventeen-year-olds were to have a separate focus group to ensure that additional safeguarding could be afforded to them, as they are minors.

For each focus group, between 8 to 10 men who participated in the household survey would be invited to participant. This is considered an optimum group size to maximise discussions (Crossley 2002). The likelihood of some age groups being overrepresented in the household survey meant that the research planned to be flexible to additional focus groups for certain ages, of further dividing the age categories into five-year intervals.

FGDs planned to be guided by vignettes, which would be shared for discussions among participants. Vignettes can be an effective way to generate discussions in group contexts, including where respondents might otherwise feel shy or reticent to share (Barter and Renold 2000). These were short stories relating to sex and reproduction (see Appendix E). The vignettes were designed to vary with regards to the age of the protagonist, their sexual life, and the circumstances in which they found themselves. Men would be asked to put themselves in the shoes of the protagonist and what they would do, or to discuss what they thought about the vignette. Vignettes were initially developed from the work of Marlow et al. (2019), which explored abortion among men in northern Ghana, and were piloted with men in Accra (see *Part II: Preparation Work and Piloting*).

In-depth Interviews

In-depth interviews (IDIs) are a common method used to gather data on men and masculinities (Hearn 2013). IDIs provide a mechanism through which to explore particular

themes and an opportunity to gain a respondent's personal insights and thoughts on topics (Bernard 2006). In demography, qualitative methods have been increasingly used to understand attitudes and motivations, interrogating the reasons why people make certain decisions and behave in certain ways (Randall and Koppenhaver 2004). This makes in-depth interviews a particularly salient method through which to interrogate men's roles within sexual and reproductive health and particularly their perceptions and reasons for their behaviours.

The topic guide for the interviews was developed to encourage men to discuss their perceptions of gender, masculinities, and their sexual and reproductive lives (Appendix F). It opened with questions intended to create a more relaxed environment, asking about a man's life and how they are. This sought to create a conversational atmosphere and ideally encourage dialogue. The interview guide was semi-structured, designed to be adaptable so that questions would be responsive to the directions that the respondent wished the conversation to move towards. The use of a semi-structured guide ensures that while allowing for some flexibility in direction, key questions are still covered, and conversations can be steered back towards the main topics of the research.

The guide was iterated during the training workshops (see *Part II: Preparation Work and Piloting*). In addition, the workshops involved role playing between researchers to help hone qualitative interviewing skills, as well as allow me to assess researcher interview skills for final hiring. The qualitative interview guide was comprised of seven sections. These were not prescriptive, with the exception of the first section, which was to get the respondent to tell us about themselves, their livelihood, and how they were feeling. The other sections could be switched and questions asked in different orders, depending on the flow of the interview. These sections covered relationships, sex, pregnancy, emergency contraception, abortion, and masculinities.

The guides were designed to prompt men to talk about their own opinions and thoughts, as well as how they felt their community saw sexual and reproductive health and masculinities, what they discussed with their friends, and whether they felt that there were differences between men and women around topics such as sex. The aim was to understand how men situated themselves within their social environments – interpersonal and community level – to be able to generate evidence on how their views were potentially constructed through

interactions. As the researcher who conducted the interviews was fluent in Ga, English, and Twi, a translated guide was not used. The final guide can be found in Appendix F.

Knowing how many in-depth interviews to hold can be difficult. Deciding when ‘saturation’ is reached is subjective, and this research follows the best practice outlined by Saunders et al. (2018). For inductive research that seeks to generate new knowledge on an existing topic – which this thesis does – saturation can be assumed when no new themes emerge within the IDI data. Such a process is similarly recommended by Onwuegbuzie and Leech (2007). Thus, I read interview transcripts as they were translated and transcribed (where not in English) and during this preliminary reading, themes were noted. Where interviews showed consistent repetition and no new themes appeared to be emerging, saturation was deemed to have been reached.

Part II: Preparation Work and Piloting

Scoping Trip

A three-week scoping trip was conducted in January 2019, during the formative phase of the thesis and prior to the commencement of fieldwork. Scoping trips are particularly useful when there is a paucity of research on a topic (Kuper, Lingard, and Levinson 2008). There are a number of important and generative studies that cover gender and sexual and reproductive health in Ghana, but fewer that focus on the nexus between men, masculinities, and SRHR. The aim of the scoping trip was threefold: (i) to conduct expert conversations with critical stakeholders to iterate the thesis aims and objectives to the context; (ii) to identify a relevant potential study site and develop a partnership with a community-based organisation; (iii) to pilot the focus group discussions using vignettes.

Expert conversations were conducted with sixteen advocates, activists, researchers, policymakers, and SRH providers in Accra. Experts were understood in their most heterogeneous sense to reflect the diverse actors involved in SRHR (Muskat, Blackman, and Muskat 2012, Darbi and Hall 2014). I made the decision was made to not turn these expert conversations into research interviews. Where interviews are more formal, expert conversations are a means to map information and have private conversations about some more political and sensitive SRHR issues that might otherwise not be captured through a research orientated approach (Bernard 2006). I identified experts through my existing networks as well as online searches, and snowball sampling helped identify further experts (Morse 2018).

Conversations indicated that emergency contraception was a current "hot topic" in Ghana, and that NGOs and providers were keen to understand more about the dynamics of its use. Moreover, men were considered to be "major stakeholders" in women's abortion trajectories. Through the expert conversations, it was evident that of most interest were men's roles within pregnancy avoidance, particularly the negotiation and use of contraceptives and abortion. This, therefore, reinforced the focus of the thesis on pregnancy avoidance and fertility regulation within the broader remit of sexual and reproductive health.

Pilot Focus Group Discussion

During the scoping trip, the focus group discussion I tested the vignettes. This allowed for both the assessment of whether the vignettes might be a feasible method, as well as broader insights into the potential complexities of researching on sexual and reproductive health and gender among men. A facilitator was hired via academic networks, who was experienced in conducting focus groups, which also provided me a chance to observe and hone my own FGD facilitation skills. The test focus group was conducted in English for my benefit. Respondents were purposively sampled by the facilitator.

The focus group consisted of eight men and was structured as follows: introduction and ice-breaker questions about life in Accra; exercise where men were given paper and asked to write down what made a good man and what made a good woman, followed by a discussion; open questions on contraception, emergency contraception, and abortion; and vignettes.

Participants particularly enjoyed the vignettes, and it provided an opportunity for the group to share jokes and laugh together at some of the scenarios. Moreover, men were very engaged in the overall questions of the research. Men showed varying levels of knowledge around contraception, emergency contraception, and abortion, but overall a high level of engagement in discussing this both with the facilitator, myself, and fellow participants. This gave positive indication that the topics that this thesis covered would elicit conversation and discussion.

Study Site Selection and Collaboration

James Town, a neighbourhood in Accra, was chosen as the study site. Expert conversations indicated that it would be an area where the research topic could be useful for local activists as well as the Ghana Health Service and key experts. Key stakeholders in the community, including the Secretary to the Paramount, a key figurehead in the Ga community in James Town, expressed approval for the research to be conducted.

The majority of residents are ethnically Ga, with largely internal migration meaning that there is an increasing mix of cultural representation from across Ghana (Tutu et al. 2017). Ga communities have historically been patrilineal, compounded by the imposition of patriarchal British values during colonialism. Existing research in James Town provides important and

generative insights from which this thesis can expand, develop, and interrogate further. While constructions of gender afford women some autonomy, strong gendered norms around acceptable sex, sexuality, and reproduction remain (Atobrah 2017).

Across the neighbourhood, access to healthcare remains inequitable and overall coverage of care limited (Accra Metropolitan Assembly 2017). This includes challenges in both accessing healthcare and in public health, with recent incidences of diarrheal disease and cholera outbreaks (Abu and Codjoe 2018, Tutu et al. 2019). Despite a number of maternity-based clinics in James Town (Da Pilma Lekettey et al. 2017), the largest of which is Ussher Polyclinic, not all SRHR services are immediately visible and available – particularly abortion-related care. Evidence indicates that rates of less and least safe abortions remain high, with women often choosing to self-manage their abortions outside of facilities, often with less safe methods such as herbs, toxins and pharmaceuticals (Bain et al. 2019). In addition, partners, predominantly men, create barriers to sexual and reproductive healthcare through withholding moral support or financial resources (Bain et al. 2019).

During the scoping trip, I linked with an advocacy and activist NGO called 'Act for Change'. This was facilitated by the links between Act for Change and existing SRHR organisations and was seen as a particularly relevant partnership due to their community-based campaigns and activist theatre on SRHR. I spoke with the Director (Collins Seymah Smith) as well as Samuel Lamptey, who coordinated and developed the organisation's activities. The latter would be an incomparable support for this project and work as a paid researcher during data collection and as a co-author (see Chapter 4). Together, they agreed to support my research being conducted within the community pending the necessary community approval (see section on *Ethical Approval*), and in return I would ensure that the project collected salient data that could be utilised for future community based SRHR programmes. Post-data collection Knowledge, Exchange, and Impact work, in partnership with Act for Change, is described in Chapter 7.

Fieldwork

The main period of in-person fieldwork began in September 2019, ending in March 2020 with the COVID-19 pandemic. Fieldwork was facilitated by funds through the ESRC.

Language Training

As the study site was finalised to be in James Town, a Ga community, the decision was made for the research to be conducted in three languages: English, Twi, and Ga. This reflects the prevalence of Ga among coastal communities in Accra, that Twi is the most widely spoken language in Ghana, and the continued colonial legacy of English, particularly in the capital Accra. Studies based in Accra similarly identified that these three languages were most effective for conducting research (for examples, see (Tutu et al. 2019, Bain et al. 2019, Atobrah 2017)). Moreover, feasibility meant that hiring a research team to proficiently cover all the language groups in Ghana would be too costly. The limitations due to language are discussed later in this section.

Prior to starting data collection, I made a successful application to the ESRC to obtain Difficult Language Training for six months in Ghana. During these six months (September 2019 – February 2020) I was able to spend significant time among the community in James Town, as well as settle into Accra. Conversations with friends and with strangers made it clear that it was important to speak some Ga with members of the Ga community. People discussed the impact that Twi was having on local languages, such as Ga. Some expressed ill-feeling towards individuals who came to James Town and spoke Twi, as they felt that reciprocity was not given to Ga speakers when they left their communities and went to predominantly Twi speaking areas.

I took lessons in both Twi and Ga, with the aim to be able to hold basic conversations in each language and introduce myself. Six months is not long enough to become fluent in either language or have the proficiency to conduct complex research that requires being able to grapple with meanings of language. The intention was rather to be able to show respect to respondents and community members. This would have an impact in a variety of tangible ways, discussed in the section *Listing Reflections* below.

Strengthening partnerships and collaboration

Language lessons also provided me an opportunity to become more familiar with the cultural context of James Town, having previously spent most of my time in Ghana living with extended family in-laws in Tema, a nearby city to the east of Accra. I volunteered to help

with the activities that Act for Change was running, and Samuel arranged for me to meet various key stakeholders in the community to introduce the research. This including the Secretary to the Paramount. At the time of the research, there was no sitting Paramount for the Ga-Mashie community. Thus, the Secretary was charged with the day-to-day functioning of the community leadership. After an amicable conversation where I explained the purpose of the research, he approved my plans and for the research to take place.

Whilst I was undergoing my language training, I was privileged to join Act for Change as they conducted interactive theatre-based activism on topics of sex and consent with school-aged children. I joined them going to different schools in the community as part of their outreach. Moreover, I worked with them to obtain materials and resources – particularly condoms – to hand out during a large-scale march to raise awareness of contraception for adolescents. This was organised by Samuel Lamptey and garnered widespread community engagement through the hard work of him and his team. It allowed me to further introduce myself to the community and to talk about sexual and reproductive health.

Building a Research Team

The scale and scope of the research project required that I hired a research assistant to work with. This was also important, given my own language limitations, and the intention was that the research assistant would also be someone with whom I could discuss critical contextual nuances about the research project. Thus, I advertised via WhatsApp for a researcher to join the team. The researcher needed to be based either in or near James Town and fluent in Ga or Twi, ideally both. Reflecting the nature of research with men on sex, gender, and masculinities (Hearn 2013), it was deemed more appropriate for the researcher to be a man.

Over 80 candidates applied with their CVs, and seventeen were longlisted for interviews based on their competencies and interest in the work. As I planned to run a training workshop for shortlisted candidates to do data collection training, I was less interested in previous research experience and more interested in a connection and interest in the subject. I did not want to discount someone purely because of their prior employment, given the complexity around formal employment for many people in James Town. Interviews were conducted in James Town and all candidates were given 20 GHC (Ghanaian Cedi) for their travel expenses and a soft drink or water during the interview.

Training Workshop

Eight candidates were shortlisted and invited to take part in a paid training workshop, which would last one working week. Seven candidates took part, with the eighth dropping out due to unforeseen circumstances. Workshop attendees were paid 300 GHC for the week plus 30 GHC per diems for travel expenses and food. The workshop was held at a private space at Ussher Polyclinic, a medical facility in the heart of Ga Mashie (of which James Town is part). The training module can be found in Appendix G and was designed to develop the candidates' qualitative and quantitative data collection skills, as well as assess their values and attitudes towards SRHR through a values clarification toolkit (Turner et al. 2018).

I took notes during the workshop to help me to help me decide which person to ask to join the team. This included notes on candidates who may have shown stronger skills in certain areas but not others, as it was not necessary that the same researcher be used for both the survey and the interviews (for example). The values clarification exercise was an important mechanism to determine particularly levels of abortion stigma among participants. This was a necessary component to understand the views of the potential researchers. Given the stigmatised nature of abortion (in particular), it was important to ensure that as a research team we limited our contributions to that stigma, which could in turn shape the types of responses from and discussions with study participants.

The result of the workshop was that one person was offered to work on the project full time, one person was offered to work on the project in a part-time capacity, and one person was asked if they would be willing to work ad-hoc with the structure of their hours to be determined once the scope of the need was identified during data collection. All three accepted.

Household Listing

To map out households for random selection for the household survey, it was necessary to conduct a listing. The only available map of households in James Town at the time of the research project was from the Population Census conducted in 2010. Some of the enumeration area maps used for the census were older than that. It was likely, therefore, that

some structures containing households might have changed and would be missed if these maps were relied on. It was determined that given the dynamic and changing nature of James Town an up-to-date listing was necessary. A listing describes the process of mapping current households in a given area, to create a sample frame for random sampling.

Enumeration areas from the 2010 census were obtained from the Ghana Statistical Service for the James Town community area. Each area was estimated to include roughly the same proportion of people. 23 maps of enumeration areas were obtained and 16 were randomly sampled for the listing. A further two were selected, one to run a pilot listing and one for piloting methods at a later date. Applicants who took part in the training workshop were offered a paid role to join the team conducting the household listing.

Defining a Household

What constitutes a household is culturally and contextually specific, varying across and within countries and regions. This thesis was informed by the work of Sara Randall and colleagues, who critically examined definitions of 'household' within harmonised demographic surveys (Randall, Coast, and Leone 2011). The survey in this thesis was not intended to be harmonised across different contexts. This allowed for the development of a definition of household that was specifically salient for the James Town community. The approach reflects the conceptual framework by reflecting the context within which the research is occurring. Moreover, it means that the household survey is able to more accurately capture the living conditions and lived realities of respondents.

Intensive discussions with the research team around what different people considered a household allowed for the development of a new definition. This was also informed by existing research conducted in the community, particularly work by Tutu et al. (2019). One team member indicated that, historically, houses in James Town were based on families, of which there would be a clear overarching head (the eldest male or female). However, the challenge was that with shifting dynamics and lack of space, families have splintered, tenants have arrived, and a definition based on the eldest person in a compound / family unit would create fewer households of a much greater size. Other members of the team rejected the idea that the head of their family was the same as the head of their household. One individual gave the example that they lived with their brother in one room but would consider themselves as

independent of each other and, therefore, as separate households – they simply shared the same space. Another discussed how a compound doesn't mean a household; they lived in a compound with other members of their family, but they are in charge of their own provisions e.g., bills.

The definition of a household was taken to centre around all those living under the same household head. The household head, in turn, was determined as the person who was in charge of ensuring that all members of the household were provided for. This is not necessarily the same as the person who actually provides i.e., the household head ensures that members are being fed, but does not necessarily cook or buy food. This definition of a household was similar to that used in the 2010 census, which defined a household as "a person or a group of persons, who live together in the same house or compound, share the same house-keeping arrangements and recognize one person as the head of household" (Ghana Statistical Service 2010, p. 26).

Conducting the Listing

Men who took part in the training workshop formed the research team for the listing. This included the successful applicants who would continue as researchers during data collection. The team were divided with the majority of researchers obtaining information about each household and who lived there, while one researcher drew a map of the area with numbers to correspond to each household, and a 'chalker' marked in chalk each structure with the relevant household number. This meant that the households could be re-identified for the survey.

In total, approximately 2,500 households were listed in the enumeration areas that would be used for the study. During the listing, a small sample of households were cross-checked to ensure that there was consistency in household members and no households were missed. A random number was generated for every group of ten households, and the household that corresponded to the random number (between one and ten) was double checked. Some structures were removed from potential cross-check reviews because listing assistants found that the residents were aggravated at being asked questions and close to refusing to help; the decision to remove some structures from cross-check reviews was necessary to keep central the safety of the team and respect the wishes of the residents being asked questions.

Two cross-checks that were conducted showed differences (the remainder were consistent between the initial listing and the follow up cross-check). In these instances, half of the structures in that block were randomly selected for re-listing by the whole team. This was to check whether there had been a systematic inconsistency for the entire enumeration area. The first of the two inconsistent cross-checks was specific to the household selected, as the re-listing found all other households were consistent. This meant that we could bring together the two listings (the initial and the cross-check) together and discuss where the inconsistencies lay. We checked these with residents of that household. The second problem was due to rooms that were on the exterior of households being systematically missed. This was discovered during the re-listing, so the enumeration area was re-listed in its entirety.

Listing Reflections

The definition of household developed for this research was not perfect, and where the definition appeared to conflict with what a researcher was being told by a resident, a discussion would take place to find a solution. Two such incidents included a woman who saw herself as financially separate from her husband but conceded that he was in charge of ensuring that she was provided for (therefore taken to mean one household), and an older man who saw himself as head of his son's household, in conflict with his son's role as ensuring provision for his household (taken as two separate households and a difference due to family head versus household head).

On very few occasions, where residents in other households in the same compound were all out, we relied on neighbours to provide information. This was normally relatively straightforward; given the proximity of the rooms in the compound it was assumed likely they would know their neighbours. Often the absent residents returned while we were still in the enumeration area and could be asked directly. On one occasion a dispute meant that a resident refused to provide any information on their neighbours. Multiple revisits at different times of the day and on different days meant that we were able to map out the other households.

We also listed a coastal area that comprised of informal settlements and had a local reputation as being where sex workers, drug sellers, and other marginalised groups would move to. The

area had an extremely negative experience with state machinery, with household structures routinely being destroyed by police and ongoing threats of being cleared from the area.[6] In other areas of the listing, there were some residents who wanted reassurances that we were disconnected from the government – for example that we were not counting households for the purposes of initiating a tax. In this coastal area, the need for these reassurances were heightened. As a team sensitive to these complexities, we were able to list effectively and spent longer in the area to allow for any questions.

Being an oboroni / borofoni [foreigner / white person] meant that I attracted attention. This was understandable, particularly as we were also seen to be 'counting' people. While supervising, I made myself as available as possible to sit with anyone who wanted to talk to me and understand more about the project. This proved a useful way of helping to reassure people that I was not working for the government or seeking to count them for negative purposes and to discuss the research to make people aware that I would be working in the area over the next few months.

The ability to speak (very) limited Ga was particularly important; some residents made it clear that they would not have responded to our listing had we approached them in Twi. Speaking Ga also helped connect and break any tensions with residents. In one instance, a group of women wanted to know all the research team's Ga names (a way of assessing our connections to the community). The tense atmosphere surrounding my presence was eased when I was able to introduce myself in Ga, which generated much laughter (at least in part on account of my terrible accent and obvious speaking errors) and a lively discussion about when I was going to be given a real Ga name. However, my lack of fluency meant that I was limited in how much I could converse and explain the research to people. Invariably, my presence impacted the experience and process of the listing and it is unknown whether it might have meant that certain households limited the information they told us. Our overall listing suggests a comprehensive covering of households and individuals within these.

Survey Iteration and Piloting

[6] Since the fieldwork took place, the homes in this area have been destroyed and the groups and communities living there forced to move.

With the final research team (described in the hiring process above), the survey was translated into Ga. This was an iterative process, particularly working through questions where translations of concepts were complex. The decision was that questions would be finalised first in Ga, and the Twi and English versions would be developed from the Ga. The aim of this was to design a survey that was grounded in the primary language of the community, thus meaning that non-primary languages would be adapted. This was a way to mitigate a survey that manipulated Ga to match assumptions and concepts derived from English. This was particularly helpful for questions that related to social concepts such as relationships and gender.

This process of translation was also extremely helpful for questions relating to sexual and reproductive health methods. In particular, the phrase "emergency contraception" has no transliteration. Both Ga and Twi translations of emergency contraception are the descriptions of its use – a pill taken after sex to avoid a pregnancy. As this survey was attempting in part to understand men's knowledge, I felt that this would generate misleading responses, as respondents answering the English survey would be given the biomedical phrase whereas the respondents answering the Ga or Twi surveys would be given a description. Though the aim was to centre the Ga language in the survey, 'emergency contraception' is a phrase used in contraceptive policy and provision, the decision was made to test men's knowledge of the biomedical term before asking men whether they had ever heard of a pill that could be taken after sex to prevent a pregnancy. This allows for an interrogation both of men's knowledge of emergency contraception as a phrase as well as the method itself (see Chapter 5).

The survey was piloted in Ussher Town, a neighbourhood bordering to James Town but not included in the household survey enumeration areas. This was purposeful, as Ussher Town has a similar community context to James Town, but pilot respondents would not be at risk of being re-surveyed in the final household survey. The survey pilot had four purposes. The first was to conduct cognitive interviewing with respondents to see whether the current questions made sense to them (Beatty and Willis 2007). The second was to speak to respondents about questions or considerations that were missed in the survey that they considered relevant. The third was to test the approximate timings of the survey to ensure that it was not overly long. The fourth was an opportunity for me to work with the research team to develop their own and my survey interviewing skills and techniques.

A total of 39 men were interviewed for the pilot and cognitive testing over a period of four days. Men were given five Ghanaian Cedis (GHC) in compensation. I purposively selected men to cover a range of ages, in order to test interpretation of questions across life experiences. They were men who we met while spending time in Ussher Town and who consented to take part in the survey. Surveys were printed and filled in using pens. The research team would ask men the survey questions and ask them to talk through their answers. They would probe in cases where responses that seemed misaligned to the original question intent to understand more about how a respondent understood the question. I circulated between each member of the research team to also observe how they interacted and communicated with respondents and to be able to reflect on the survey responses immediately after completion. At the end of the first day, surveys were iterated to reflect the pilot. The new survey was piloted the following day and iterated again that evening. On the final day, I focused more on working with the research team on survey technique and we focused less on cognitive interviewing.

Survey Pilot Results

Men who were surveyed in the pilot showed no reticence to talk about sex, emergency contraception, or abortion. Surveys usually lasted between 40-60 minutes on the final day (when cognitive interviewing was deprioritised), which was the desired length. When asked during the piloting, one respondent requested that we include a question on sexual performance within the Washington Group Questions. He thought it was important, reflecting on his own struggles meeting expectations of sexual performance. This question was added to the survey and elicited no pushback when piloted the following day, so was kept. A challenge of the surveys was that men, particularly older men, wished to speak longer and therefore as a team we worked closely on how to be respectful to elders while also moving the survey along. The decision was made to estimate more time post-survey, particularly if the respondent was older, for discussion.

The pilot led to a number of changes and adaptations to the survey instrument (a table of changes can be found in Appendix H). The order of questions had an effect on how respondents answered. To avoid being prescriptive, we asked men if they were in a relationship. This question elicited confusion regarding to what is defined as a ‘relationship’. Moreover, as the question followed questions on whether the respondent was religious, a

number of men in the first day of piloting understood this to be about their relationship with God and their church. Thus, the question order was changed and re-tested, and responses showed a consistent understanding that this referred to intimate or sexual relationships. The pilot and preparation finished March 13, 2020. Data collection was set to commence on March 16, 2020.

Part III: The COVID-19 Pandemic

This part of the methodology draws on the research protocol published in *BMJ Open*: *Strong, J. (2021). "Exploring the roles of men and masculinities in abortion and emergency contraception pathways, Ghana: a mobile phone-based mixed method study protocol." BMJ Open **11**(2): e042649.*

Everything Changes

The COVID-19 virus had begun to garner global attention in the early stages of 2020. Whilst many governments sought to play down its effects, conversations with colleagues at the London School of Economics who work in global health and infectious diseases made it clear that this likely would be serious and potentially long-term, with the WHO categorising it as a pandemic March 11, 2020.

On March 12, two cases were confirmed in Ghana. Both of these cases had originated from overseas – one form Norway and one from Turkey. There was a noticeable shift in Accra; street sellers sometimes steered clear of white foreigners (e.g., Europeans) as increasing numbers of infections in those countries was being reported.

While little was known about the exact modes of transmission, it was clear that human contact was critical. A research project that involved going in-person from house to house, focus groups, and interviews necessitated close contact and carried unreasonably high risks. As a I was living in a building with Ghanaians and Europeans, many of whom travelled frequently, my risk of contracting COVID-19 was higher than many others.

On Sunday, March 15, I spoke with my PhD supervisors and we agreed that I needed to return to the UK. LSE then sent out a similar directive for students and faculty researching overseas. That evening, President Nana Akufo-Addo banned public gatherings.

By Thursday, March 19, I was on a flight returning to the UK. British Airways (the only carrier between the UK and Accra), began cancelling all flights soon after, and on Sunday, March 22, Ghanaian borders closed.

In the interim period between Sunday and Thursday, while packing up my apartment, stacking my notes and files, saying goodbyes, I also developed a new methodology that would allow the research to continue in ways that mitigated any need for human contact. Cynically (though ultimately realistically), I was not convinced by rhetoric that the virus would pass by summer, and thus needed to consider ways to ensure the continuation of the research that fundamentally and unwaveringly centred the principle of 'do no harm'.

I would not return to Accra until January 2023.

Methodological adaptations

The safeguarding and protection of people's health and wellbeing was more important than this research project. No research is ever more important than a person's life. Given the need to adapt research methods in the four days between the decision to leave Ghana and my flight (which was one of the last to depart before the borders closed), it was apparent that remote methods were the only way to ensure COVID-19 safe data collection.

Different technologies allow for different modes of data collection. Ultimately, mobile phones presented the most viable option for the study context. Mobile phone use in Ghana has risen (Porter et al. 2016), with an estimated 94% of people living in urban areas having shared or individual ownership of a phone (Zupork Dome, Adu Duayeden, and Armah-Attoh 2020). These phones are predominantly "yam" phones (non-smart phones).

There are a number of different approaches to telephone-based surveying. For this research, the most appropriate methods were for a researcher to ask survey questions over the phone and record answers on a computer-based survey form, and for in-depth interviews to be conducted over the phone and recorded. The alternatives – self-administered surveys using smart technologies (e.g. apps) or audio-visual platforms – were rejected. These methods required greater reliance on survey literacy among respondents, connection to the internet / data services, and ownership of smart phones. Moreover, developing a self-administered questionnaire had both time and financial costs that made them unfeasible for this thesis.

As I would no longer be physically present and able to work on location on the project (calling between the UK and Ghana was prohibitively expensive), I needed to adapt the research team to increase capacity. Samuel Lamptey, hired to work on the project full time, was given additional salary and was the main liaison with me. Due to payment transfer complexities, money was sent from me first to Samuel and then to the team to cover salaries and cover costs of additional equipment as well as ensure that sim cards were topped up and had enough money to compensate respondents quickly. Nii Kwartei Owoo and Nii Kwartelai Quartey were given full time roles, compared to their previous part time and ad-hoc roles. Steven Foster, who participated in the research workshops, was recruited to conduct remove data checking (see later in this section). Budget that would have been used for my housing during fieldwork was reallocated to salaries, as I managed to recoup some funds from leaving my apartment in Accra early.

The necessary equipment was bought: mobile phones for each team member, sim cards for the three major networks (MTN, Vodafone, AirTigo) as this would reduce the costs of conducting the research and ease of transferring compensation to respondents, headsets, and recording equipment. Encrypted USB devices were used to store project data, which was then deleted once shared with me via a secure cloud-based software. Data management and security followed the protocols outlined in the LSE Data Management Plan, approved as part of the LSE and GHS ethical approval.

Respondent-driven sampling

Conducting a household survey was not possible, and there was no existing sampling frame that could be used randomly sample men via mobile phones. Using mobile company data was too expensive and would have required negotiating access with multiple phone networks. Respondent-driven sampling (RDS) was first conceptualised as an alternative to snowball sampling for populations less likely to participate in research or for whom there was no reliable sampling frame to conduct a simple random sample (Wejnert et al. 2012, Volz and Heckathorn 2008). As there are no appropriate existing methods to identify men through socially distanced, mobile phone means, RDS was considered suitable. It relies on a peer-referral system in which pre-existing relationships are utilised to create chains, with the intention of referrals from peer to peer eventually spread to the point that the final respondents are not known to the initial respondents.

RDS has historically been used for populations who are hidden / hide due to social and political contexts, as well as individuals who are harder to reach due to their residence type (Decker et al. 2014). It uses the concept of 'seeds', individuals who are selected as people belonging to the particular group of interest. Seeds are approached to take part in the research and are then asked to refer on members of the same community of interest who belong to their personal network. As recruitment through referral continues, it creates a chain-referral effect. If done successfully, the sample will reach 'equilibrium', which is the point at which the chain has continued long enough for new recruits to be independent of the original seeds (Abdul-Quader et al. 2006). Due to the ability to calculate selection probabilities, RDS is a probability sampling method (Magnani et al. 2005). This is achieved through systematic and sequential questioning of respondents about their self-reported social network size (Decker et al. 2014).

Four key elements are required for effective respondent-driven sampling:

1. The recruitment networks must be tracked and documented;
2. Recruitment must be limited per respondent;
3. Personal network information must be gathered;
4. Recruiter and recruited must have a pre-existing relationship.

(Magnani et al. 2005).

RDS has traditionally used 'coupons' in order to fix the number of people a seed / recruiter can refer (Magnani et al. 2005, Johnston and Sabin 2010). This aims to reduce undue influence by some recruiters over others (e.g. those with larger social networks), and elongate the 'chains' of social networks, encouraging greater reach across populations (Magnani et al. 2005, Johnston and Sabin 2010). Participants are then typically compensated both for participating in the study and for providing new recruits (Lattof 2018a).

RDS Survey Considerations

The original population of interest in this study was men aged over 16. However, because 16- and 17-year-olds are minors, parental /guardian consent was required. In addition, the study originally had aimed to incorporate d/Deaf people who could communicate with sign language through partnering with a local sign language interpreter. The use of mobile phones

no longer made the inclusion of these groups possible. In particular, it was not possible to ensure that assent/consent was given and that minors were provided a safe and secure environment to answer questions away from parents or guardians, nor was it possible to ensure adequate quality communication services (e.g., sign language interpretation) for people who needed them.

The sample was thus amended to include men aged over 18 who could provide verbal consent, to be recorded by the interviewers, as per the approved IRB amendments submitted to the LSE-REC (ref. 000802c) and GHS-ERC (ref. 008/11/19). Information sheets were read in either English, Ga, Twi, or a combination as per the respondents wishes, and then the informed consent sheets were read out and respondent answers to each checkbox recorded, alongside their verbal consent (see Appendix B).

Seeds and Recruitment

A recruitment matrix was developed (Table 2). I decided that the seeds should be stratified based on age, ethnicity, and location to reflect existing evidence and observations of the most common factors determining relationship network (Atobrah 2017).

Table 2: Sampling matrix for RDS seeds and interview respondents

Age Group	James Town North		James Town South	
18-24	Ga	Non-Ga	Ga	Non-Ga
25-39	Ga	Non-Ga	Ga	Non-Ga
40-59	Ga	Non-Ga	Ga	Non-Ga
60+	Ga	Non-Ga	Ga	Non-Ga

The research team were allocated different age groups – one researcher sought seeds aged 18-25, one sought seeds aged 26-39, and one sought seeds aged 40+. The decision was made to combine the two older age groups due the smaller population aged 60 and over. Men who had large networks or had experience working in jobs that created large social ties – such as working in large teams, or as a barber or other trade in which they had contact with lots of other men – were desired seeds. The research team were able to build on their knowledge as members of the community to identify who these men might be.

All respondents who took part in the survey were compensated 5 GHC, through a mobile credit transfer.[7] Each respondent was asked to identify a maximum of three referrals who belonged to their personal network and met the criteria of Question 4 of their personal network size (see below). Respondents were asked to provide referrals with the mobile number of the researcher or provided the number of the referral to the researcher, in order to call and arrange an interview time. Even if initial contact was made by a referred man, the interview was always conducted with the researcher calling, in order that the respondent did not assume the costs of the phone call. Each respondent was given a code that they would pass onto their referral, in order for me to track the referral process and link the RDS chains. For each additional referral that generated a survey, the respondent who made the referral was compensated an additional GHC 2.

A module was added to the end of the survey to calculate a respondent's personal network size. This was necessary information to provide subsequent weighting of the final sample for analysis and was based on the questions developed by Decker et al. (2014):

1. How many [age category] do you know in James Town?
2. How many [age category] do you know in James Town that know you?
3. How many [age category] do you know in James Town that know you and that you have seen in the past two weeks?
4. How many [age category] do you know in James Town that know you and that you have seen and talked to in the past two weeks?

[7] Mobile credit transfers were both cited as preferred compensation by men themselves, but also were able to be sent without any in-person contact, suiting the COVID-19 adaptations of this research.

Answers to the final question (Question 4) were taken as the respondent's personal network size, as it was from this group of people that respondents were asked to recruit.

Remote data checks

Being based in London meant that I was not able to conduct any data checks in person, to ensure that the surveys were taking place and not being fabricated. The need for data-checks was in response to concerns raised during a review process of PhD projects at the LSE.[8] To account for this, a fourth research assistant (Steven Foster) was hired on an hourly rate to conduct a quality check. This involved a random respondent within each complete set of ten surveys being selected and recontacted. In the recontact, the respondent was asked a small subset of questions. Their responses would be matched against the original survey to check that they were consistent, and the respondent would be compensated an additional GHC 3 for taking part. The checking process took no more than ten minutes.

Initially, the intention was to ask respondents questions relating to their household structure materials and their education, as these were considered to be the most likely to remain static. However, it become clear that these were subject to variation, particularly as men's living arrangements could change due to the nature of moving around the community for work and personal reasons. As the purpose of the checks was to ensure that men were being contacted by the research team, it was instead decided that respondents would be asked their name, the code they were provided when they were referred, and the researcher who spoke to them.

The quality checks were conducted by Steven, who was not involved in the primary data collection. Once the survey period ended, in order to expedite the process, the main researchers were also paid to conduct data checks, in which I provided each of them with a list and ensured that no researcher was checking their own respondent. There was no evidence of fabricated respondents.

Calculating a new survey sample size

[8] This was not a reflection on the incredible work done by the research team but a bureaucratic concern.

Sample size estimation for RDS is complex and there are numerous discussions around what constitutes best practice for estimation (Lattof 2018a). The most frequently used method for calculating estimated sample size is to take the simple random sample size and multiple by a design effect ($deff$) (Salganik 2006), using the formula below:

$$n = deff \cdot \frac{P_A(1 - P_A)}{\left(se\left(\widehat{P_A}\right)\right)^2}$$

Where:

- $deff$ = the design effect
- P_A = the proportion of the population of interest to the broader population of men
- se = standard error

P_A represents the proportion of the population of interest. This was taken as 0.73, which is the proportion of men aged 15-59 who believed that men should be involved in some aspect of SRHR (Ghana Statistical Service, Ghana Health Service, and International 2015). The assumption was made that this holds true for a population of men aged 18+. The standard error (se) was set at 0.05.

Debate continues about an appropriate $deff$ value for RDS. The initial use of a $deff$ value of 2 has been shown to be low for most RDS studies, and even a revised value of 4 might be lower than necessary (Johnston et al. 2013). To minimise the risk of having a $deff$ value too low for meaningful analysis, the survey assumed a $deff$ of 10, as used in recent RDS studies (Lattof 2018a).

$$n = 10 \cdot \frac{0.73(1 - 0.73)}{(0.05)^2} = 788.4$$

Thus, it was determined that this survey should aim to reach 789 men.

Qualitative Data Collection

The original intention had been to pilot the interview guides, and to do practical training with the research team for interviews conducted in Twi or Ga – I would interview any respondents who opted to interview in English. COVID-19 interrupted the ability to do these pilots and training, beyond the broader training that researchers received at the workshop. The switch to mobile phones meant that it was no longer feasible to conduct focus group discussions as there was no effective way of bringing people together to capture critical data on the role of group interactions.

Conducting the interviews

As with the survey, interviews were conducted over mobile phones to reduce risk from COVID-19. Equipment was bought that allowed for the interviews to be recorded (headsets, recording equipment, secure encrypted storage devices). The recording equipment plugged directly into the mobile phone that the researcher was using and was connected to a headset, which meant that the interviews were not audible for others to listen to. Men were compensated 10 GHC for participating in the interviews.

Respondents were purposively sampled, selected by me to represent a range of different ages and SRH experiences based on their responses to survey questions. In particular, I sought to include men with different sex and relationship histories and experiences, and varying involvement (including non involvement) in emergency contraception and abortion. The seed matrix was also used to aim to have a non-probability sample of men from a range of ages. Men had been asked in the survey if they would be happy to be considered for a follow up interview and any men who responded they wished to not be contacted were not evaluated for purposive sampling. Men were called and an interview date and time was chosen that suited them. For some men, interviews took place across a number of sessions, either because mobile phone signal was bad or because they were busy and could offer limited time periods.

The intention was that the interviews would be piloted. However, with the changes due to COVID-19, this proved more complicated. As such, I asked that the first interviews were conducted in English. This allowed me to listen to the interviews and provide feedback to the researchers about their interviewing techniques and to ensure that the researchers were comfortable with the guides and probing the relevant topics. This decision was made in lieu of being able to formally pilot the materials due to COVID-19. The English interviews were

high quality with rich discussions and thus were included in the final sample, having been purposively sampled using the same process as future interviews.

Qualitative Translation and Transcription

A translation service used by the Regional Institute for Population Studies (RIPS) at the University of Ghana was hired to translate and transcribe interviews (identified via professional connections to RIPS faculty). Confidentiality agreements were signed, and I discussed with the translator and transcriber that I wanted to keep any language in brackets that either could not be translated easily or related to sexual and reproductive health, in order to be able to capture as closely as possible the meaning behind men's responses.

Initially, the plan was that a proportion of the interviews would be back translated to ensure consistency. However, a number of interviews were returned with areas where the translator could not hear what was being said properly. A member of the research team fluent in all three languages, who helped translate the survey and interview guides, then reviewed the original recordings and updated the interview transcripts where possible. This included adding context or qualitative information in brackets to indicate sub-text, to clarify meaning, and to explain a complex translation.

Part IV: Critical Reflections

Data collection was completed in January 2021, having commenced in June 2020. The survey took place between June and November 2020, with qualitative interviews conducted between August 2020 and January 2021. This was longer than expected, and reflects the realities of data collection, particularly using mobile phones (discussed below). Budgetary constraints meant that the decision to have a larger research team and the slower process of data collection limited the length of time data collection could continue. However, a significant volume of data was collected that allowed for rich, in-depth analysis.

Sample size limitations

A total of 306 men were surveyed (including 26 seeds), with 296 finishing the survey (a completion rate of 97%). This was more seeds than originally anticipated and reflects a lack of 'germination' of some of the referral chains (few or no men were successfully referred). Thus, new seeds were sought. In addition, 37 men were purposively sampled for interviews. These survey and interview numbers reflected the realities of the methods change. Mobile phones presented a novel mechanism for data collection in this context. Particularly, it afforded men more autonomy to decide the conditions of their survey or interview – particularly deciding the time and place – and more power to leave or shorten the survey or interview. This positive increase in respondent autonomy meant that it was harder to schedule multiple surveys in the same day, as delays and time changes were common. Thus, the period of data collection was longer and would have been prohibitively long to collect enough responses to meet the ideal sample size.

The method change also meant that geographic boundaries were blurred. While it was desired to survey only men in James Town, using social networks meant that this was harder to maintain. Moreover, men with multiple living locations were harder to categorise as living in James Town. Thus, the decision was made that the survey would include men who spent the majority of their time in James Town, whether working, socialising, or living. This was taken under the assumption that these men would be influenced by and influence the cultural and gendered community context. This undermines the assumption made in the sample size estimation that was based on census data of the James Town population. It was not possible

to assess whether the men had participated in the pilot, though no respondents included indicated when asked that they had been contacted by the research team at another time.

These considerations meant that the final survey sample was not large enough to be representative or make inferential claims about the general population of men in the community, though it still allowed for analyses of the sample itself. With the sample size of 296 completed interviews, the design effect of the estimate would need to be reduced to 3.88, from 10. While a higher design effect is recommended for making stronger inferential claims, this is close to a *deff* of 4 that has been previously recommended for RDS to conduct meaningful survey analysis (Salganik 2006, Wejnert et al. 2012).

Reflections of data collection

Overwhelmingly, the research showed men's willingness to talk openly about sexual and reproductive health. Surveys with older men sometimes lasted twice as long as those with younger men, due to the stories that they shared. These were too long and complex to be captured in a survey instrument but highlighted just how significant creating the spaces to talk can be. Men also shared detailed and sometimes personal information, even when not being asked about these directly. This included men giving additional details about their sexual and reproductive experiences, which were able to be captured using the open text response options in the survey instrument.

Navigating the element of 'out of sight, out of mind' that comes with mobile phone-based research was important. Whilst I wanted to ensure that the researchers were able to follow up with interested men and complete a survey, I was aware of the need to not overburden potential respondents. I therefore created a process of follow up: no calling the same person twice in one day and no more than three times in one week. Some respondents also expressed a desire for face-to-face interviews, so that they could trust who the researcher was. The researchers were instructed to refuse politely but firmly, as maintaining COVID-19 safe protocols was paramount.

In response to the first survey question on the respondent's gender (designed to screen for any potential respondents who did not identify as men), men also outlined their sexuality. This felt significant and a positive outcome of the use of open questions. While I did not seek

to ask men about their sexuality, that men both felt that questions allowed them to express themselves and felt comfortable and secure enough to do so was significant. Though this represented only six men in the sample, it suggests that the research approach had succeeded in creating a safe environment for sharing personal information, particularly given the anti-LGBTQ+ political environment in Ghana (Acquah et al. 2023).

Mobile phone-based data collection can require different modes of reflexivity and research practice than face-to-face interviews (Irvine 2011, Holt 2010). Non-verbal communication is completely removed when using mobile phones, and thus it was necessary for researchers to verbally "check-in" on respondents during the interviews. No respondents indicated that they were finding the interviews troubling or harmful, which may reflect that as a nested sample they had already taken part in the survey and understood the broad remit of the research.

Critical Reflexivity

Throughout this research, I aimed to be as reflexive as possible to the assumptions and biases that my positionality brings with it. This reflects the necessity of remaining critically reflexive throughout the research project, as articulated by Folkes, who outlined the:

> *…omnipresence of positionality throughout the research process, from the very beginning and choosing the research topic, to the methodological choices made, analytical approach taken and theoretical underpinnings of the project – (Folkes 2022, p. 14)*

My cultural and epistemological socialisation has occurred exclusively in the British academic system. This means that I am taught to value and privilege certain types of knowledge and ways of knowing within the parameters of accepted theoretical and conceptual frameworks. This is even more so as a trained demographer, in which my learning centred around positivist paradigms of knowing 'facts'. While I cannot remove the influence of my positionality on the research project, I aimed to confront the realities of what this could mean for the research and how I might challenge my own assumptions.

Critical reflexivity emphasises that need to challenge assumptions and biases, not just recognise them (van Heugten 2004, Zempi 2016). I attempted through the research design,

preparation, and implementation phases to build in different challenges to myself. This included seeking out the voices and opinions of experts and allowing their thoughts to challenge my assumptions about what topics were relevant and necessary in the study. Partnering with Act for Change also meant that I was confronted by realities that enabled me to iterate my thinking and adapt to the reesearch context in a more meaningful way. Moreover, to reflect the knowledge, expertise, and data collection experiences of the research team, Chapter 4 was co-authored.[9] This process was led by me but was designed to allow for the research team to provide feedback, iterate the paper, and produce work that is more contextually grounded.

More direct challenges came in the process of working with a research team. Developing a survey first in English, before then translating it to Ga and reiterating the questions to primarily make sense in Ga before translating back to English, meant that certain assumptions and ideas I originally had were no longer salient. For example, while I wished to ask individuals their gender and not simply if they were men, to try and not guide a respondent's answer, it became clear this was fraught and overly complex in Ga. Where possible I sought to champion thinking that more closely aligned to the community context than to academic debates and theories, particularly those that centred around Global North epistemologies. The survey piloting was also a chance to be directly challenged as well as discuss with men the relevance of the questions that we were asking about their lives.

To try and maintain an iterative and reactive set of research tools, to maximise capturing realities, open ended questions were used frequently. This helped challenge categorical thinking, particularly allowing men to expand on questions that might otherwise have been assumed simple binary yes/no choices. It does, however, still mean using typical academic research instruments (a survey, interviews) that are founded on specific assumptions around data and evidence generation. The decision to use these academic methods reflects that the thesis aims to grapple with research and evidence production within demography and global health and international development. The thesis considers how evidence might better reflect realities but cannot and does not make claims to produce evidence able to perfectly capture these realities.

[9] The stipulations for a thesis mean that this was the only paper co-authored. As lead author, the vast majority of the work was conducted by me. Co-authorship both reflects the research team's reflections and thoughts on the draft chapter. Their thinking and their work as data collectors was invaluable and required recognition.

It is difficult to fully ascertain the extent to which my position as an ‘outsider’ and the position of the research team as ‘insiders’ impacted this research (Ademolu 2023). This is particularly because of the role of mobile phones in creating a degree of separation and anonymity between researcher and respondent. Efforts to have discussions as a team and for me to challenge my positionality were important, but these are not able to overcome the inherent nature of my role within this research and the context more broadly. The findings in this thesis are, therefore, a product of the design and will reflect some of the biases and assumptions that were not mitigated by the overall methodological approach. However, the richness and the complexity of the data, the ease with which respondents spoke with the research team, and the consistent commitment to including contextual nuance and centring relevance to the instruments mean the data are useful and provide critical insights into men’s sexual and reproductive lives.

Chapter 3: Men's involvement in women's abortion-related care

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Abstract

Men's involvement in abortion is significant, intersecting across the individual, community and macro factors that shape abortion-related care trajectories. This scoping review maps the evidence from low- and middle-income countries relating to male involvement, including male abortion providers, in abortion trajectories.

Five databases were searched, using search terms, to yield 7,493 items published in English between 01.01.2010-20.12.2019. 37 items met the inclusion criteria for items relating to male involvement in women's abortion trajectories and were synthesised using an abortion-related care-seeking framework.

The majority of studies were conducted in sub-Saharan Africa and were qualitative. Evidence indicated that male involvement was significant, shaping the ability for a woman or girl to disclose her pregnancy or abortion decision. Men as partners were particularly influential, controlling resources necessary for abortion access and providing or withdrawing support for abortions. Denial or rejection of paternity was a critical juncture in many women's abortion trajectories.

Men's involvement in abortion trajectories can be both direct and indirect. Contextual realities can make involving men in abortions a necessity, rather than a choice. The impact of male (lack of) involvement undermines the autonomy of a woman or girl to seek abortion and shapes the conditions under which abortion seekers are able to access care. This scoping review demonstrates the need for better understanding of the mechanisms, causes and intensions behind male involvement, centering the abortion seeker within this.

Key words: abortion, men, masculinities, LMICs, reproduction, SRHR

Introduction

Trajectories to abortion-related care can be complex, iterative and are affected across individual, community, national and international contexts. Men have a significant impact on the sexual and reproductive health and rights (SRHR) of others. In 1994, the International Conference on Population and Development recognised this by outlining the need for further engagement with men and boys in its Programme of Action (Basu 1996). It aimed to grapple with how men contribute to shaping the contextual conditions under which women and girls have to navigate their SRHR (Saewyc 2012). Following the Programme of Action, there was an increase in policy and programming aimed at engaging men, particularly as 'partners' in SRHR (Chandra-Mouli et al. 2019). These have been particularly focused in low- and middle-income country (LMIC) settings (Dodoo and Frost 2008, Dodoo 1998, Starrs et al. 2018)

Autonomous and free access to safe abortions remain a major concern across the world, particularly where resources and capabilities to provide safe abortion services is limited (Starrs et al. 2018, Ganatra et al. 2017). Of less and least safe abortions, 97% are estimated to occur in LMIC contexts (Ganatra et al. 2017), and contribute to higher rates of complications than safer abortions (Starrs et al. 2018). The conditions under which these abortions occur are shaped by intersecting abortion-specific, individual, and sub-/national factors (Coast et al. 2018), including structurally violent, gendered power systems (Nandagiri, Coast, and Strong 2020), that implicate men in a person's abortion-related care trajectory.

Engaging men is a critical mechanism to challenge and reshape the normative environment that shapes abortion (Ramirez-Ferrero 2012, Hartmann et al. 2016, Davis et al. 2016). However, it risks increasing men's power and control by inserting them as actors into abortion trajectories (Tokhi et al. 2018, Adewole and Gavira 2018, Sternberg and Hubley 2004). Studies among abortion-seekers have consistently referenced the role and influence of men at the structural level and the individual level (Hook et al. 2018). Evidence from the multi-country IMAGES emphasised that men were "substantially" involved in abortion decisions if a pregnancy was disclosed (Barker et al. 2011), while evidence from abortion-

seekers illustrates that a large proportion of women cite that their (male) partner was a reason for their decision to seek care (Chibber et al. 2014). This includes the potential benefits of partner involvement within care decisions, such as emotional, material, and financial support (Altshuler et al. 2021, Coast et al. 2018).

Previous evidence syntheses highlight that abortion care is linked to broader economic, social, and political structures (Coast et al. 2021, Moore et al. 2021, Shearer, Walker, and Vlassoff 2010), focused on abortion and postabortion care (Tripney, Kwan, and Bird 2013, Rogers and Dantas 2017), as well as specifically self-management (Moseson et al. 2020, Endler et al. 2019). Altshuler et al. (2016)'s systematic review on the roles of men in abortion-related care was primarily focused on 'male partners', with studies ranging across 1985-2012. Studies were excluded if abortions were done outside of legal frameworks, due to foetal indications, or where men's involvement was considered coercive. They found that male partners were involved in four areas: presence at medical facilities, participation in pre-abortion counselling, presence in the procedure room or while a partner obtained a medical abortion, and participation in post-abortion care.

The review emphasises the role of men as significant. However, considering the increasing need to engage men beyond their role as partners (Hook et al. 2018, Shand and Marcell 2021), in order to fully grapple with the normative environments and conditions under which women obtain care (Dudgeon and Inhorn 2009a, b, Basu 1996), a broader scoping review of men's involvement in abortions is both relevant and necessary.

Methods

This scoping review aims to map the recent evidence of men's involvement in abortion-related care trajectories. It understands involvement to be both direct – where men are present in the decision-making process – and indirect – where men exert influence and shape an abortion trajectory without bring actively involved in the decision-making process. This includes understanding how men have been included in research samples, methods used, and geographic foci, in order to consider how future research can develop the evidence. A scoping review is the most appropriate method, as it produces an overview of evidence rather than clinical or policy guidelines, which require a systematic review (Peters 2020). The protocol for this study is available (Strong 2021b) (Appendix I).

This review utilises the abortion trajectories framework, developed by Coast et al. (2018), in order to situate men's involvement. The framework establishes three intersecting domains that shape the trajectory of an abortion, from the decision to abort, the ability to access care, choice of method, and outcomes of care. The first - abortion-specific experiences - begins with pregnancy awareness and include time-orientated factors that shape the experience of care. The second - individual context - considers the characteristics and relations (e.g., interpersonal network) that influence whether a woman obtains abortion-related care. The final domain – (inter)national and sub-national contexts – includes the norms and contextual conditions within which an individual and their abortion are situated.

A note on terminology

Findings in this study refer to men and women. This reflects the language that was used within the included studies. It is not used to exclude the reality that people of any gender can and do become pregnant and require abortion care (Riggs et al. 2020, Riggs et al. 2021).

Inclusion and exclusion

Articles were included if they met all of the inclusion criteria: published between 01.01.2010-20.12.2019, research on humans, English language, peer-reviewed, focused on abortion, include men as the sample or evidence on men, or evidence on male providers.
The shifting landscape of abortion-related care trajectories, impacted by new technologies, methods, and legal changes, made a short publication date range suitable (Berer 2017, Broussard 2020). Moreover, the only systematic review of men and abortion included publications between 1985 and 2012 (Altshuler et al. 2016). This evidence mapping aims build on this current evidence on men's involvement, whilst ensuring the studies included are relevant to the current abortion landscape.

In preference of depth over breadth of evidence, non-article publications (e.g., published abstracts) were excluded. Studies were included irrespective of geo-political categorisation,

labelling them as either a high-income country (HIC) or LMIC study post hoc, using World Bank classifications[10].

Databases and search strategy

Five social science databases (EMBASE, PsychINFO, MEDLINE (Ovid), CAB Direct, CINAHL) were searched using a web of connecting terms, including Subject Heading terms for MEDLINE (Ovid) and EMBASE where applicable (Table 3). These search terms were designed to reflect the focus on male involvement in women and girl's abortion trajectories. The dates, language and peer-review were constrained in all journal searches. For EMBASE, PsychINFO and MEDLINE (Ovid), constraints to ensure only studies involving humans were used.

Table 3: Search terms for EMBASE, PsychINFO, MEDLINE (Ovid), CAB Direct, CINAHL

1. Abortion / pregnancy search terms	2. Gender / men search terms	3. Pathways and trajectories search terms	4. Involvement search terms
Abortion* Termination* (Menstru* and regulat*) Antenatal	Man Men Male Masculin* Adolescen* Boy*	Pathw* Passage* Rout* Course* Traject* Direction*	Influen* Involv* Support* Participat*

The * indicates truncated search terms.

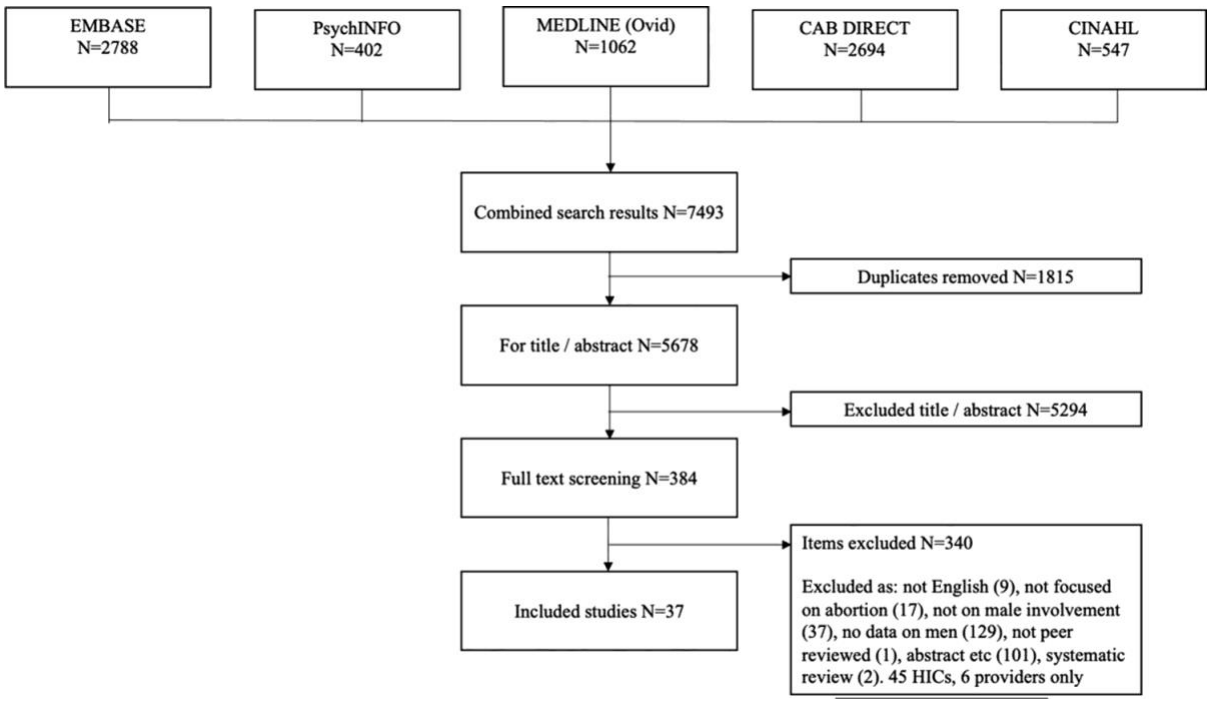
((Abortion* or termination* or (menstru* and regulat*) or antenatal) and (man or men or male or masculin* or adolescen* or boy or boys) and (pathw* or passage* or rout* or course* or traject* or direction* or influen* or involv* or support* or participat*))

The author removed all duplicates before screening the titles and abstracts (TIAB) of articles, excluding any that did not indicate meeting the full set of inclusion criteria. A full text screening of all included articles was then conducted. After a combined result of 7,493 articles, 1,815 were excluded as duplicates, 5,678 were screened on TIAB (see Figure 1). A

[10] https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

5% sub sample of studies included for TIAB was cross checked by Clara Opoku Agyemang (see Methodological Limitations)

Figure 1: flow diagram of screening process



Studies with a focus on abortion were included if they had men in the sample, or if a key finding related to men's involvement, regardless of whether the sample included men. The decision was made to be more inclusive for full text screening, to reflect that the gender of parents, partners, friends, and family members might not be specified in the abstract. 384 articles were taken from TIAB to full text screening. Of these, 9 were not in English, 17 not focused on abortion, 37 did not include male involvement, 129 had no evidence on men, 1 was not peer-reviewed, 101 were abstracts, posters, etc., and 2 were systematic reviews.

A total of 88 studies were included across geographies. The decision to separate the scoping review between low- and middle-income countries (n=43) and high-income countries (n=45) reflects the nature of policy and research within these geo-political domains. LMICs are more directly impacted by global health discourse and rhetoric, illustrated by the increasing focus on men in global health policies within these contexts – for example in the recent maternal mortality reduction initiatives in LMICs (McLean 2020, World Health Organization 2015).

Thus, this evidence mapping can engage with specific audiences and political currents that shape the research agenda in LMICs.

Of the 43 studies taken to full text screening, six of these related solely to abortion providers, which was an initial component of interest. However, the data extraction process indicated that the research on providers was less developed with regards to involvement. This scoping review, therefore, presents the results of men's involvement exclusive of men who work within medicalised spaces. 37 studies have been included for this review.

Data extraction was conducted on Endnote X9 (Analytics 2018). This followed a codebook that had categories for background information (author, date, study setting, country(ies) of study), study information (methods, sample, recruitment sites), and primary outcomes of interest based on the abortion trajectories framework (abortion-specific experiences, individual context, (inter)national and sub-national contexts). These data were extracted solely by JS. A copy of the extraction codebook is available on request from the author (Appendix J) and the abridged summary table can be found in Appendix K. A formal quality rating of the included studies was not conducted, as this is not standard protocol for a scoping review (Peters 2020). The quality of the studies is not essential when mapping the existing evidence and gaps.

Methodological limitations

The inclusion criteria reflect the constraints of the research team, and therefore, only studies in English were included. This scoping review is, therefore, limited to English-language studies and does not reflect the full scope of evidence on men's involvement in abortion published in other language or on platforms outside of the databases used.

Due to resource constraints, the majority (95%) of studies in the evidence mapping were screened by the author, with a randomly selected 5% sub-sample blind double-screened by a Research Assistant. 'Blind' refers to neither reviewer knowing the results of the other's screening until after both are completed. The purpose of this was to identify any systematic subjective biases in the screening process by the author, through emergent discrepancies in results. Within the 5% sub-sample, if minor (<1%) discrepancies were found, these would be discussed and an outcome for each agreed upon. Efforts were made prior to conducting the

screening to ensure that both the author and Research Assistant felt comfortable with the review and the process of screening, so as to facilitate a discussion space for any discrepancies. If there were major (>1%) discrepancies, or systematic differences in which the same type of discrepancy over an exclusion/inclusion criterion emerged, then a larger sample of the studies would be drawn for a second blind review. No discrepancies did emerge during the sub-sample screening.

This sub-sample blind screening process does not negate the possible bias as a result of a single author screening but does aid in mitigating these biases. Moreover, it remains possible that papers were missed due to language constraints and during the screening. A previous systematic review on men and abortion similarly identified that the lack of detail in abstracts and gender disaggregation might have led to studies being erroneously excluded (Altshuler et al. 2016). The decision to take more texts to full screening was aimed to mitigate that, as well as the need for a scoping review, as opposed to a systematic review, to allow for more flexibility in the methodological limitations (Peters 2020). Data extraction was conducted by one individual, due to constraints. It is possible that during data extraction, some data and evidence were missed, however, re-reviewing each full text for a second extraction review aimed to mitigate this possibility.

Results

The majority of studies (26/37) were qualitative, with the remainder quantitative (5/37) or mixed method / unclear (6/37). Study contexts were predominantly located in sub-Saharan Africa and South Asia. The largest sample size of the studies used Demographic and Health Survey data, which surveyed 3,848 women in Kyrgyzstan (Shekhar, Sekher, and Sulaimanova 2010) and was the only nationally representative sample used. 23/37 studies used samples recruited in or referred from health facility lists (including pharmacies, abortion providers, post-abortion care facilities). The remainder were recruited through community networks / household surveys (10/37) or from schools or universities (4/37). See Appendix K for included studies.

The results are divided into the three domains identified in the trajectories of abortion-related care framework: abortion-specific experiences, individual contexts, and (inter)national / sub-

national contexts (Coast et al. 2018). This allows for the scoping of men's involvement to be mapped onto abortion trajectories.

Abortion-specific experiences

The majority of studies (27/37) reported on abortion-specific experiences, ranging from men's direct and indirect involvement in decisions and responses to pregnancy disclosure, support for / against abortion, (non-)provision of material and physical resources, and access to abortion providers or methods.

Disclosure is a critical component of an abortion-related care trajectory, as it can impact whether and how a woman is able to obtain an abortion (Coast et al. 2018). With the exception of study of young men in the Philippines (Hirz, Avila, and Gipson 2017), all evidence on the experience of disclosure was from women who had sought abortions, or studies where men were a secondary sample of interest. Women who had either sought abortion care or post-abortion care at a facility in Lusaka, Zambia, reported that the fear of disclosure also included fear of partner interference in the pregnancy or abortion decision, and fear of repercussions from fathers (Freeman, Coast, and Murray 2017).

The fear of potential responses to disclosure also shaped the conditions under which women and girls made pregnancy and abortion decisions. A study with women aged 15-49 in Ghana highlighted how fears of being disowned, abused, or ejected by parents (not disaggregated between mothers and fathers) impacted their pregnancy disclosure and subsequent abortion decision-making (Challa et al. 2018). Women in a study of abortion care-seekers in Ghana reported that fear of disclosure, including to partners influenced their decision to self-manage (Rominski, Lori, and Morhe 2017), with women in a second study interviewing men and women in Ghana reported similar fears of disclosure (Schwandt et al. 2013). Among women in Brazil, fear of disclosing induced abortions related to their partner's potential reaction, whereas disclosure of a miscarriage led to fear of family reactions (Nonnenmacher et al. 2014). In one study, men and boys also reported fears of disclosure of a pregnancy impacting their decisions and involvement in an abortion. Respondents in a qualitative study of attitudes towards abortion in the Philippines reported that their interference and pressuring for their partner to an obtain an abortion stemmed from their fears to disclose their partners pregnancy (Hirz, Avila, and Gipson 2017).

The most common evidence of men's involvement in abortion-specific experiences was in the provision of material and physical resources. Financial provision was important in shaping the type of abortion that women obtained, as well as the impacting women's choice whether to disclose their pregnancies. 50.4% of respondents in a study in Zambia reporting that they had to involve men in their decisions in order to obtain the necessary finances to cover the costs of care (Leone et al. 2016). In a qualitative study of 112 women who had obtained abortions or post-abortion care in Zambia, women's disclosure was determined by their desires to maintain autonomy over their decision-making; for those that involved men through pregnancy disclosure, this included men paying for the cost of care (Freeman, Coast, and Murray 2017). Adolescents in a study of reproductive decisions in Mexico City reported that their partner's support for their abortions was conditional, and that the latter's provision of resources impacted women and girls' choice of abortion care (Tatum et al. 2012).

The provision of resources was also interlinked with the provision of support for/against an abortion decision. In a qualitative study of 80 women in Nairobi, men were reported as exerting pressure on the decision-making process, including giving women money to influence them to obtain an abortion, as well as some men pushing for the pregnancy to continue (Izugbara and Egesa 2014). A mixed methods study with 401 women who had obtained abortions in Ghana reported that men utilised their position as 'breadwinners' – providers and controllers of financial resources in the household – to pressure women to obtain abortions (Kumi-Kyereme, Gbagbo, and Amo-Adjei 2014).

A study of men and women living in the same household in Uganda indicated that men considered their support of abortion to primarily involve the provision of finances for medicine, transportation, food, and costs of potential post-abortion care (Moore, Jagwe-Wadda, and Bankole 2011). Evidence from men and women in Nigeria similarly found that men (as partners) provided financial, as well as emotional and material, support for women's abortion-related care, though women also reported that men would give them money as a way of expressing their own desires for a woman to obtain an abortion (Omideyi et al. 2011).

Partners were not always the main sources of finances and resources, nor supportive, and adolescent men in a study in Peru reported that their financial dependence on parents reduced their role in pregnancy decision-making, which was also reported by adolescent women in

the study (Palomino et al. 2011). An exploration of community perceptions of abortion in Kenya reported that women relied on boyfriends, as well as friends, relatives, and mothers, for financial support (Ushie et al. 2019). Moreover, in a qualitative study of 34 unmarried young women seeking abortions in India, only two reported that their partners provided financial support, with the majority citing mothers as supporting their abortion trajectories (Sowmini 2013).

Non-financial support included emotional support, accompaniment, and supporting women's autonomous decisions. Two studies of abortion experiences among 549 women in India reported that 92% of respondents were supported by their partners, of which 86% reported emotional support and 51% financial support (Kalyanwala et al. 2012, Kalyanwala et al. 2010). In Thailand, women who had experienced complications from abortions reported that finances were an important component of their partner's support, alongside emotional support, particularly accompanying and telephoning them (Chatchawet et al. 2010). A study of women in Malaysia similarly found that men provided financial support, but also accompanied women and provided moral support, including googling whether abortions were considered a sin under the Islamic faith (Tong et al. 2014).

In a study with 1,271 unmarried women aged 15-24 in China, 73-85% (variation due to multiple study sites) reported that their partner supported their abortion decisions, particularly by helping them seek care (Zuo et al. 2012). Another study of 29 women who had obtained an abortion in China found that men were able to accompany women and were involved in post-abortion family planning decisions (Che et al. 2017). An evaluation of an intervention to improve knowledge of medical abortion in Cambodia found that men learnt about abortions through newspapers and radio, with four of six men interviewed accompanying their partners for medical abortion and three accompanying for post-abortion care (Petitet et al. 2015).

Among students in six public-secondary schools in Nigeria, 26.8% of the 11% of men who knew a partner was pregnant provided assistance (Alex-Hart, Okagua, and Opara 2014). In a study with men in northern Ghana, the two main reasons given to support an abortion was for a person to finish schooling or for birth spacing – fewer men supported abortions for unplanned pregnancies (Marlow et al. 2019). Men in this study reported buying pharmaceutical and non-pharmaceutical abortion methods to support a partner's abortion, in order to keep the abortion secret from the community.

Boyfriends were among the people that women in Ghana reported obtained abortion medication for them (Rominski, Lori, and Morhe 2017), and were similarly found to be key sources of medication in a separate study among adolescents in Ghana (Aziato et al. 2016). In both studies, women reported being concerned over the safety and efficacy of the medicines. Evidence from women and adolescents who sought abortions or post-abortion care in Zambia included one adolescent reporting that her boyfriend's brother gave her correct abortion information and provided support through his medical insurance scheme (Coast and Murray 2016). In a study of medical abortion users and their partners in India, men reported accessing the medical abortion kits on behalf of their partners (Srivastava et al. 2019). However, the study also reported that key health information on medical abortion was sometimes not passed on from the partner who obtained the kit to the person obtaining an abortion.

Support from men was reported as conditional on their own desired outcomes, and studies also reported that men could be coercive in attaining these. While young women in Mexico, aged 13-17, reported in focus groups that men offered emotional support for their pregnancy decisions, they discussed that these were often in accordance with men's desired outcomes and not their own (Tatum et al. 2012). A study of women in Kenya included a respondent reporting that her husband found a provider to help him induce her abortion without her consent (Rehnstrom Loi et al. 2018). In the study, it was reported that almost all women expressed that they disagreed with their partner and feared possible consequences of their pregnancy disclosure (violence, divorce), which led them to seek care without telling their partner. However, some women disclosed their pregnancies in order to obtain financial support for care.

Individual context

17 studies included evidence relating to the individual context within which a person seeks an abortion. These focused on the partner, family, and community context shaping the perceptions of pregnancy and abortion, denial / rejection of pregnancies.

Denial / rejection of pregnancies was one of the foremost ways that studies reported the context shaped a woman's abortion trajectory. Rates of pregnancy denial could be high, with

a study of 1047 secondary school students in Nigeria reporting that 48.2% of men who's partners were pregnant had denied paternity (Alex-Hart, Okagua, and Opara 2014). A study of women who had obtained abortions in Ghana reported that being unmarried and in a partnership was a factor in obtaining abortion care, as women reported that they feared their partner could and would abandon them, resulting in their navigation of the stigma of being an unmarried mother (Schwandt et al. 2013). In a qualitative study of men and women at local universities in Nigeria, women reported that concerns over their partner denying a pregnancy and leaving them without a "responsible" partner influenced decisions to abort (Omideyi et al. 2011)

The impact of partner rejection of a pregnancy was emphasised in a study with women seeking abortions or post-abortion care in Zambia, who reported that their abortion was specifically due to partner rejection, which was also more likely among younger respondents than older (Freeman, Coast, and Murray 2017). Moreover, where women reported that their partner was present and knew of their abortion, the majority obtained safe abortions, while those whose partners were absent were predominantly seeking post-abortion care. A mixed methods study of 15 pregnant adolescents aged 15-19 in Tanzania indicated that the decision to keep a pregnancy was done despite male partner rejection and led to feelings of regret towards becoming pregnant (Mwilike et al. 2018). Of the 34 adolescents interviewed who had induced abortions in Lusaka, Zambia, 16 reported that their partners rejected or denied paternity and requested them to obtain an abortion (Dahlbäck et al. 2010). This rejection of pregnancy included withholding financial support for the pregnancy or future childcare.

The broader individual context also included the attitudes and desires of partners, as well as the living conditions and the relationships of women and girls to their partners and families. Women and girls in Nairobi, Kenya, reported that their partner's fertility desires meant that some respondents felt pressured into obtaining an abortion (Izugbara and Egesa 2014). An analysis of the Kyrgyzstan demographic and Health Survey, which had a sample of 3848 women aged 15-49, suggests that men's attitude towards abortion was significantly associated with the likelihood of a woman obtaining an induced abortion (Shekhar, Sekher, and Sulaimanova 2010). However, among 142 university students in Ghana, women reported that their own beliefs, including religious beliefs, were important in their abortion decision-making, and that their partner's and peers' views were less influential (Appiah-Agyekum, Sorkpor, and Ofori-Mensah 2015).

A study with 401 women who had obtained abortions in Ghana found that knowledge of the law, occupational status, number of children living, and level of formal education all increased the odds that a women sought consent of male partners in comparison to those that sought consent from 'others', including friends, siblings, and aunts (Kumi-Kyereme, Gbagbo, and Amo-Adjei 2014). Living with parents, particularly fathers, was associated with increased pressure to allow their involvement in abortion decisions among adolescents who had been pregnant at least once in a study in Accra (Bain et al. 2019).

Many of the studies that reported on the family context, however, did not disaggregate between type of parent or carer. While studies in Peru (Palomino et al. 2011), Ghana (Challa et al. 2018), and Zambia (Coast and Murray 2016) indicated that the relationship an adolescent or young person had with their parents and family influenced their abortion trajectory, it was not clear if male family members had differing involvement to female family members. For respondents in Peru, male respondents argued that the decisions on pregnancy and abortion were theirs, whilst others supported women's decisions (Palomino et al. 2011). Women and girls described that being younger or less informed was linked to partners taking control of decisions, in addition to describing being coerced to have an abortion by partners and parents.

Evidence also suggests that the type of relationship between partners influenced abortion trajectories, particularly women's perceptions of their partner as stable and (maritally) committed. In two studies – one in Mexico and one in Sri Lanka – the stability and perceived future of a relationship impacted the abortion trajectory. For women in Mexico, all women whose partners were not involved obtained an abortion (Tatum et al. 2012). Among Sri Lankan women, partners who refused to marry or denied paternity also had an impact on the decision to obtain an abortion (Olsson and Wijewardena 2010). In addition, respondents cited the involvement of their brothers in pressuring them to obtain an abortion, if they were pregnant while unmarried. A study of pregnancy reactions among adolescents who recently had an abortion in Ghana suggested that a partner being a student or unemployed could lead to them suggesting an abortion, and respondents also cited men's ability to deny a pregnancy as significant (Aziato et al. 2016).

(Inter)national and sub-national contexts

Seven studies reported on how the (inter)national and sub-national contexts are both shaped and maintained by men, as well as have an influence on men's involvement in abortion decisions. These studies primarily focused on the role of men in operationalising social norms around abortion in their response to a pregnancy or abortion. Community leaders in a study in the Democratic Republic of the Congo, who were all male, reported that women who sought abortions would be actively stigmatised, isolated, and/or forced to leave their communities (Steven et al. 2019). However, in instances where a women's partner was abusive, alcoholic, or unemployed, or where there were financial difficulties, community leaders were more supportive of abortions, as well as considering themselves responsible for post-abortion care. Men could utilise cultural norms to involve themselves in abortion decision-making. A study of the national discourses around masculinities and abortion in South Africa revealed that the 'New Man' discourse – referring to men who considered themselves committed, caring, and loving to their partners and family – was a mechanism through which men reported being supportive of pregnancies to order to dissuade partners obtaining an abortion (Macleod and Hansjee 2013).

Attitudes towards abortions that drew on, and bolstered, prevailing social and cultural norms were complex and varied. In a study of abortion in Uganda, men responded that they were generally not supportive of women having abortions, aligning their beliefs with prevailing socio-cultural norms, which shaped their decisions to provide support or finances in the event of a pregnancy (Moore, Jagwe-Wadda, and Bankole 2011). Young Filipino men discussed in focus groups how they viewed abortion as a 'sin' and that, in accordance with their normative environment, they were not supportive of women obtaining care (Hirz, Avila, and Gipson 2017). However, in-depth interviews indicated that these men considered abortions acceptable under certain conditions. Among men in Ghana, abortion was similarly labelled as a 'sin' and unacceptable by community norms, although these norms were also operationalised by men in focus groups to discuss how stigmatised pregnancies were a reason to encourage an abortion (Marlow et al. 2019).

While men in a study in Kenya were reported to consider women who had abortions as not "wife material", a norm which forced some women to relocate in order to obtain care, men and women in the study also reported that abortions were increasingly normalised in the

community (Ushie et al. 2019). Community norms could also be enacted to minimise men's involvement. In a study of parental attitudes towards induced abortion in Nigeria, mothers reported that it was a social necessity that decisions be between mother and daughter, while fathers suggested that their role was as breadwinners (Obiyan and Agunbiade 2014).

Discussion and Conclusion

Studies highlight the potentially significant – and diverse – role that men and boys can have in women's abortion trajectories across low- and middle-income settings. The evidence emphasises that men's involvement was present across abortion-specific experiences, the individual context of an abortion seeker, and the community context. This review complements broader evidence on the role of men in sexual and reproductive health, which has highlighted their ability to influence fertility and contraceptive decisions (Kriel et al. 2019, Shattuck et al. 2011, John, Babalola, and Chipeta 2015, DeRose and Ezeh 2010, DeRose, Dodoo, and Patil 2002, DeRose and Ezeh 2005), shape care seeking through financial gatekeeping (Story et al. 2016), in addition to providing positive support for partners (Sternberg and Hubley 2004). Similarly to this broader evidence on men and SRHR (Yargawa and Leonardi-Bee 2015, Kalmuss and Tatum 2007, Chikovore et al. 2002), this review highlights the diverse implications of men's involvement in abortion trajectories.

Partners – boyfriends, husbands, sexual partners, etc. – are the men who are most often included in study samples or referred to by women, mirroring the focus on partners in global health discourse (Wentzell and Inhorn 2014). However, included studies also indicated that other relations of men can be important – including fathers and brothers – as well as how men – such as community leaders – are able to shape the normative structures that can govern abortion trajectories. While parents were referenced in numerous studies, this was not always disaggregated to investigate whether there were differences between parental roles of fathers and mothers, as well as other guardians or carers.

An important component of the abortion trajectory that studies indicated men's involvement were in abortion-specific experiences. Evidence on men's involvement was particularly prevalent for abortion-specific experiences and highlighted how this intersected across experiences of disclosure and financial and emotional support. The real or perceived expectations of how a partner, or sometimes father, would react to a pregnancy had an impact

on a woman's decision over pregnancy or abortion disclosure. The most frequently reported area of men's involvement in abortion-specific experiences in studies, however, came in the control and provision of resources. This was referred to in studies across different contexts, emphasising the widespread nature of men's control of resources and finances. Women are, therefore, made to navigate the complexities of disclosing their abortion intention to possible negative reactions, or having the resources and finances necessary for transport or facility costs limited. The included studies suggest that men are integral to creating the conditions that shape the ability for women to make free and autonomous choice on their abortion intention and desired care pathway.

Studies also provide evidence of how men shape both the individual contexts and the broader environments within which women seek care. The relationship between a woman or pregnant person and their partner, as well as the age of an adolescent, impacted their decision-making and the trajectory of their abortion. Studies with a sample of men most frequently provided evidence of men's roles in shaping the broader discourse of abortion, upholding and (re)producing contextual norms. These norms create the conditions under which pregnancies can be stigmatised, resulting in women seeking abortions, or that require abortions be conducted privately away from institutions or public facilities. These norms and contexts were linked to the denial or rejection of paternity, which in turn (re)shapes the contextual conditions that impact an abortion trajectory.

It is not possible to ascertain the extent to which this indirect involvement from men, particularly their involvement in shaping the broader conditions of care, shapes the explicit choices and experiences of women seeking abortions. Few studies made clear in the evidence whether men's involvement was sought by women as part of their free and autonomous choice for care, or out of necessity for information, resources, and to make the context of their abortion more acceptable. Moreover, it is not clear in current studies the biases of the sampling frame, not only that men who are sampled often accompanied their partners and might be more supportive by virtue of this, but also that abortion experiences outside of facility recruitment are less represented.

In addition to the methodological considerations, this scoping review is limited in its capacity to synthesise evidence to make policy and clinical based recommendations, in comparison to a systematic review. However, the strength of this review is the map of evidence for where

men are currently involved in abortion trajectories. It provides a roadmap for future research, and exploration of other areas within the abortion-related care trajectories framework where men are both directly and indirectly involved. Evidence on men emerges from women's own narratives, with fewer studies included men in their sample, and fewest having men as their primary sample.

The influence that men and boys can exert can directly and indirectly undermine the autonomy of women and girls, placing them at risk of self-managing in less safe ways or accessing abortion services and methods that delineate their reproductive rights and choices. The ability of women and girls to navigate the contextual realities of abortion-related care is too often defined by men, which limits the fundamental right to autonomy and safe, legal, and free choice for people seeking abortions. Future research could consider interrogating the mechanisms, causes, and intentions that drive men's attitudes and behaviours, to better understand the conditions under which women seek abortions.

Chapter 4: “If I Am Ready”: Exploring the Relationships Between Masculinities, Pregnancy, and Abortion Among Men in James Town, Ghana

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The inclusion of the research team as authors reflects their work both in shaping the design of the research tools and in carrying out the research during COVID-19. All the analysis and the first draft and responsibility for iterating to incorporate co-authors’ feedback was conducted by me.

Abstract

The ability to exercise full sexual and reproductive health and rights is shaped by the contextual environment, meaning that women must navigate patriarchal norms when seeking care. Despite growing evidence that men are able to influence pregnancy outcomes, there remains a paucity of research on how and why men are able to involve themselves in pregnancy and abortion decision-making.

This study interrogates the mechanisms that drive men’s involvement in pregnancies and abortions in James Town, Ghana. Data from a survey (n=296) and in-depth interviews (n=37) were collected between July 2020 and January 2021. The mixed method analysis critically examined the relationship between men’s support for a pregnancy or abortion and their constructions of masculinities.

Findings framed sex and reproduction as both a facilitator and a threat to men’s masculinity. Reproduction was an essential component of being a man. Men discussed the need to fulfil masculine ideals of being independent, provide financially, and be in an acceptable relationship in order to be ‘ready’ for fatherhood. However, men similarly operationalised the notion of ‘readiness’ as the driving force behind their involvement in abortion decision-

making. As being a father without being ready could lead to social ostracism and derision, men discussed forcing their abortion desires onto their sexual partners and other pregnant people. Achieving masculine ideals, therefore, was a critical motivation for controlling women's bodies. Understanding the role of masculinities is critical in acknowledging the contextual and environmental factors that women navigate, which contribute to continued reproductive injustices.

Key words: Abortion; Pregnancy; masculinity; men; Sexual and Reproductive Health and Rights

Introduction

Sexual and reproductive health and rights (SRHR) demand bodily autonomy, freedom of choice, and access to care. Men are able to shape these conditions for women by maintaining and upholding patriarchal norms and structures through embodied masculinities (Ampim, Haukenes, and Blystad 2020, Connell 2005, Connell and Messerschmidt 2005, Lohan 2015, Shand and Marcell 2021, Wentzell and Inhorn 2014). Reproductive policies and programmes frequently individualise SRHR, placing responsibility on women, with limited acknowledgement of their lived realities (Kimport 2018). This is despite the call to interrogate "male involvement" and engage with men at the 1994 International Conference on Population and Development, alongside the recent integration of gender mainstreaming in reproductive health in the Sustainable Development Goals (Goal 5) (Shand and Marcell 2021, Fredman, Kuosmanen, and Campbell 2016).

Policy and programme-based efforts to address harmful patriarchal norms have sought to reshape rather than dismantle gendered power structures, meaning men continue to control normative sexual and reproductive environments (Almeling and Waggoner 2013, Lohan 2015, Connell and Messerschmidt 2005). Most programmes and policies have responded to the need to include men in SRHR by approaching men "as partners" (Shand and Marcell 2021, Wentzell and Inhorn 2014). This reinforces assumptions that men are at best supportive to SRHR, and not critical for its fulfilment (Greene and Biddlecom 2000, Almeling and Waggoner 2013, Wentzell and Inhorn 2014). Thus, policies continue to burden women with the responsibility of improving SRHR behaviours and health outcomes.

This is despite the role of men and broader, normative environments shaping how a person feels about their pregnancy (Macleod 2016). It is essential to understand the mechanisms that drive men's attitudes and behaviours towards pregnancies and abortion, in order to meaningfully engage with how men impact women's reproductive choice, access, and autonomy (Basu 1996, Dudgeon and Inhorn 2009a, b, Strong 2022). Men can deploy gendered power dynamics to influence and involve themselves in the SRHR of others. For women seeking abortions, studies emphasise that their sexual partners can be crucial in providing or withholding the physical and emotional support, information and resources (e.g., finances) to access care (Varga 2003, Hook et al. 2018, Freeman, Coast, and Murray 2017, Altshuler et al. 2021). A recent review of men's involvement in abortion emphasised the growing evidence, particularly from care-seekers, of men shaping a woman or pregnant individual's ability to decide their pregnancy outcomes and choose their desired care (Strong 2022).

To understand men's roles more fully, this study utilises the pregnancy supportability framework (Macleod 2016). The framework provides a lens to better understand the role of interpersonal and community level factors in determining pregnancy outcomes, including abortion. It is sensitive to how, for example, a change in partnership status, financial stability, or a community / global event, could shift a person from considering their pregnancy supportable and desiring a live birth towards seeking an abortion (Macleod 2016). This study interrogates the constructions of masculinities among men in James Town, Ghana, to analyse how and why men are involved in pregnancy outcomes and decision-making. The evidence contributes to our understandings of how to engage men in future research, policy, and programming.

Study Context

The social and economic importance of reproduction is significant in Ghana and part of gendered norms that privilege parents over adults without children (Bain et al. 2019, Atobrah 2017). Evidence shows men's involvement in fertility decision-making in Ghana, including the association between men's characteristics and their ability to influence women's reproductive decision-making (DeRose and Ezeh 2005, Pearson and Becker 2014, DeRose, Dodoo, and Patil 2002). While contraceptive acceptance and access has increased and men's and women's fertility desires have lowered (PMA2020 2017, Finlay and Fox 2013), stigma

by men towards women continues, particularly towards women who use contraceptives (Butame 2019).

Ghanaian legislation provides three legal exemptions for abortion: foetal abnormality; maternal health; rape / incest. Recent estimates suggest an abortion incidence range of 30-61 abortions per 1000 women aged 15-49 years, equating to approximately 23% of all pregnancies in 2017 (Keogh et al. 2020). Many women self-manage their abortions outside of the formal health system, and – though self-management with medical abortion is medically safe – the use of pharmaceuticals, toxins, or herbal medicines to self-manage are associated with higher morbidity and mortality rates (Aziato et al. 2016, Bain et al. 2019, Geelhoed et al. 2002, Rominski, Lori, and Morhe 2017).

Studies in Ghana emphasise that men are involved in the provision of support and finances for people seeking abortions, and can shape women's care pathways and desires to avoid formal health systems (Bain et al. 2019, Marlow et al. 2019, Schwandt et al. 2013, Aziato et al. 2016). Less is known about why men involve themselves in pregnancies and associated outcomes and how this shapes women's care.

Methodology

To generate data that could provide both depth and breadth, a multi-method, concurrent research project was designed, utilising a respondent-driven sample quantitative survey (RDS) and nested in-depth qualitative interviews. The sample site, research design and methodologies are detailed in the project protocol (Strong 2021a), including provisions that were made in response to COVID-19 (see Appendix C and F for the research instruments).

Sampling

Any man over the age of 18 who lived or whose networks predominantly were based in James Town were included. Three researchers, Samuel Lamptey, Nii Kwartelai Quartey, and Nii Kwartei Owoo, recruited 'seeds' from men they knew in the community, using a sampling matrix (Strong 2021a). A total of 306 men participated in the survey, with ten surveys (3.3%) being too incomplete to remain in the final sample. The final sample was large enough for a design effect of 3.88 which is sufficiently close to the recommended

design effect of 4 recommended for regression analysis of RDS collected data (Wejnert et al. 2012).

A total of 37 men who took part in the quantitative survey were invited to take part in qualitative interviews. Initial qualitative interviews were selected to represent a range of age and sexual and reproductive health experiences among the survey respondents, and purposive sampling carried on until no new themes were created in the interviews. Men aged over 40 were purposively over-sampled, to reflect that these men were less likely to be represented in the quantitative survey due to age disparities in mobile phone access (Zupork Dome, Adu Duayeden, and Armah-Attoh 2020).

The study was conducted in the respondent's language of choice (English, Twi, Ga or a combination of the three) and recorded. An external service transcribed these into English, which were then checked by Nii Kwartelai Quartey to ensure full meanings were captured. The original language was kept and explanation in parentheses for when idioms, colloquialisms, or concepts were used that had no transliteration.

All members of the research team were trained in research ethics, informed consent, and the different research techniques required for a survey and interviews. Informed consent was translated in Twi and Ga and read to participants, allowing space for any questions. The research team were also trained on SRHR service provision and support in the study location, in case participants requested more specific information.

Ethical approval for this research was obtained from the Ghana Health Service Ethics Review Committee (GHS-ERC 008/11/19) and London School of Economics and Political Science (REC ref. 000802c). Approval was also sought and obtained from the Ghana Health Services Regional Director for Greater Accra, and community stakeholders in James Town.

Mixed Methods Approach

Quantitative survey responses, which included open and closed questions, were read through by Joe Strong as they were collected to identify emerging themes. Qualitative interviews were also read through, and the themes that were constructed from initial readings of both tools were used to develop the qualitative codebook. Once data collection was complete

qualitative and quantitative data were read through in conjunction, to continue constructing key themes. These were used to decide which quantitative variables were of interest for the analyses.

Qualitative Analysis

The abductive approach required an in-depth understanding of key theories related to this study – masculinities and pregnancy supportability – in order to facilitate the process of going between interview observations and theorisations (Earl Rinehart 2020, Tavory 2014, Timmermans and Tavory 2012). The puzzle identified in this process was the pluralistic, incongruous nature of men's attitudes towards pregnancies and abortions.

To unpack this further, transcripts were cyclically read and re-read to create relevant 'codes' (Miles, Huberman, and Saldaña 2020). These codes were grouped into themes (Braun and Clarke 2006), analysed using Dedoose Version 9.0.46 (Dedoose Version 7.0.23). Transcripts were read by Joe Strong to familiarise with the themes, and each survey contained a feedback form for the research team to record their reflections. All of this information was then used to develop a codebook to capture key themes.

Two themes were developed in response to the constructed 'puzzle' in the qualitative data, which are presented in this paper. The first was that men's idealised masculinities were situated within a broader, unexpected construct of 'readiness', referenced across different interviews. The second theme was how this construction of readiness was explicitly tied to the plural and relational nature of pregnancy and abortion supportability among men.

Quantitative Analysis

Quantitative data were analysed using RStudio Version 1.4.1717. Volz-Heckathorn weights ("RDS-II") were applied, which used the inverse probability of a respondent being chosen based on their personal network size (Volz and Heckathorn 2008, Yauck et al. 2021). Clustering at the recruiter level was accounted for and all seeds (n=26) were excluded from analysis as required for RDS (Yauck et al. 2021, Wejnert et al. 2012).

The quantitative analysis focused on two outcomes of interest, in order to examine the relationship between reproduction and masculinities: pregnancy supportability and abortion supportability. Supportability of pregnancy was measured through the question "Would you be happy if [insert relationship] becomes pregnant now?". Responses were coded as binary for currently supportable or currently unsupportable. The question was asked in relation to men who reported currently having a partner (n=174) and repeated in relation to each partner for men with multiple partners (n=223). Logistic regressions were run for each sample.

To understand abortion supportability, men were asked whether they would hypothetically support different sorts of relationships with women obtain abortions using a survey matrix (see Appendix C for the survey instrument). A sum score was created to indicate the supportability of abortion. A response of "don't know", "no", or NA scored zero. "It depends", scored one, whilst "yes" scored two. This makes the scale sensitive to degrees of supportability – where the maximum (score=22) could be seen as largely supportive of abortions while the minimum (score=0) as consistently unsupportive. Poisson regressions were run for abortion supportability, with a full sample excluding seeds and incomplete surveys (n=270).

Explanatory variables

Age groups categories were created to allow for a reasonable sample size within each, whilst also reflecting context specific social age groups. As such, 18- and 19-year-olds were made a single group, as the differences between an 18-year-old and a person in their early twenties is likely to be greater than, for example, the differences between men in their thirties.

Men were asked to describe their sexual relationships in their own words in an open-ended question. Responses were then categorised into five variables – married; second wife / long-term partner; intimate partners; girlfriend; unpartnered. A dummy variable was made to indicate whether men had multiple relationships or not.

Ethnicity was recorded based on contextually relevant ethnic groups and then these were combined where the number of respondents was low – Akan and Asante were combined due to their historic and cultural links (Akyeampong and Obeng 1995). Remaining ethnicities – Hausa, Mosi, Ga-Dangme – were categorised as 'Other'. Current educational attainment and

whether a man was religious were also included. The latter is a binary variable, in which men who reported observing a religion were coded as religious and men who reported no religious affiliation were coded as not religious.

A wealth index was created through a Principal Components Analysis (PCA), in line with recommendations (Fry K. 2014) recommendations informed by Filmer and Pritchett's methodology (2001). Housing materials and water source were recoded to be binary higher quality materials / sources and lower quality materials / sources based on contextual knowledge of the area (see Appendix D).

Considerations

Reflections on the impact of COVID-19 and the method change to mobile-phones are outlined in the study protocol (Strong 2021a). While the sample size means that the data gathered are not representative, James Town was purposively chosen as a study site in part because it represents an area where access to care is more limited, and where more people seek informal than formal abortions. Thus, it is a community that can be informative for similar contexts.

The evidence relies on self-reporting and, therefore, must acknowledge the impact of social desirability, sensitivity, and bias in men's answers. However, mobile phone methods and the lack of spatial and temporal limitations on the data collection tools (respondents could stop and restart easily or hang up without cause for concern about leaving the interview space), allowed for greater respondent control of the data collection process. Men's answers were detailed and the provision of sensitive information around sex, sexualities, and reproduction suggests that men were largely comfortable talking on the phone.

Reflexivity

This study was conceptualised, funded, and led by a researcher in the Global North, situated in an institution in London. To mitigate the creation of an extractive research, a scoping trip was conducted and a partnership with a local organisation Act for Change was developed.

Along with a rigorous training and hiring process to build a research team of men from the James Town community, the trip and partnership was used to develop a study that would collect relevant and useful information for practitioners, advocates, and activists in Ghana. The research tools were drafted by JS and workshopped with the research team to discuss meaning and relevance. Cognitive survey interviewing with men (n=39) in a nearby community was used to iterate the tools and make them contextually relevant.

Due to the pandemic, JS was not able to conduct any primary data collection from the UK. Therefore, the respondents were talking to a research team from their own area. This could result in the potential for 'insider' influence on the responses. Operating strict confidentiality, and the use of mobile phones, allowed for separation between the respondent and the researcher. Moreover, the interest in normative environments and the constructions and presentations of masculinities means that even if respondents provided socially desirable answers, these were useful for our analysis of the expectations and the perceptions of critical concepts.

Sample Description

Table 4: Study sample characteristics

		Quantitative	**Qualitative**
N		**296**	**37**
		N (%)	N (%)
Seeds		26 (9)	-
Age	18-19	43 (15)	7 (19)
	20-24	108 (36)	7 (19)
	25-29	69 (23)	6 (16)
	30-39	33 (11)	7 (19)
	40+	43(15)	10 (27)
Education	Primary	23 (8)	5 (13)
	Middle	90 (30)	14 (38)

	Senior	144 (49)	14 (38)
	Higher	39 (13)	4 (11)
At least one occupation	Yes	164 (55)	23 (62)
	No	132 (45)	14 (38)
At least one partner / relationship	Yes	200 (67)	31 (84)
	No	94 (32)	6 (16)
	Don't know/Did not answer	2 (1)	-
Currently a father / guardian / carer	Yes	114 (39)	19 (51)
	No	182 (61)	18 (49)

51% of respondents (n=151) were aged under 25, which might reflect a combination of both the sample method – using mobile phone technology and the research team's personal networks – and the relatively youthful age structure of Ghana, with an estimated 58% of the urban population aged under 25 (Ghana Statistical Service 2014). Most respondents had at least one current relationship, of which around half described having a 'girlfriend', and roughly a third of respondents were a carer/parent. Approximately half of respondents had some form of work. The characteristics of this sample are broadly comparable with general socio-economic and demographic characteristics at the national and regional levels (Ghana Statistical Service 2014, Ghana Statistical Service, Ghana Health Service, and International 2015).

Results

Men's constructions of masculinities had an explicit and direct impact on their attitudes and behaviours towards pregnancies and their outcomes. This was evidenced by the emergence of two key, linked themes during analysis. The first theme ties together evidence on how men construct their masculinities. It unpacks the relationship between masculinities, sex, and fatherhood, the concept of 'readiness' in men's narratives, and perceived consequences of failure to fulfil masculine norms. Quantitative evidence on pregnancy supportability is used

to explore critical associations among the sample. The second theme explores the connection between masculinities, readiness, and abortion, utilising quantitative data to explore abortion supportability among men. It examines how attitudes and behaviours are situational and reflect a man's relationship with the pregnant person.

Constructions of masculine ideals are embedded in notions of 'readiness' to parent

Within both quantitative and qualitative data, men indicated the complex and dynamic nature of idealised masculine norms. The behaviours and attributes that aligned to these masculine ideals developed as men progress from adolescents through to older ages and required continual upkeep.

Masculinities, sex, and fatherhood

Men's idealised form of masculinity presented in the interviews emphasised sex, relationships, and fatherhood. Sex was frequently mentioned by men across age groups as something that is not only part of the process of 'becoming' a man, but also an outcome of 'being' a man.

> ***R**: We always say that it is something you can't take away from a man, if you are a man you can't say you can never have sex*
>
> 18-year-old, currently in a relationship, no children

> ***R:** If you are a man you must be able to impregnate someone*
>
> 26-year-old, currently in a relationship, no children

> ***R:** That is what I am telling you that life like the problems in work like we know but I see it that if a man impregnates someone and he accepts it, that shows he is a man*
>
> 58-year-old, currently in a relationship, 7 children

Reproduction and masculinities are deeply interlinked – with sex and reproduction embedded in dominant ideals of masculinities. Men framed the need to be reproductive – to be having sex and becoming and being fathers – as both an external (community) and internal

(personal) expectation. The second respondent outlines that a man – and by extension, the person he has sex with – is fertile and a pregnancy is possible, embedding negative values towards infertility into constructed masculinities. These respondents build on the connection between sex and reproduction. The final respondent's reference to the notion of 'accepting' a pregnancy introduces the key question of this study of what constitutes an acceptable – and supportable – pregnancy to men.

To critically examine the factors that were associated with men's propensity to support a pregnancy, quantitative data were investigated. Table 5 uses a sample of men and their primary partner, while Table 6 accounts for all current partners for men with more than one current partner.

Table 5: Pregnancy supportability binomial regression for primary partners

Variable		Coef	Lower CI	Upper CI	Sig
Intercept		0.21	-0.22	0.65	
Age	18-19				
	20-24	0.22	-0.01	0.45	
	25-29	0.30	0.04	0.57	
	30-39	0.21	-0.12	0.54	
	40+	-0.15	-0.50	0.19	
Ethnicity	Ga				
	Ewe	-0.16	-0.42	0.10	
	Fante	-0.15	-0.40	0.10	
	Akan	-0.06	-0.31	0.19	
	Other	0.19	0.01	0.37	
Religious	No				
	Yes	0.06	-0.23	0.36	
Parenting	No				
	Yes	0.05	-0.10	0.19	
Multiple Relationships	No				
	Yes	0.11	-0.06	0.28	
Relationship Type	Married				
	Second wife / Long-term partner	-0.27	-0.50	-0.05	
	Intimate partner	0.09	-0.18	0.37	
	Girlfriend	-0.12	-0.30	0.05	

Wealth Index	Low	0.07	-0.09	0.23	
	Middle				
	High	0.26	0.10	0.42	**
Working	No				
	Yes	0.29	0.15	0.43	**
Education	Primary	0.02	-0.27	0.31	
	Middle				
	Secondary	-0.09	-0.26	0.08	
	Higher	-0.47	-0.74	-0.21	**

** =p<0.05, **=p<0.01, ***=p<0.001*

The results in Table 5 emphasise the significance of wealth and finances. Men who belonged to the highest wealth group had 0.26 higher log odds of supporting a pregnancy than men in the middle wealth group. Similarly, men who were working had 0.29 higher log odds of supporting a pregnancy than those not working. Men who attained higher education were significantly less likely to be supportive of a pregnancy than those who attained middle school education levels (lower log odds of -0.47), suggesting that men with the means to access higher education have different reproductive attitudes than other men.

Table 6 indicates the same trends as Table 5 for wealth, working, and education. However, the results also emphasise that the type of relationship has important implications. Compared to being married, men who had a long-term partner or a girlfriend had lower log odds of supporting a pregnancy (-0.28 and -0.17 respectively). Finally, compared to 18–19-year-olds, men aged 25-29 had 0.27 higher log odds of supporting a pregnancy.

Table 6: Pregnancy supportability binomial regression for multiple partners

Variable		Coef	Lower CI	Upper CI	Sig
Intercept		0.18	-0.20	0.57	
Age	18-19				
	20-24	0.22	0.01	0.42	
	25-29	0.27	0.03	0.50	*
	30-39	0.16	-0.13	0.46	
	40+	-0.16	-0.47	0.15	
Ethnicity	Ga				

	Ewe	-0.23	-0.45	-0.01	
	Fante	-0.20	-0.43	0.03	
	Akan	-0.06	-0.29	0.18	
	Other	0.12	-0.05	0.28	
Religious	No				
	Yes	0.01	-0.28	0.30	
Parenting	No				
	Yes	0.09	-0.03	0.22	
Relationship Type	Married				
	Second wife / Long-term partner	-0.28	-0.49	-0.06	*
	Intimate partner	-0.01	-0.26	0.23	
	Girlfriend	-0.17	-0.32	-0.02	*
Wealth Index	Low	0.01	-0.14	0.16	
	Middle				
	High	0.25	0.12	0.39	***
Working	No				
	Yes	0.34	0.21	0.46	***
Education	Primary	0.06	-0.20	0.33	
	Middle				
	Secondary	0.02	-0.13	0.17	
	Higher	-0.31	-0.56	-0.07	*

** =p<0.05, **=p<0.01, ***=p<0.001*

Both tables emphasise that working and wealth are significant, in both instances, men with higher wealth and men who are working more likely to find a pregnancy supportable. Thematic analysis of the qualitative interviews allows for an interrogation of these findings, by exploring in greater depth the reasons for men's attitudes towards pregnancies.

During interviews, men described the importance of being 'ready' for sex and fatherhood. These were not necessarily synchronous – i.e., one was not expected to be ready for sex and at the same time ready for fatherhood. This crucial complexity – of needing to be sexually active whilst also avoiding pregnancies before being ready – was a critical area in which dominant constructions of masculinities could be undermined. Particularly among older interview respondents, having sex and/or children before being ready was undesirable.

Men most frequently discussed the role of resources in relation to 'readiness', particularly readiness for fatherhood. This entailed a combination of having work, a place to sleep, and/or the resources to provide for children – e.g., food and school fees. The majority of respondents linked this explicitly to access to finances.

> ***R:*** *A man must have a good job and also have a place to sleep … and if you are not working too it makes the child struggle, the child cannot get to the level he/she needs to get*
>
> 36-year-old, currently in a relationship, 1 child

> ***R:*** *…for the man he takes care of the family so he is the head of the family. He goes to work to bring money and then gives to the wife to take care of the children.*
>
> 57-year-old, currently in a relationship, 5 children

Some respondents focused on the practical realities of resource acquisition and access to finances; in particular, to cover food, clothing, and school fees. Others situated this in their broader expectations of gender roles, specifically that women were expected to be 'carers' while men should act as 'providers'. Underlying these two response types were how finances and readiness could determine whether sex and pregnancy (and then fatherhood) were supportable, with these being critical milestones in fulfilling masculine expectations.

The predominant focus on finances, and the role of finances in obtaining resources, within the interviews complements the strong quantitative association between whether men were working and whether they would be happy for their partner to become pregnant. The precarity of paid labour among the sample, in which 55.4% reported working, points to a fragile environment for men to fulfil ideals of readiness. For many men the potential of pregnancy being unsupportable could be high.

Intertwined with desires for financial stability and resource access was the need for independence, particularly from parents. Men linked certain living conditions, particularly having a 'room' [living unit] of one's own, as a necessary requisite for fatherhood, which requires finances. Other forms of independence could include ensuring that becoming a father would not be disruptive to a man's parents.

R: *He must get cloths and his personal things [ehewɔɔ nibii] […] there are some who don't even have a rag but are going to have a child to disturb his parents*

39-year-old, currently in a relationship, 5 children

Being considered irresponsible was antithetical to achieving masculine ideals among men. The respondents' negative attitudes towards men who are dependent (living with and / or relying on their parents) at the time of a pregnancy are indicative of the need for independence as a fulfilment of acceptable, valued masculine ideals. Access to resources is a critical component of readiness, as financial readiness is a proxy and facilitator for being independent and prepared specifically for a pregnancy and fatherhood. These idealised notions of independence were also embedded in some men's notions of when sex is acceptable.

R: *…but I feel that if you are a man especially and you are not self-reliant, you don't have a good job, you don't have a good place to rely on I think you should be able to control yourself*

36-year-old, currently in a relationship, 1 child

The quote highlights the imperative of being self-reliant; the respondent frames his sexuality in terms of control, that without the necessary components constituting 'readiness' a man should not have sex. This emphasises the complexities of navigating masculinities, wherein sexual relationships are a means to perform masculinity, yet also can undermine masculine ideals where a man is not 'ready'.

The focus on independence and self-reliance within interviews complements the survey data. In this study, the wealth index draws on available data on materials a home is made from, water supply, and working items within the home. Alongside material wealth and paid work, the qualitative data allows for greater insights into the interconnectedness of independence with pregnancy supportability.

In addition to the idealisation of independence, the type of intimate relationship was significant in the quantitative results and an important component in men's constructions of being 'ready' for a pregnancy in the qualitative evidence. Respondents constructed the notion

of the ideal woman to have sex and parent with based on various characteristics, including her family, and her interactions with her partner:

> ***R:*** *If you are going in for a woman you have to look at the woman, where she comes from, the home she is from, her parents, are they neat people, do they have good behaviour, are they good people, is she well trained, is she educated, she is a good woman she knows how to humble herself for a man and things, then [he] can have sex with her.*
>
> 27-year-old, currently in a relationship, one child

This process of identifying some women as 'acceptable' partners was a consideration in whether a man is ready to have sex, again creating boundaries and thresholds to navigate in attempting to achieve masculine expectations. The respondent describes gendered power dynamics – in which a woman would "humble" herself – in his construction of an acceptable relationship, illustrating masculinities built on power hierarchies between genders. For other men interviewed, ensuring not only that the woman fulfilled gendered expectations, but also that the relationship with that woman was acceptable, was important.

> ***R:*** *My friends see a good man as someone who is with a woman but would never have sex with her until he marries her, so when he sees him he can say this person is a good man and the other person is not, you understand*
>
> 28-year-old, currently in a relationship, no children

For men, an 'acceptable' partner, within an 'acceptable' relationship, was integral to being ready for fatherhood. For many respondents, that form of relationship was marriage. The respondent above explicitly links that marriage is the optimal mechanism through which to demonstrate he is a good man. The results of the quantitative data, in which all relationship types had a negative association with pregnancy supportability compared to marriage, are emblematic of this idealisation. Interviews show how marriage can be a means through which to prove manhood, and to ensure that both sex and fatherhood are socially acceptable.

Inability to fulfil masculine ideals

‘Readiness’ and the constructions of masculine ideals were not simply theoretical exercises with no meaning among participants. Men expressed concern that there would be real consequences for the inability to fulfil masculine ideals around fatherhood. Respondents discussed how being unable to fulfil the tenets of readiness meant that their desired masculinity was undermined, and they could face shame, ostracism, and ridicule within their communities.

> ***R:*** *Let’s assume that you have to play your part fending for your family and you need finances to do that, so if you can’t fend for your family then you become less powerful, you will become a form of mockery to others citing that you are a lazy person and all those things*
>
> 40-year-old, currently in a relationship, no children

> ***R:*** *Most of the time you only see a woman shouting on the streets of James Town the man cannot fulfil his responsibilities. Someone would give birth with a man and the person cannot pay the child’s school fees….*
>
> 20-year-old, currently not in a relationship, no children

These interactions between men and their communities were often centred around the notion of good and bad fatherhood. Readiness is, therefore, an important mechanism to ensure inclusion and respect as a man within the community. The complex relationship between masculinities and sex and fatherhood, at once driven by these behaviours and attributes and made vulnerable by their occurrence when not ready, shapes pregnancy supportability. Thus, it is essential to explore how masculinities shape men’s real or potential responses to a pregnancy and its potential outcome.

Readiness to parent shapes pregnancy and abortion supportability among men

Interview respondents made clear that masculine ideals were a key determinant in their readiness for sex and fatherhood. The consequences of being unable to fulfil these, for example by not being sexually active or not being able to provide for children, could lead to stigmatisation and shaming by their partners or other members of their community.

Men explicitly linked the notion of being 'ready' to their decision to support an abortion. In discussions of abortion, readiness not only shaped the supportability of a pregnancy – or abortion – but was operationalised by men to support or pressure a person into obtaining an abortion.

> ***IN:*** *I am saying abortion, what is your opinion on abortion?*
> ***R:*** *It would depend on when I give birth what the child would eat, if I have money it would determine if I will abort it or not. If you don't work, you can't give birth*
> 20-year-old, currently in a relationship, no children

In the quote below, the respondent directly links his readiness to be a father with 'forcing' his partner to obtain an abortion.

> ***R:*** *I am the one who force her to do it because I had made up my mind that…. She got pregnant and I wasn't ready to have a child.*
> 42-year-old, currently in a relationship, 2 children

This quote exemplifies the link between readiness and abortion, and that men use abortions a mechanism to control reproduction in order to preserve their masculinity.

Men also emphasised how the type of relationship shaped their attitude towards abortion. Relationships or sexual encounters that were less socially acceptable – where a possible pregnancy was considered unsupportable – were often described by men as a core underlying reason to support – and possibly pressure – for a person to obtain an abortion.

Some men considered abortions to be within their decision-making control – there was rarely an acknowledgement of the desires of the pregnant person. Some men did discuss readiness beyond themselves. However, it is notable that in the response below, the man still considered it his place to "tell" the pregnant woman what she must do.

> ***R:*** *There are days you feel for sex and desire to have sex and maybe the woman you desire is also not ready so when you meet someone on the street you have to satisfy your desire first but if that happens and you impregnate the lady you must tell the lady to go and abort the child*

55-year-old, currently in a relationship, 4 children

The quote emphasises the importance of relationship type by explicitly linking the necessity of an abortion to the nature of the sexual encounter. The emphatic language used is indicative of the attitude men had and of their belief in their right to involvement in pregnancy or abortion decisions. If the pregnancy is with someone either less known to a man, or who is not the person the man wishes to have a relationship with, it becomes unsupportable.

Among survey respondents, 84.8% of men indicated that they would not support their current (or hypothetical) partner obtain an abortion. Of men in multiple concurrent relationships (n=37), 19 men held a consistent view regardless of the relationship/partner, while 18 men had different abortion attitudes depending on which relationship/partner they were asked about.

All men, regardless of relationship status, were asked whether they would support a number of different relations of women obtain an abortion in the survey (see Table 7). 60% (n=162) of men reported that an abortion was unsupportable regardless of the type of relationship they were asked about (data not shown), while 40% (n=108) men answered that it depends, or that they would support an abortion for at least one relationship type. Only one man answered that he would support an abortion for any relation of person.

Abortions were most supportable for second wives, girlfriends, and schoolgirls, while they were least overtly supportable for other relatives (daughters, sister-in-law, wives). The survey captured qualitative data on men's reasons for their non-/support. For sisters and sisters-in-law, men felt that it was not their place to support, instead implying that it was the partner or husband who should be involved. For schoolgirls and daughters, men inferred that as a good father their priority was their children finish school. The table highlights the nuance and roles that men saw themselves having in the pregnancy and outcomes of different women – and the men they believed ought to be involved.

Table 7: Survey responses (N=270) to whether the respondent would support specific (hypothetical) people obtain an abortion (%)

	Yes	No	It depends	Don't know	Did not answer
Wife	3.3	85.2	11.1	0.0	0.4
Second wife	10.7	77.4	10.4	1.1	0.4
Girlfriend	9.6	78.9	9.3	8.9	0.7
Sister	3.7	83.3	11.9	0.7	0.4
Sister-in-law	3.3	88.5	7.0	0.7	0.4
Daughter	3.3	85.6	10.4	0.4	0.4
Other relative	2.2	89.3	8.1	0.0	0.4
Friend	5.2	85.6	7.8	0.7	0.7
School girl	10.0	80.7	8.5	0.4	0.4
Sex worker	5.2	90.0	2.6	1.9	0.4
Colleague	4.8	88.5	5.6	0.4	0.7

The results from Table 8 add further depth to the role that relationality had on men's attitudes towards abortion. Men in multiple relationships had an associated abortion supportability score 1.24 higher than those not in multiple relationships, meaning that they were significantly more positive towards abortions.

Moreover, men who had long-term partners (1.60), intimate partners (1.13), or were single (1.54) had higher associated abortion support scores than those who were married. These results are comparable to the significant associations in Table 6, suggesting that men who find pregnancies less supportable might have higher support for abortions. It reinforces the significant association between relationship type and decisions to support an abortion among men.

Table 8: Abortion supportability Poisson regression results

Variable		Coef	Lower CI	Upper CI	Sig
Intercept		-0.82	-1.42	-0.24	
Age	18-19				
	20-24	0.71	0.35	1.09	
	25-29	0.58	0.17	1.01	
	30-39	0.55	0.08	1.04	
	40+	1.24	0.76	1.75	
Ethnicity	Ga				

	Akan	-0.29	-0.68	0.08	
	Fante	-0.10	-0.45	0.23	
	Ewe	-0.06	-0.44	0.30	
	Other	-0.65	-1.00	-0.33	
Religious	No				
	Yes	-0.64	-0.99	-0.27	
Parenting	No				
	Yes	0.37	0.14	0.60	
Multiple Relationships	No				
	Yes	1.24	1.02	1.46	***
Relationship Type	Married				
	Second wife / Long-term partner	1.60	1.24	1.95	***
	Intimate partner	1.13	0.84	1.42	*
	Girlfriend	0.38	0.02	0.74	
	Single	1.54	1.12	1.95	*
Wealth Index	Low	0.27	0.05	0.48	
	Medium				
	High	-0.72	-1.04	-0.41	
Working	No				
	Yes	0.60	0.39	0.81	*
Education	Primary	-0.61	-1.03	-0.22	
	Middle				
	Secondary	-0.05	-0.28	0.18	
	Higher	0.33	-0.01	0.67	

** =p<0.05, **=p<0.01, ***=p<0.001*

Men who were working were associated with a 0.60 increase in the relational scale, indicating more positive abortion support. This is notable, as men who were working were also more likely to support a current partner become pregnant. For abortion supportability, the wealth category of a man led to no associated differences.

There are a number of possible underlying causes for the association for working. Men who work might have the finances and resources considered necessary to cover the cost of abortion, thus making abortion feasible as a pregnancy outcome.

***R**: You see some of the men do not work so if…you got pregnant he would look for ways to get you money to go and abort*

22, not in a relationship, no children

Moreover, it could be that men who are working already have financial obligations – including existing children – that mean that they are more inclined to support an abortion:

***R:** I have two [children] already and there is no good job attached to it, the door to door work is nothing to go by and I don't want to trouble the kids and trouble myself to put myself under work pressure*

31-year-old, in a relationship, 2 children

However, even with financial obligations for men who are working, respondents in qualitative interviews were consistent and emphatic that a working man should support a pregnancy:

***R:** […] a job is the issue. If he is working and has money and the wife is pregnant he cannot say go and abort, you see?*

21-year-old, not in a relationship, no children

These nuances between the qualitative responses and the quantitative results suggests a need for further research. This includes the potential underlying factors such as increased financial obligations among working men, and the potential that men considered being supportive of an abortion distinct from their description of men who were not 'ready' pushing for abortions.

Discussion

This study provides critical and novel insights into the mechanisms that drive men's involvements in pregnancies and abortions. Men can have a significant impact on whether and how a woman or pregnant person can obtain the care they want. Men were clear in their constructions of masculine ideals that pregnancies and their outcomes were essential to control, and women's own bodily autonomy and choice rarely appeared in data. By

understanding men's desires to determine pregnancy outcomes, this study contributes to our understanding of why women may choose pregnancy non-/disclosure and abortion self-management away from public scrutiny as a strategy to avoid navigating men and masculine norms (Coast et al. 2018, Freeman, Coast, and Murray 2017, Berro Pizzarossa and Nandagiri 2021, Nandagiri 2019).

Men's constructions of masculinities in James Town, Ghana, resonate with evidence from across the world, indicating the influences of global masculine hegemonies in idealising notions of men being 'breadwinners', reproductive decision-makers, and fathers (Connell 2005, Connell and Messerschmidt 2005). Men's constructions of masculinities are rooted in sex and reproduction – the appropriate timing of which is determined by men's 'readiness'. This research emphasises how readiness is intrinsically reliant on the fulfilment of masculine ideals. Men's attitudes and behaviours were shaped by their ideals and through their lived experiences. While they primarily discussed reproduction within partnered units, the normative environment, their interaction with the community around them, and their own constructed ideals had significant impacts on their support for a pregnancy or abortion. This includes men's assumptions that they can impose their desired outcome for a pregnancy on the pregnant person.

Sex and reproduction were not singularly supportable but defined by whether a man was ready – defined by his fulfilment of specific masculine ideals (Ouedraogo, Senderowicz, and Ngbichi 2020). Readiness was conditioned on the need for men to be mature, responsible, able to provide care or be seen to be striving to provide care, as well as in the context of a socially sanctioned form of fatherhood. Men emphasised the need to be financially stable and accrue resources, particularly to provide food, shelter, and clothing for children, which aligns to globalised, colonial 'breadwinner' models (Ganle et al. 2016, Dery and Apusigah 2020, Ampim, Haukenes, and Blystad 2020, Pasura and Christou 2017). Financial instability threatened dominant masculine ideals (Izugbara 2015), and was a key component in men's decisions of whether a pregnancy was un/supportable and their desired timing for fatherhood (Smith 2020). Given the high economic volatility of the area (Pasura and Christou 2017, Ampim, Haukenes, and Blystad 2020), the dominance of finances in masculine ideals links pregnancy supportability among men to macro-economic systems via constructions of masculinities.

Notions of readiness among men were tied explicitly to their justifications of their involvement in abortion decisions. Men across age groups emphasised the similar influence that individual expectations, interpersonal relationships, and community norms had on determining their support for an abortion. Attitudes and behaviours towards pregnancies and abortions were not static or consistent but situated within a man's view of the nature of the relationship (Nandagiri 2019). Men provided nuance on how their support is defined by the type of relationship, as well as continuing to emphasise that answers can vary depending on partner type (for men with multiple partners). Moreover, while most men shared similar views towards the need for finances and being 'ready', older men drew on personal experiences and circumstances when considering abortion, younger men had more idealised notions of abortion supportability rooted in desires and norms rather than experiences. This research develops evidence from within Ghana (Miescher 2007) and in other contexts that emphasise the role of age, relationship type, and experiences on men's attitudes towards abortion (Marlow et al. 2019, Dalessandro, James-Hawkins, and Sennott 2019).

The collaboration with Act for Change and cognitive testing allowed for the development of questions relevant to the experiences of men in James Town, as well as capture the nuance and complexities of respondent's lives. Cognitive testing with men in a nearby community created space to include questions that men considered relevant to their lives and to test understandings and assumptions within existing questions, while collaboration with a partner institute allowed for the co-creation of a study that generated dual-purpose evidence for research and activism. Moreover, the use of mobile technology provided men control of the research time and space, with men providing in-depth responses to the assumed-sensitive questions on sex, sexuality, and abortion. The combination of collaboration and methodological innovation generated evidence that is useful for both academic analysis and the creation of community-based programmes by Act for Change.

Conclusion

The findings in this study provide important recommendations for engaging men in sexual and reproductive health and rights. Current research and interventions on gender transformational change targeting men and boys have almost no components addressing safe abortion care (Ruane-McAteer et al. 2019). This study emphasises that men have a significant

ability to shape the conditions under which women are navigating pregnancy and abortion trajectories. It is critical to address men's roles in abortion to tackle reproductive injustice.

This research generates new insights into how masculinities are embedded in pregnancy and abortion supportability. The collaboration with Act for Change grounded these research insights in the James Town community and has a resulted in a pilot of gender transformational workshops (see Chapter 7). The experience during research data collection of how men desired spaces to talk about sex, sexuality, and manhood became an integral component of these subsequent pilot workshops.

Ghana's *National Gender Policy* (2015) called for SRHR education in schools and bringing men into the policy's "mainstreaming framework" (p.36). This research highlights how men were occupied with notions of 'good' fatherhood and the need to control reproduction until they were 'ready'. Creating educational programmes that focus on sexual and reproductive autonomy, as well as positive, non-financial ways men can be supportive fathers, partners, family-members, and friends, would help transform masculine ideals. Social spaces designed for men to share their experiences of masculinities and to talk openly could help mitigate fears of not meeting masculine ideals and perceptions of judgement from the broader community. Community engagement - e.g., with media campaigns - that normalise child-free adults and men in non-financial care giving roles could also help to reshape norms that men should be fathers and breadwinners, which in turn drives men's need to fulfil masculine ideals.

At the international global health policy level, programmes that grapple with engaging men and boys in abortion-related care – for example International Planned Parenthood Federation and UNFPA's *Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys (2017)* – continue to focus on men in their role as partner (Shand and Marcell 2021). However, the relationality of attitudes and behaviours uncovered in this study indicate that efforts to create positive attitudes within a relationship dynamic might not necessarily have a consequential impact on attitudes elsewhere. This study highlights that grappling with masculinities as they are constructed at the individual and community levels is essential for understanding how men can shape the broader conditions under which women are able to access care.

Finally, within evidence-generation, research tools must recognise that attitudes and behaviours are not static but fluctuate. This includes creating qualitative and quantitative sampling frames that move beyond only sampling men in their role as a partner towards a broader population of men and boys, as in Promundo's *IMAGES* survey (Barker et al. 2011). Such inclusion allows for a deeper understanding of norms and constructions of masculinities that are essential in a critical examination of the determinants of pregnancy and abortion supportability. This study illustrated that normative ideals within communities formed men's notions of what was expected of them – as fathers, providers, and men. Future research should be conducted that incorporates all genders, in order to gain greater understanding of the construction of gender ideals at the individual and community levels. This will help generate evidence to inform policies and interventions that are designed to normalise positive and pluralistic expressions of gender.

Ensuring that questions relating to attitudes and behaviours are specific to relationship types and are asked about all the relationships a person reports, will allow greater analytic depth. The Demographic and Health Survey, a dominant tool for collecting SRH data across the world, does not incorporate a broad sample of men, and, in cases where there are multiple partners, multiple responses to attitudinal questions are not yet possible (Ghana Statistical Service, Ghana Health Service, and International 2015). These data are crucial for the creation of more nuanced attitudinal and behavioural transformation policies and programmes, and this study in James Town emphasise that questions should be repeated for each sexual partner to examine relational attitudes.

This study provides original evidence on the mechanisms that drive men's involvement in pregnancies and abortions, contributing key knowledge to a current research gap. It develops understandings of the complex and nuanced constructions of gendered normative environments for future research to expand on. It is imperative to continue engaging and transforming masculinities, to ensure that universal SRHR and freedom of sexual and reproductive choice and autonomy is made a reality.

Chapter 5: "Even when you write with a pencil there is an eraser to clean it": Examining men's conceptualisations of and involvement in emergency contraceptive use in Accra, Ghana

This chapter is currently under R&R at Social Science & Medicine

Abstract

Emergency contraceptive pills are an essential and unique post-coital method to avoid a pregnancy, with evidence showing the significant role men can have in procurement and decisions to use. Global Health recommendations specify that emergency contraceptive pills be used sparingly and under specific conditions. This increasingly misaligns with the myriad conceptualisations and rationales among the public for why they choose to use emergency contraceptive pills. There has been a paucity of research aiming to understanding men's involvement and how they shape women's access, choice, and autonomy.

This study interrogates how emergency contraceptive pills are conceptualised by men in James Town, Ghana, and how this intersects with their motivations to be involved in its use. Mixed method data from a survey (n=270) and in-depth interviews (n=37) were collected between July 2020 and January 2021. The analysis examines men's framings of emergency contraceptive pills and how these shape their involvement in its use.

Men's knowledge of post-coital contraceptives was high, while knowledge of the specific term 'emergency contraception' was lower. While some men understood the pills in ways that aligned to Global Health framings, many more men saw emergency contraceptive pills as another means of pregnancy prevention in line with other contraceptives. This included its conceptualisation as a contraceptive that facilitates pleasurable (condomless) and spontaneous sex. Gendered perceptions of women who use emergency contraceptive pills were bound in sexual stigma, and men indicated that emergency contraceptive pills were a directly observable form of contraception that they could pressure their partner into using. Understanding plural conceptualisations away from 'emergency' are necessary to create policies and programmes that account for men's involvement. This includes understanding how emergency contraceptive pills are located within people's sexual and reproductive lives

and gendered power dynamics, to reflect the public's own rationales for and experiences using post-coital contraceptives.

Key words: Emergency Contraception; Men; Gender; Masculinity; Sexual and Reproductive Health and Rights

Introduction

Emergency contraceptive pills (ECPs) – most commonly medication that can be taken up to 72 hours post coitus – is the only post-coital form of contraception that individuals can self-administer (Palermo, Bleck and Westley 2014). Understanding how men's involvement influences women's ability, choice, and autonomy to use ECPs provides evidence to inform global and national level ECP policy and provision and ultimately progress towards universal sexual and reproductive health and rights (SRHR) (Starrs, Ezeh et al. 2018). This conceptualisation of SRHR includes the recognition of not only disease in 'health' but also notions of relationships, trust, communication, wellbeing, and autonomous and free informed choice around sex, sexuality, relationships, and related care (including contraceptives). Men's conceptualisations of and involvement in purchasing emergency contraceptive pills intersects across these components of universal SRHR. However, there is a dearth of critical research on men's involvement in ECP use.

The term "emergency contraception" was developed after research suggested that the phrases 'post-coital contraception' and 'morning-after pill' were resulting in provider and user confusion (Reader 1991). This evidence, gathered in the early 1990s, explicitly framed ECPs as a mechanism to reduce the number of abortions (Burton and Savage 1990). "Emergency contraception" became adopted into international and national health policies and guidelines. The justification for this language was outlined in the WHO's 1998 *Emergency Contraception: A Guide for Service Delivery*, which argued that "[alternative] terms do not convey the important message that emergency contraceptive pills should not be used regularly because they are intended for "emergency" use only" (World Health Organization 1998, p. 19).

Within this framing, which became mainstreamed in Global Health, ECPs are recommended as only for use under specific, unplanned for circumstances. This constructs a definition of "emergency" as one of contraceptive non-use, contraceptive failure, and / or sexual assault where contraception was not used (World Health Organization 1998, Hobstetter, Sietstra et al. 2015).Thus, what distinguishes ECPs from other contraceptives – the 'emergency' – can be understood as an unplanned incident of at least one of three specific circumstances that revolve around contraceptive failure or non-use. The World Health Organization does not recommend ECP use beyond this somewhat narrow frame; a frame which is reflected in national health policies on ECPs, such as that in Ghana (Ghana Health Service 2014).

Recent studies of ECPs with women have suggested the Global Health framing of ECPs is not necessarily aligned to behaviours, with an increasing number of women having used ECPs and incorporating it into their regular contraceptive mix (Engle, Hinson and Chin-Quee 2011, Abiodun 2016, Black, Geary et al. 2016, Han, Saavedra-Avendano et al. 2016, Barbosa, Kalckmann et al. 2021, Milkowski, Ziller and Ahrens 2021). Women report preferring ECPs because of more acceptable side effects than those experienced using other contraceptives (Engle, Hinson and Chin-Quee 2011), and the ability to hide taking it from a partner (Rokicki and Merten 2018). A study of the features of contraception most important to women in the US found that ECPs were notable for their ease of use, accessibility, and effectiveness, compared with some other non-emergency contraceptives (Lessard, Karasek et al. 2012). Evidence highlights how other terminology has remained salient among the public, for example 'morning-after pill' or 'Plan B' in the United States (Johnson, Nshom et al. 2010).

The evidence highlights a disconnect between how Global Health frames acceptable ECP use and women's own preferences and behaviours. Discussions around how best to align Global Health rhetoric with public behaviour have occurred with regards to other components of sexual and reproductive health and rights. For example, there is debate over whether 'family planning' or 'contraception' is a better term for capturing the realities of contraceptive decision-making (Rodríguez, Say and Temmerman 2014, Rodríguez, Say and Temmerman 2014, Trinitapoli, Verheijen et al. 2014). The Global Health framing of when and why to use medical abortions – linked to notions of abortions needing to be 'rare' (Weitz 2010) – misalign with women's own rationales for when and why to use medical abortion (Alam, Kaler and Mumtaz 2020). There is increased awareness of the importance of recognising the

relational nature of sexual and reproductive health (e.g., the role of partners, friends, parents) (Strong, Lamptey et al. 2022), and the need for Global Health discourse and framing to reflect this reality (Trinitapoli, Verheijen et al. 2014).

Interrogating the evidence of the relational nature of ECPs highlights the sometimes significant level of involvement from men, through the sharing of information and knowledge, decision-making, and procurement that shapes the choices that women are able to make (Nguyen and Zaller 2009, Abiodun 2016). In Nigeria, women reported that male partners were a more common source of information about ECPs than providers (Abiodun 2016). Research in Saudi Arabia and the USA indicates how men's motivations to be involved in ECPs are shaped by their own fertility and parenting desires (Harper, Minnis and Padian 2003, Karim, Irfan et al. 2021). Men's involvement in women's ECP use is embedded in gendered power relations, which affords men the ability to dominate contraceptive decision-making (Dudgeon and Inhorn 2009, Dudgeon and Inhorn 2009, Fennell 2011). Women frequently report that the reasons for using ECPs are due to their partner's sexual preferences (e.g., sex without a condom) and the unequal power that women having in choosing when to have sex and what, if any, contraceptives are used (Engle, Hinson and Chin-Quee 2011, Marcell, Waks et al. 2012, Rokicki and Merten 2018).

This study interrogates how emergency contraception is conceptualised within the sexual and reproductive lives of men, and how this intersects with their attitudes, behaviours, and motivations to be involved in its use. Using a case study based in Accra, Ghana, men's conceptualisations of ECPs are examined, alongside their motivations for and experiences of involvement in its use. This case study aims to analyse the extent to which current Global Health terminology around ECPs is aligned to individual and community-based realities.

Case study: Accra, Ghana

In Accra, emergency contraceptive pills are an extremely important and wanted component of people's contraceptive mixes (Engle, Hinson and Chin-Quee 2011, Henry, Agula et al. 2021). ECPs have been included in Ghana's health policy since 1996 (Steiner, Raymond et al. 2000) and they can be bought over the counter without a prescription, obtained from family planning clinics, or through informal providers and marketplaces (Baiden, Awini and Clerk 2002, Henry, Agula et al. 2021). While provision is unrestricted and specifically

includes all individuals (regardless of gender), the language around ECPs within the Ghana Reproductive Health Service Policy and Standards (2014) explicitly utilises the Global Health framing. It states that "Emergency contraception shall not be promoted as a regular family planning method" (p.11) and emphasises that ECPs are to be used only under specific circumstances (Ghana Health Service 2014).

The separation of ECPs from other forms contraceptives was compounded in the National Health Insurance Scheme adopted in January 2022, which included permanent contraceptives, IUDs, implants, and injectables, but not ECPs (MSI Choices 2021). This fails to address financial barriers that women report when accessing contraceptives (Dassah, Domapielle and Sumankuuro 2022), thereby potentially limiting the contraceptive choices available and the ability for people the right to make sexual and reproductive health decisions that meet their desires.

Despite Ghanaian national policy alignment to the rhetoric of ECPs as distinct from other contraceptives, ECPs are an important and preferred contraceptive among the general population. In particular, evidence from Accra, where this study is also located, highlights that ECPs were a critical component of women's contraceptive mix (Engle, Hinson and Chin-Quee 2011, Chin-Quee, Hinson et al. 2012, Henry, Agula et al. 2021, Kalamar, Bixiones et al. 2022). Furthermore, current evidence illustrates the significant misalignment between Ghanaian policy, which draws on the Global Health framing, and people's own motivations to use ECPs (Engle, Hinson and Chin-Quee 2011, Chin-Quee, Hinson et al. 2012, Henry, Agula et al. 2021, Kalamar, Bixiones et al. 2022). This included women's negative perceptions of condoms, unwanted sexual encounters, and preference of ECPs over other contraceptive methods (Engle, Hinson and Chin-Quee 2011, Rokicki and Merten 2018).

Studies highlight the significant role that men can play in the procurement of ECPs alongside reports by women of men's influence in their decision-making (Engle, Hinson and Chin-Quee 2011, Chin-Quee, Hinson et al. 2012). Women who work as head porters in Accra are enrolled for free onto the NHIS; where their partner refuses to wear condoms, women report desiring ECPs but being financially unable to cover the costs (not covered by the NHIS), an issue exacerbated by their simultaneous reliance on the same men for finances to procure ECPs (Dassah, Domapielle and Sumankuuro 2022). This highlights how the exceptionalism of ECPs in Ghanaian health policy, aligned to the Global Health framing, can exacerbate

barriers to access as well as abilities for women to navigate gendered power dynamics in contraceptive procurement and use. Further evidence with men in Accra highlights that men systematically planned for ECP use in advance of sex, not necessarily only in cases of an "emergency" (Teixeira, Guillaume et al. 2012). In addition, evidence among university students found that 55% of men would use condoms less frequently if ECPs were more available (Baiden, Awini and Clerk 2002).

The existing evidence in Accra highlights that men can be significantly involved in ECP use, that men and women have a variety of reasons for using ECPs, and that these reasons are not always congruous with Ghanaian policy and provision, which aligns to the Global Health framing of ECPs. This disconnect has the potential to mean that policies around the regulation and provision of ECPs are not meeting the people's needs. Moreover, a dearth of information on men limits the capacity to meaningfully engage with the ways in which men can influence and shape women's decision-making. Taken together, these can significantly curtail progress towards universal sexual and reproductive health and rights, which necessitate the right to make "free and responsible decisions and choices" with "unhindered" access (Starrs, Ezeh et al. 2018, p. 2644).

Currently, there is no research that centres men in the sampling frame and looks at the general population outside of a university / higher education setting. There is a need for a greater understanding of how men's knowledge and conceptualisation of ECPs ties to their motivations to both purchase it and influence their partner's decision-making around use. These motivations are embedded in gendered constructions by men of their sexual and reproductive roles and relationships to women. Greater understanding of their knowledge, conceptions, and motivations to use ECPs is fundamental for effective policies and programming to promote women's sexual and reproductive rights.

Analytic Framework

This paper approaches emergency contraceptive pills through the lens of Critical Global Health and Critical Demography, which seek to trouble existing assumptions and frequently positivist and medicalised biases in these interlinked fields (Greenhalgh 1996, Williams 2010, Barot, Cohen et al. 2015, Storeng and Béhague 2017). It utilises the lens of pleasure, often minimised within Global Health, to understand ECPs within the contexts of choice,

access, desire, and community (Higgins and Hirsch 2008, Mitchell, Lewis et al. 2021, Philpott, Larsson et al. 2021). These lenses help deconstruct positivist, medicalised approaches to the sexual and reproductive health and rights, which is necessary for an interrogation of emergency contraceptive pills that moves towards the holistic, universal understanding of SRHR as more than just the absence of disease (Starrs, Ezeh et al. 2018).

Approaching emergency contraceptive pills through theses lenses requires an analytic framework grounded in social constructivism that captures the complexities, nuances, and plural meanings of sex, sexuality, and relationships. To maximise on the analytic potential of researching with men, the foundational components of a feminist-grounded Critical Studies of Men and Masculinities (CSM) were used as a framework. This approach understands men as gendered, with socially constructed masculinities and gender norms ordered through hegemonic masculinities, which are rooted in cultural contexts and articulated in respondents' own words. The framework has particular salience for feminist-informed masculinities research in Ghana, where it has been used to respond to a dearth of studies that critically examine the constructed and relational nature of masculinities (Dery 2019). The analytic approach in this study provides a tool to situate ECPs within men's gendered sexual and reproductive lives and interrogate the ways in which they construct meanings around ECPs.

Methods

Mixed method study

Data in this paper come from a mobile phone-based study in 2020-2021 with men aged 18 and over. It explored the relationships between men, masculinities, and sexual and reproductive healthcare in Accra, Ghana. The survey collected both quantitative and qualitative data through categorical and open text questions, using Respondent-driven sampling (RDS). A nested sample of men who completed surveys were purposively invited for in-depth interviews. Selection of interview respondents was designed to ensure a range of SRH experiences and demographics were represented to cover the themes of the larger research project (Strong 2021a). In-depth interview questions were centred around masculinity, emergency contraception, and abortion (see survey and interview instruments in Appendix C and F).

Mobile phones were used for the interviews to ensure full adherence to COVID-19 safety protocols. Respondents were asked survey questions by a member of the interview team who recorded their responses on laptops and saved them to a secure cloud-based software. Interviews were recorded on mobile phones and saved to the same software for translation and transcription. Details of the rationale, strengths, and limitations of mobile-phone methods in this study are described elsewhere (Strong 2021a). A total of 306 men were successfully recruited for surveys and 296 men completed interviews, giving an overall final sample of 296. Of these, 26 were removed from the analysis for being RDS seeds (Wejnert et al. 2012, Yauck et al. 2021), leaving a final survey sample for analysis of 270. In-depth interviews were conducted with 37 men.

Ethical approval was obtained from the Research Ethics Committee at the London School of Economics and Political Science (REC ref. 000802c) and the Ghana Health Service Ethics Review Committee (GHS-ERC0104/10/19). Approval was sought and obtained from the Ghana Health Services Regional Director for Greater Accra, and community stakeholders.

Data analysis

The qualitative data are rich, complex, nuanced, and the most effective at interrogating men's conceptualisations of ECPs and motivations to be involved in its use. Quantitative data are used in this paper to complement the qualitative by providing necessary details of the trends among the broader sample.

Qualitative data were analysed using a combination of inductive and deductive techniques, to generate, review, and iterate themes (Bryman et al. 2021, Braun and Clarke 2006). The deductive component of this process drew on existing literature on the reasons that men use contraception, including to prevent pregnancies, to facilitate pleasure, and to navigate risks of STI. The inductive approach drew on elements of the qualitative data that were novel, such as men's involvement and their perceptions of women's sexuality (Timmermans and Tavory 2012). Alongside creating codes from the existing literature, transcripts and qualitative survey data were read and re-read in order to create additional relevant, data-driven codes for the final codebook.

These codes were grouped into themes that were constructed by JS. The key themes were: conceptualisations of emergency contraception in line with global health framings; from 'emergency' to pregnancy prevention; emergency contraception and sex, sexuality, and pleasure; men's involvement, perceptions of secrecy, and stigma. Analysis was conducted on Dedoose Version 9.0.46 (Dedoose Version 7.0.23 2016). Quantitative survey data were used to produce descriptive statistics using RStudio Version 1.4.1717 (RStudio Team 2020).

Considerations and Reflexivity

Men in this study were only asked about the emergency contraceptive pill, which meant that potential alternative post-coital methods that men knew or had used were not consistently captured. A small proportion of men discussed alternative methods, such as women drinking brandy after sex. During interviews, no men discussed the IUD as a method of emergency contraception, which informs the specific focus of this article on ECPs. The exploratory nature of the study and the sampling methods are designed to allow for theory-based generalisability by situating the case study in the broader Global Health literature and policy (Cornish 2020). Moreover, the study specifically asks men about their perceptions and behaviours and ties these to their relationships to others – partners, friends, community. However, the relationality of gender in this study can only be understood from men's perspectives as other genders were not included (Bottorff, Oliffe et al. 2011).

The principal investigator in this project is not Ghanaian and was raised and educated in the UK, which is also where the funding for this project was based. A critically reflexive approach was taken to grapple with and challenge my assumptions and biases, with processes to facilitate this embedded throughout the research process (van Heugten 2004, Zempi 2016). This included centring the voices of community members, expert stakeholders, and project partners in the design, particularly piloting and interviews with space for respondent feedback and iteration of the research questions and tools. Partnering with [omitted for peer review] also meant that assumptions and biases of the author were confronted by collaborative conversations that enabled iteration and adaptation of the research to the context in a more meaningful way. By designing the research instruments in Ga language with subsequent translation into English and Twi, questions, topics, language, and assumptions that made sense in English were challenged and troubled, including how to ask about "emergency contraception" discussed in the results. This critically reflexive process does not remove

assumptions and biases. However, it ensures consistent challenges to the author and mechanisms to ensure that the voices of respondents can be centred to produce relevant and contextually grounded research.

COVID meant that JS travelled back to the UK and data were collected exclusively by the research team from the community using COVID safe methods. It is important to consider how quotes might have been impacted by the nature of talking to researchers from the same community. The use of mobile phones, however, and researcher reports after each survey and interview indicated that a degree of anonymity could have a mitigating effect. Surveys were translated and transcribed and then the research team worked together to double check each survey, and Twi and Ga phrases were retained where meaning was considered by the team to be lost in the process of translation. Throughout the process of the research, results were discussed among local partners approached for project approval, and the findings in this paper were discussed to ensure they were reflective of the discussions and original translations of interviews and relevant to the research context.

Results

The sample description highlights the youthful age structure of the sample, with most men in partnerships (Table 9). This reflects broader socio-demographic structures in the region (Ghana Statistical Service, Ghana Health Service and International 2015), and further information on the full sample can be found at [removed for peer review].

The results centre the voices of respondents through quotes, and are used to critically examine the relationships, nuances, and incongruities between men's conceptualisations and Global Health framings of EC. All quotes are from interviews and are from the respondents, in cases where the interviewer's question is also included, "I" used to represent an interviewer and "R" respondent.

Table 9: Survey sample description (excluding seeds)

	Included survey sample description (n=270)

		N (%)
Age	18-19	42 (15.6)
	20-24	101 (37.4)
	25-29	62 (23.0)
	30-39	31 (11.5)
	40+	34 (12.6)
At least one current partner / relationship	Yes	181 (67.0)
	No	88 (32.6)
	Did not answer	1 (0.4)
Knowledge of EC	Knew without prompt	96 (35.6)
	Knew with prompt	120 (44.4)
	Did not know	54 (20.0)
Ever bought EC	Yes	56 (20.7)
	No	214 (79.3)
Working	Yes	150 (55.6)
	No	120 (44.4)
Wealth Index	Lower	76 (28.1)
	Middle	130 (48.1)
	Higher	64 (23.7)

The results below are presented thematically based on the qualitative analysis, focusing first on ECP knowledge, then considering the different attitudes and conceptualisations men had of ECPs, and finally on behaviours and men's involvement. Knowledge, attitudes, and conceptualisations are linked but distinct, with men's knowledge of the terminology of emergency contraceptive pills and medical-recommended uses not necessarily tied to their conceptualisations and perceptions. This is reflected in the presentation of the results, in which knowledge is presented separately.

Knowledge of 'emergency contraception'

There is no transliteration into Ga or Twi of the phrase "emergency contraception". The survey first asked the question "have you heard of emergency contraception", retaining the

English term. A follow up prompt then described ECPs in either English, Twi, or Ga (or a combination) depending on respondent preference (Table 10). Responses in the survey as well as interview responses indicated that men were exclusively discussing ECPs and not the IUD, which is reflected in the focus of the results.

Men's knowledge suggests some disconnect between the language used among the public and the language used in Global Health. Most men were not familiar with the specific phrase "emergency contraception" (Table 9). More men expressed knowing about ECPs when provided a specific description of their use and function. When combining both response rates, the sample in this study had higher overall knowledge of ECPs (80%) than the overall average among men estimated in the DHS (63.1%) (Ghana Statistical Service, Ghana Health Service and International 2015)

Table 10: Survey questions on emergency contraception in each language

	Question	**Follow up (if respondent answered "no" to first question)**
Ga	Ani onu emergency contraceptive he dan?	Emergency contraception ji tsfofa ni akɔɔ ŋmɛlɛtswaa 72 yɛ bɔlɛnamɔ sɛɛ, koni aka ŋɔ hɔ?
Twi	Wati emergency contraceptive da?	Emergency contraception ɛyɛ nda ekyir aduru bia yɛ fa ɛwɔ 72 hours sɛnea ɛba yɛa, yɛn nyinsɛŋ?
English	Have you heard of emergency contraception?	Emergency contraception is commonly used within 72 hours of having sexual intercourse, in order to avoid pregnancy. Have you heard of that?

Men's varied knowledge of ECPs, compared to their relatively consistent knowledge of ECPs brands and where to buy them, suggests that the phrase has little resonance with them:

> ***R:*** *I heard it through friends, through our conversation they would tell you so many, they will tell you about Lydia, Postinor 2[11], they said some G tablets or so, there are more of them.*

[11] Lydia and Postinor 2 are the names of two common brands of emergency contraception in Ghana

36-year-old, one girlfriend, 1 child, previously bought a partner ECPs

The largest proportion of men heard of ECPs through friends, predominantly - though not exclusively - male friends. The quote indicates that in the process of learning about ECPs was an exchange of practical information – brand names, for example – rather than specific terminology of ECPs. Men also reported knowing that ECPs were available from pharmacists and all men who reported having ever bought ECPs did so at a pharmacist / chemist.

Men's conceptualisations of emergency contraceptive pills aligned to Global Health recommendations for use

Within surveys and interviews, some men utilised language and conceptualised ECPs in ways that reflected and were aligned to the framing of ECPs in Global Health. It suggests that current Global Health framings are reflective of how ECPs are viewed among the public, though this linking was not explicit nor mentioned among respondents. This included a small number of men who discussed the importance of its use in the context of contraceptive non-use or failure:

R: *I remember my senior brother had sex with his girlfriend and the condom burst and he asked me to go with him to the pharmacy, but the lady had one in her bag.*

29-year-old, fiancée, 1 child, previously bought ECPs for fiancée and for an ex-partner

IN: *So what do you think of women who use emergency contraceptives?*
R*: I don't have any negative thought about them, I feel they are being responsible because life gives second chances and if you commit an error…. Even when you write with a pencil there is an eraser to clean it*

40-year-old, two intimate partners, no children, never bought ECPs

These respondents describe the use of emergency contraceptive pills in instances that would be categorised as an "emergency" within the Global Health, WHO-based frame (World Health Organization 1998). However, respondents themselves do not necessarily label these incidents as an "emergency". This might reflect the fact that 'emergency contraceptive' is not a widely known linguistic phrase among the sample and, therefore, the specific language is

not used. ECPs are, however, conceptualised as having a specific value in the event of contraceptive non-use or when an "error" has occurred. This exemplifies how the value of ECPs is tied to their function as a post-coital method of fertility regulation.

The first respondent above also highlights that his brother's sexual partner had already bought ECP in anticipation. ECPs were taken due to contraceptive failure, which would be categorised as an 'emergency' as understood through a Global Health frame. Nuancing this is the preparedness of the brother's partner. This suggests the importance of advanced provision of ECPs, not waiting until the 'emergency' has occurred to seek the pills.

Men's rationale for using ECPs sparingly or not at all included their preferences for other contraceptives, specifically condoms:

> ***R:*** *Now I will use condom because STIs are high amongst the girls*
>
> 27-year-old, not in a relationship, no children, bought ECPs for an ex-girlfriend

While the first respondent prefers using condoms as a single man having sex with multiple people, his history of purchasing ECPs for an ex-girlfriend indicates the links between relationship status, sexual partner, perception of STI risk, and contraceptive preference. This highlights the situational role that ECPs can have, in particular how decisions over whether to rely on ECPs or to use other methods among men (exclusively focused on male condoms among respondents) are embedded in their perceptions both of STI prevalence in the community and among the women that they are having sex with.

From 'emergency' to pregnancy prevention

Many men conceptualised the positive role ECPs have in preventing pregnancies, which linked to notions of readiness for parenthood, for both men and women. ECPs were presented as allowing both men and women to wait until they are ready for parenthood, and was linked to positive attitudes towards ECPs among some men:

> ***IN:*** *Okay. So if I may ask in your opinion is this drug [ECPs] a good drug?*

R: *It is good […] because the person is protecting herself from pregnancy because she is not ready to have a child*

19-year-old, has a girlfriend, no children, never bought ECPs

R: *If I'm not ready I will be happy [to buy it] but I won't if I am looking to have a child.*

23-year-old, no relationship, no children, never bought ECPs

In both these instances, men conceptualised ECPs in relation to men's and women's 'readiness' for parenthood, connecting ECP use to broader planning around when to have children. This contrasts Global Health framings of ECPs as to be used only in cases of unplanned emergencies. The first respondent had not heard of ECPs until the survey, where it was explained to him. His response that it was a "good" thing mirrored the responses men who knew of ECPs gave when asked what they thought when they first heard about it. These men recalled being "happy" and "relieved" when they first heard about ECPs, which points to an overall positive attitude towards an addition method of pregnancy prevention. For some men, ECPs were a means of family planning, specifically in order to ensure space between births:

R: *You are making sure that what you are doing … you have not made up your mind to give birth with this lady or I have not made up my mind to give birth now or the two kids I have I need to maintain them for a while until I get a better job.*

31-year-old, one co-habiting partner and one occasional partner, 2 children, bought ECPs for the occasional partner and also for ex-partners

IN: *Okay. So if I may ask, what are your opinions about these drugs?*
R: *It is very good, it is very good because you must be able to protect yourself so that you can take good care of the children, you must protect yourself so that you don't have another child or it is not so?*

57-year-old, two wives, 5 children, never bought ECPs

In each of these examples, from men who are fathers, ECPs were a method to achieve birth spacing or preventing future births. Readiness was linked to expectations that men had of both their own and women's responsibilities. Respondents discussed the role of employment

and finances, as well as the capacity to care for their children, as critical determinants for whether they were ready for another pregnancy and, therefore, their perception of the positive value of ECPs. The link between ECPs and responsibility was made explicit when men discussed their views of women who used ECPs:

> ***R:*** *It is good, I think it can help us with this kind of responsible and irresponsible issue going on… this mother is irresponsible and stuff…I think this is going to help us with this kind of high cost of living and unwanted pregnancy and stuff so I think it is cool.*
>
> 28-year-old, girlfriend, cares for 2 siblings, never bought ECPs

The respondent frames a woman – specifically a mother – as being irresponsible whilst also acknowledging that ECPs are 'cool' for helping women navigate complex and challenging economic structures. For the respondent, the "mother" is irresponsible as a parent, failing to meet gendered expectations, but that her ECP use was acceptable in the context of this 'irresponsibility'.

Emergency contraception and sex, sexuality, and pleasure

Throughout the survey and interviews, men framed reproduction as just one of many aspects of sex, bringing sexual pleasure, desire, and sexuality into their discussions on ECPs. Men highlighted how ECPs allowed them to navigate these perceived positive and negative components of sex. EC's role as a contraception was framed by respondents as providing a protection, in order that a person might fulfil their sexual desires without consequence to themselves or their futures:

> ***R:*** *They [women] are protecting their future […] Maybe she has so much to do… but, you know, she was also feeling for sex so she has to protect herself and continue what she wants to do*
>
> 23-year-old, early stages of a relationship, no children, bought ECPs for a friend

> ***R:*** *You might get carried away along with this thing… you are there, and you have forgotten to put on a condom or whatever, and then you are playing with your*

girlfriend then you guys ended up having sex. You know, definitely within that day and the next day you need to take an emergency contraceptive… so that you can prevent… unwanted pregnancy.

20-year-old, no relationship, no children, never bought ECPs

The respondents highlight that ECPs facilitate spontaneity and enjoyment, which for them are important elements of sex. Where access to a condom can be limited or a condom might not be immediately available or perceptions of condoms are tied to reducing pleasure, ECPs allow for respondents to have the sex they desire, when they desire. Both of these respondents are younger with no children and in either a very early stages of a relationship (described as "not serious but growing") or not in a relationship. This may suggest age-based differences in the role of emergency contraceptive pills and how perceptions of the role and reason for sex might shift depending on age and relationship status. Perceptions of a generational and contextual shift in attitudes and conceptions of ECPs are emphasised by the following respondent:

R: *My advice is that the ladies that use it say it is good for them, it allows them to do a lot of things and even if you ejaculate in them it doesn't allow them get pregnant and that is where I realized that, that is what majority of the youth have done, they are not afraid of having sex because they are also looking for a way to feed themselves, that is what is going on in some of the Ga communities especially the community we are in*

42-year-old, no relationship, 1 child, never bought ECPs

This respondent perceives younger adolescents to be less concerned about sex resulting in a pregnancy and more with 'feeding' their pleasure, implicating generational shifts in attitudes that ECPs both facilitate and symbolise. Within discussions of pleasure, men were primarily focusing on pleasure as ejaculation. This gendered approach to pleasure was reflected in men's labelling of women's sexuality as unacceptable and inappropriate. For some respondents, ECPs were a mechanism through which to identify and mark sexual women:

R: *They [women] use it because they roam a lot in a day, so it is something they must use.*

IN*: Okay. So in your opinion is it good or bad?*

R: *It is not good*

42-year-old, wife and 3 girlfriends, 2 children, never bought ECPs

R: *If she is an addict and has been having sex for a long time, she will know how to deal with unprotected sex herself but if not, the boy will have to go and buy them the pills [ECPs]*

21-year-old, girlfriend, no children, bought ECPs for girlfriend

R: *She starts using that thing without telling you... you don't know but some other time you might see it in her bag… that means she goes to have sex elsewhere.*

39-year-old, one 'baby mama' [mother of his child] and one casual relationship, 5 children, never bought ECPs

Gendered constructions – and perceptions – of women's behaviour shape men's attitudes towards ECP use. The respondents above link use to specific women who have frequent sex with different partners ('roam'), layering stigma through the notion of those women being 'addicted' to sex with multiple partners. In their responses, men are constructing the 'responsible' or 'good' woman as being monogamous or not engaging in frequent sex with multiple partners. For the second respondent, it is sexually active women who would know and be expected to buy ECPs for themselves, while men need to buy for those women that are not sexually active nor 'addicted' to sex. This conceptualisation of ECPs are linked to norms around purchase; male involvement in the purchase and use of ECPs is a positive reflection on women, but women who purchase ECPs for themselves are sex 'addicts' and viewed negatively.

Other respondents explicitly connect ECPs to the type of relationship they are in, framing the contraception as appropriate depending on their relationship rather than necessarily because of an 'emergency' situation:

R: *It is not a good thing as I have said, it is not a good thing so to me I wish there were no emergency contraceptives …. it is not nice that someone will go and taste something [have sex with a woman] and leave it for someone else to go marry her. It is not nice; it is disgraceful and troubling.*

45-year-old, has a wife, 2 children, never bought ECPs

R: *The reason why I wouldn't buy it, is that it has in the past that I have a lot of girlfriends and that is why I say now I have stopped and I am only with my wife and that is why I said I won't buy.*

28-year-old, girlfriend [used by respondent interchangeably with 'wife'], no children, bought ECPs for girlfriend

These two respondents show the complex connection between emergency contraceptive pills and relationship type – particularly marriage – another expression of the relationality of contraception decision-making. The first considers it unacceptable for men to purchase ECPs for a woman without marrying them, embedding in his response implicit sexual stigma that it is inappropriate to have sexual relationships with women without intention to marry. The second respondent implies that he purchased ECPs specifically because it was acceptable to him for a non-marital partner to take ECPs, but that it was not appropriate to use once married.

Men's involvement, perceptions of secrecy, and stigma

Men's conceptualisations of ECPs directly linked to their subsequent motivations and involvement in its use. Most men in the sample considered the decision over whether to use ECPs to be their decision, or a joint decision led by men:

R: *After discussing with the man, the woman can go and buy it*

23-year-old, girlfriend, no children, never bought ECPs

This reveals the deeply gendered power dynamics that exist, particularly between sexual partners, which privilege men. By embedding themselves in women's decision-making, men can influence use based on their own conceptualisations of when, why, and for whom ECPs are acceptable. Respondents revealed the limits of communication where it conflicted with men's desired outcomes of sex:

R: *She told me she is fed up with EC, so I persuaded her by buying it for her to use because I told her I'm not ready for a pregnancy now*

26-year-old, fiancée, no children, bought ECPs for fiancée

The respondent frames ECPs within the realms of pregnancy prevention as it connects to readiness for parenthood. His conceptualisation of ECPs motivated his involvement in its use, despite the implication that his partner did not wish to continue using. His comment suggests that ECPs were a component of their prior contraceptive use, and that the power dynamics within his relationship allowed him to ensure the continuation of its use.

While men centred themselves in ECP decision-making, purchase, and use, they described the barriers they perceived or experienced when going to purchase ECPs. Respondents held that the interaction with an ECP provider was complex and, often, likely to be negative. This view was held regardless of whether a respondent had ever bought ECPs. Men had shifting perceptions of whether these interactions would be more positive if it was a man or a woman buying ECPs, suggesting nuanced and gendered ideas of ECP access:

> ***R:*** *Sometimes some men gather the courage and goes to buy it for the ladies (girlfriends)*
>
> 34-year-old, no relationship, no children, never bought ECPs

> ***R:*** *They [men] also think it is good but you know most of them feel shy to go to the pharmacy to say I want to buy this drug you know, that is the major problem most of my friends complain of that they can't go to the pharmacy to buy this kind of medicine so I think they are cool with it but how to get it is their problem.*
>
> 28-year-old, girlfriend, cares for 2 siblings, never bought ECPs

Notions of 'shyness' among men imply perceptions that there will be some judgement for purchasing ECPs. The latter respondent highlights that this happens even when ECPs themselves are acceptable, revealing another level of power dynamics that are negotiated and navigated in the process of buying ECPs. The expectations of judgement highlight how ECPs remain mired by stigma at the provider level, and reveals a critical tension where its use is increasingly normalised as non-emergency among men.

Men's framing of ECPs meant it was a method through which they could exert control over contraceptive decision-making and women's sexual and reproductive choices.

Simultaneously, the secrecy afforded by ECPs for women linked to men's gendered perceptions of women's behaviour:

> ***R:*** *Since they [men] are not ready and they [men] want it unprotected the ladies themselves get it without the men knowing*
>
> 23-year-old, girlfriend, no children, never bought ECPs

> ***R:*** *If she wants a baby but you are not ready, she may not take the medicine or all two of you have to agree on. And you must be there to make sure she takes it*
>
> 31-year-old, on and off relationship, no children, bought ECPs for girlfriend and for a female friend

Throughout interviews, the narrative of women's secrecy was constructed. Within these quotes, men develop on notions of women's secretiveness to describe why ECPs are used and their motivations to be involved. The first respondent highlights that ECPs provide women a mechanism to navigate men's condom non-use. This could directly link to men's own conceptualisations that ECPs provide a means to focus on pleasurable – i.e., condomless – sex. The implication is that women use ECPs rather than navigate and negotiate with men on contraceptive use. The second respondent in the two above quotes describes how ECPs can act as a directly observable medication. Here, his underlying concerns that his partner cannot be trusted to avoid a pregnancy due to contrasting readiness for parenthood, means that he sees ECPs as a mechanism to ensure his reproductive desires are met.

Discussion

Global Health policy documents and recommendations frame 'appropriate' ECP use under narrow conditions of contraceptive non-use or failure, which are defined as an 'emergency'. Through interrogating the views of men, which are not typically centred in research, this chapter highlights that ECPs were conceptualised as appropriate and useful for more nuanced and varied circumstances. This complicates and destabilises the centrality of a fixed 'emergency' and expands understandings of ECPs. This includes ECPs as a pre-planned mitigation strategy for sex that risks a pregnancy but also the unique, non-'emergency' uses of ECPs to meet men's sexual and reproductive desires. The results highlight that the narrowly defined conceptualisation of ECPs as for ""emergency" use only" in Global Health

are misaligned to people's own desires and needs for when and why to use ECPs (World Health Organization 1998, p. 19).

The findings in this study resonate with evidence on male condom use, which highlights the roles of pleasure and norms to emphasise the importance of understanding how men's conceptualisations of ECPs shape their involvement in its procurement and use (Higgins and Hirsch 2008, Shai, Jewkes et al. 2012, Fennell 2014, Higgins and Wang 2014). Interrogating the role of men in ECP use and their motivations for use or non-use are critical in fully understanding the gendered power dynamics that shape women's reproductive decision-making or choices. This provides evidence as to how ECPs are used within the context of James Town, how men conceptualise its use and their involvement with insights into the potential impact this has on women.

Knowledge of the phrase "emergency contraception" was relatively low among the sample, while more men knew of what ECPs were based on a description of them. Combined, this provides a relatively high overall proportion of men who knew about ECPs in some way, with rates higher than those found in existing surveys Ghana (Ghana Statistical Service, Ghana Health Service and Icf 2018). Current data collection on contraceptive knowledge that informs policy – notably the Demographic and Health Survey – does not disaggregate between the term "emergency contraception" and the probe describing its use (Ghana Statistical Service, Ghana Health Service and International 2015). Further research and survey tools on emergency contraceptive pills might be able to better capture the nuances of understanding and knowledge through disaggregated knowledge questions with prompts. This can inform health messaging as well as provide key insights into the language of the public that provision and policy can then reflect.

While several men in this study conceptualised ECPs in ways that reflected Global Health discourse of an emergency, which recommends its non-regular use following contraceptive non-use or failure, the notion of "emergency" did not resonate with many men's perceptions. Men frequently framed emergency contraceptive pills within the context of pregnancy prevention and family planning. This mirrors evidence from elsewhere in Accra, Ghana, that women also framed ECPs as part of their family planning and not as an "emergency" method (Henry, Agula et al. 2021). ECPs were a method that allowed for birth spacing among men who wanted to delay pregnancies, as well as a contraceptive. Far from an emergency, men

framed ECPs as a regular method of pregnancy prevention. The acceptability and motivations to use ECPs were deeply gendered and rested on notions of 'readiness' for parenthood (Ouedraogo, Senderowicz and Ngbichi 2020, Strong, Lamptey et al. 2022). Men embedded ECPs within social notions of reproduction, distinguishing between positive reasons for not being 'ready' (birth spacing, achieving future goals, improving financial standing) and negative reasons (perceptions of a woman being an irresponsible mother). These gendered notions of good and bad parenthood are embedded in judgement and stigma (Nandagiri 2019), and layer hierarchies of un/acceptable ECP users onto men's perceptions of ECPs.

For respondents, sex was about pleasure, spontaneity, and interpersonal connections, as well as reproduction. Developing on the links between pleasure, contraceptive choice, and gender norms (Marston and King 2006, Higgins and Wang 2014, John, Babalola and Chipeta 2015), men's conceptualisations were explicitly shaped by age, gender, and relationship-based norms. Compared to older respondents, younger men were perceived to be more focused on sexual pleasure, while women were often negatively labelled for their sexuality. While acknowledging ECPs fundamental role in avoiding the consequences of sex and reproduction, men simultaneously located ECPs in their ability to have spontaneous, "in the moment", condomless sex (Flood 2003). ECPs allowed men to focus on the kind of sex that they wanted and to privilege spontaneity and pleasure, without "fear" of a pregnancy.

Men's conceptualisations of ECPs reflected their views of and relationships with women. Though many men discussed the importance of communication in decisions of whether to use ECPs and who should buy it, this was underpinned by men's opinions carrying greater importance. This intersected with men's perceptions of women's capacity for secrecy, and the potential risk that a sexual partner would desire a pregnancy regardless of what the man wanted. Views of women as secretive were embedded in understandings that ECPs are a method for women to navigate gendered power structures and their own sexual and reproductive health and desires, away from men's control or involvement (DeRose and Ezeh 2010, Nandagiri 2020). The Global Health framing of contraceptive non-use as an emergency fails to consider how decisions to not use other contraceptives can be part of a complex process of navigating men's desires for condomless sex and women's (and men's) simultaneous desires to avoid a pregnancy. This reflects the gendered power differences between sexual partners and where condom negotiation is rendered more problematic than taking ECPs after sex.

Woven throughout notions of un/acceptable ECP users was the navigation and enacting of sexual stigma. Men stratified users of ECPs: women protecting their future and men seeking to have enjoyable sex were framed positively, while negative framings judged women as too sexual, promiscuous, and secretive. Respondents made clear that provider stigma was a significant real and perceived reason for their shyness and discomfort in purchasing, and that decisions over who (a man or woman) should buy ECPs were rooted in mitigating these experiences. The implications for acceptability and gendered notions of procurement reflect similar findings of provider stigma shaping ECP use (Kısa, Zeyneloğlu et al. 2012, Marcell, Waks et al. 2012, Eastham, Milligan and Limmer 2020). When describing their perceived barriers to accessing ECPs, men outlined how their involvement can be a mechanism through which to navigate stigma; by buying ECPs, men mitigated women's shyness and the potential of being labelled as promiscuous or having negative experiences with a provider. Yet men's own stigmatising views and their exercise of control and power serve to undermine women's own choices, desires, and autonomous decision-making around the contraceptives they use. Future research to understand the specific pathways and experiences among men who bought ECPs for their partners would allow for further interrogation of the nature of provider interactions.

Conclusion

Through interrogating the motivations for men's involvement in and experiences of purchasing ECPs, this study emphasises the complex, gendered environments that women navigate. Women's use of ECPs involves navigation of men's involvement, the reasons for men's involvement, the role of ECPs in shaping condom use decisions, men's desires to purchase on behalf of women, and men's own experiences of provider barriers in purchase. Taken together, these complexities impact women's abilities to exercise their free and autonomous sexual and reproductive rights. Further understanding of men's motivations are necessary for the creation of gender transformational public health programmes and policies (Zielke, Strong et al. 2022). These are necessary interventions that should aim to centre women's own motivations for use, their autonomous decision-making, and encourage men towards taking supportive roles in women's SRHR.

The current Global Health framing of when ECPs should be used, under a narrow definition of an "emergency", are limited in understanding how sex, sexuality, reproduction, power, and gender norms can all have critical role in shaping the reasons for and acceptability of ECPs. The term 'emergency contraception' was borne from a desire for consistency in understanding among providers and the general population and tied to specific recommended uses of ECPs. This needs to be updated to reflect the realities of its use, in order to ensure that Global Health policies and programmes are sensitive to gender, power, pleasure, and human rationale. Furthermore, conceptualising ECPs as for use only in instances of contraceptive non-use, failure, and sexual violence, without explicitly naming the gendered structures and unequal power dynamics in which these occur, makes invisible the causes of reproductive injustice and continues to limit sexual and reproductive choice, autonomy, and care.

Chapter 6: "It is not sweet at all using condom": examining men's motivations to use condoms within their sexual lives in Accra, Ghana

This chapter has been submitted to Studies in Family Planning.

Abstract

Male condoms are currently the only non-permanent, biomedical method of contraception available to men and people with penises. Male condoms are framed in policy and research for their ability to prevent pregnancies and STIs. This minimises the critical social meanings around condom non-/use that are embedded in men's gendered and sexual lives, limiting key insights into men's condom decision-making.

This article draws on survey (n=296) and interview (n=37) data with men aged 18 and over in Accra, Ghana, collected between 2020-21. Descriptive statistics, ordinal logistic regressions incorporating a novel set of masculinities variables, and thematically analysed qualitative data were used to interrogate men's motivations for condom non-/use.

Condom non-/use was deeply intertwined with men's sexual expectations, gendered normative beliefs, and masculine constructs. Expectations of meeting masculine norms, particularly provider models of manhood, were associated with condom non-/use. Condoms are embedded in social meanings of sex as pleasurable, loving, intimate, not only reproductive. These were deeply relational and shaped by the nature of a man's relationship to his sexual partner(s). Understanding men's motivations allows critical insights into how novel male methods might better align to meeting men's sexual desires and the importance of situating condom non-/use in gendered social systems in future demographic research.

Key words: Men; Masculinities; Male Condoms; Sexual and Reproductive Health and Rights; Sex

Introduction

Male condoms[12] are currently the only non-permanent contraceptive controlled by men[13] that does not require withdrawal or abstinence. Condoms are an effective means of pregnancy prevention and a barrier method that reduces possible STI transmission. Men's choice whether to use a condom (hereafter referred to as condom non-/use) is important and shapes the contraceptive decisions that their partner might choose or feel obliged to make (Fennell 2011). Interrogating motivations around condom non-/use is critical to gain insights into men's decisions around when and whether to use a condom. To better understand how future male-centred contraceptive developments and programmes can meaningfully engage with men, this study critically examines men's motivations for condom non-/use within masculine constructs and gendered power structures.

Men have sexual and reproductive health (SRH) needs, desires, and rights, and play a significant role in the SRH of other people. Access to contraception is a human right (Hardee et al. 2014). Policies and programmes ranging from International Conference of Population and Development (ICPD) 1994 to Family Planning 2020 and 2030 (FP2020/2030) have acknowledged the need to grapple with men and masculinities in SRH. Ideologies centred on population control mean, however, that policies and programmes continue to focus on increasing women's modern contraceptive uptake in the Global South (Senderowicz 2020, Nandagiri 2021, Hardee, Croce-Galis, and Gay 2017, Cahill et al. 2018). This simultaneously minimises men's roles in SRHR and positions them as secondary 'partners' (Basu 1996, Wentzell and Inhorn 2014). Although the development of alternative male methods has been ongoing for decades (Ringheim 1993), currently available methods mean that women bear the burden and responsibility for navigating fertility regulation and contraceptive use (Kimport 2018).

Decisions around condom non-/use are rooted in gendered interpersonal, community, and structural power dynamics (John, Babalola, and Chipeta 2015, Fennell 2011). Examining how men operationalise and are influenced by these is crucial for understanding condom non-/use. These dynamics often privilege men who can exert more influence around condom decision-making than women (DeRose and Ezeh 2010, DeRose, Dodoo, and Patil 2002,

[12] Whilst there are female condoms, this article hereafter uses 'condom' as shorthand for 'male condom'.
[13] Male condoms are designed to be used by anyone with a penis. This includes trans and non-binary people. The language of men / women used in this paper reflect gendered language used in Global Health and in the context of this study.

Blanc 2001). Power dynamics complicate condom negotiation and women might be unable to negotiate the condom non-/use outcome they desire (Wirtz et al. 2015). Furthermore, condom non-/use is tied to the relationships and interactions between individuals and can have a critical impact on a man's sexual partner. For women who wish to not use hormonal or permanent contraceptives and want to avoid pregnancy and / or STIs (Sedgh and Hussain 2014), men's condom use represents a critical way for them to meet their desired outcomes. Evidence highlights how condom non-/use is embedded in norms and expectations within different relationships, including marital relationships, extra-marital sexual relationships, as well as other forms of intimate and sexual partnerships (Becker and Costenbader 2001, Pearson and Becker 2014, Fabic and Becker 2017)

Condom non-/use can be both a cause and a consequence of different types of sex that a person desires to have (or not). Condoms are consistently associated by potential users with negative sexual outcomes such as reductions in particularly men's pleasure (Marston and King 2006, Williamson et al. 2009, Plummer et al. 2006, Winskell, Obyerodhyambo, and Stephenson 2011), as a sign of partner mistrust (Williamson et al. 2009), and as linked to HIV/STIs and associated stigma (Plummer et al. 2006, Winskell, Obyerodhyambo, and Stephenson 2011). Non-use can be associated with positive expressions of love and sexual intimacy (Corbett et al. 2009). These associations vary, however. For example, condoms can a preferred contraceptive for more fulfilling sex; couples in the USA reported longer duration, greater enjoyment, and more variation of penile-vaginal sex when using male condoms compared to female condoms (Haddad et al. 2012).

Despite the important role of love, intimacy, pleasure on condom non-/use, men's sexual behaviours and desires tend only to be considered important in policy and programming where they relate to potential risk (Jolly 2007). Condoms are most often framed in global SRH policy and programming in relation to HIV/STI and pregnancy prevention (Corbett et al. 2009, Stover et al. 2017). The focus on risk and population control minimises the important role of sex and sexuality in SRH and condom non/-use. The WHO and the Guttmacher-Lancet Commission developed a revised definition of SRH that encompasses more than just the absence of risk, disability, or death (Starrs et al. 2018, World Health Organization n.d.). This framing necessitates a more holistic understanding of sex, incorporating sexual well-being, pleasure, consent, choice, and autonomy (Philpott, Knerr, and Maher 2006, Philpott et al. 2021, Singh, Both, and Philpott 2021, Zaneva et al. 2022,

Higgins and Hirsch 2008). It centres factors beyond biomedical risk and safety in condom use (Nandagiri 2022, Jolly 2007), and emphasises the need for research to more meaningfully incorporate a holistic conception of sex that is located in its cultural and normative context (Lorimer, Greco, and Lorgelly 2022).

Current measures of condom non-/use in the Global South are predominantly based on demographic research using nationally representative surveys (e.g., the Demographic and Health Survey (DHS)). These provide important data on couple reports of condom non-/use, including within and outside of a marital union or equivalent, as well as on knowledge and attitudes (Ghana Statistical Service, Ghana Health Service, and International 2015, The DHS Program 2020b, a). DHS data are used to calculate modern contraceptive prevalence as well as couple-years protection. Alongside this, the DHS captures men's attitudes towards contraception, including views towards women who use contraception, knowledge of where to buy condoms, and whether they used one for last intercourse (for up to three different partners) (The DHS Program 2020a).

There are few surveys that collect data and evidence that can be used to interrogate sex, power, gender, and masculinities. To do so requires a conceptual approach that can advance understandings of men's motivations around condom non-/use. The conceptual notion of hegemonic masculinities necessitates an understanding of men as gendered and reproductive beings who are shaped by normative masculine expectations (Connell 2005, Daniels 2006). This provides a lens to examine how men are shaped by and shape gendered power dynamics through their interactions with their partners, friends, community-members and with the systems and structures within which they live. Moreover, it allows for an analysis of how constructions of masculinities can be a critical mechanism that drives men's operationalisation of power to meet gendered norms and expectations, both internalised and external (Connell 2005). This includes how masculinities can influence desires and expectations around sex, sexuality, and reproduction, including with motivations for condom non-/use (Wentzell and Inhorn 2014, Lorimer et al. 2018, Lohan 2015). Understanding masculinities, therefore, and the linkages it has with sex and reproduction, are critical to better understanding decisions, motivations, and condom non-/use.

Exploring the roles of masculinities within demographic research on SRHR remains limited. This study aims to understand how men's condom non-/use is related to their sexual and

gendered lives. It locates condom non-/use within a holistic and relational understanding of sex to analyse men's motivations to use condoms and the diverse meanings that men ascribe to condom non-/use. It first examines patterns of men's reports of condom use and evaluates the socio-demographic factors that are associated with use. It then interrogates why men use, don't use, or sometimes use condoms, before analysing how men conceptualise different meanings of use within their sexual and reproductive lives. Drawing on mixed methods data from a sample of men aged over 18 in Accra, Ghana, this study critically engages with how men's motivations can be captured and understood in research and evidence on condom non-/use.

Study context

Data on current condom use in Ghana varies; the 2014 Demographic and Health Survey (DHS) showed a decline in reported male condom use among women (2% overall, 1.2% currently married women, 7.9% unmarried sexually active women) compared to 2008 data (3.6% overall, 2.4% currently married women, 17.6% unmarried sexually active women) (Ghana Statistical Service, Ghana Health Service, and International 2015, Ghana Statistical Service, Ghana Health Service, and Macro 2009). The most recent estimates of condom use in PMA2020 (2017) and Ghana Maternal Health Survey (2017) estimated prevalence of condom use as 16.3% and 6% respectively among sexually active unmarried women and 6.1% and 1% respectively among married women (Ghana Statistical Service, Ghana Health Service, and Icf 2018, PMA2020 2017). Condoms were the main method men reported using in their most recent sexual encounter (12.98%), based on 2014 DHS data (Butame 2019), and an analysis of 2003 DHS data found that men were significantly more likely to report using a condom across all partners than women (18.2% vs 8.6%) (de Walque and Kline 2011).

Contraceptive use in Accra is tied to the fulfilment of social expectations around reproduction and fertility for women (Hindin, McGough, and Adanu 2014). Contextual gendered expectations around sex and reproduction are important, with evidence that the patterns, acceptability, and experiences of contraceptive use, including condom negotiation, are shaped by women's relationships with their community (Marston, Renedo, and Nyaaba 2018). Condoms play an important role in women's contraceptive mix, including where infrequent sex leads to a preference for coital-dependent methods (Marston et al. 2016, Hindin, McGough, and Adanu 2014). Evidence among women in Ghana indicates their views of male

condoms as a way to complement behavioural methods that form their fertility regulation strategies (Marston et al. 2017).

Negative associations around condom use, including its association with promiscuity, lack of trust, unnaturalness, and lack of pleasure, all contribute towards men's motivations for non-use in Ghana (van der Geugten et al. 2017, Rondini and Krugu 2009, Ganle, Tagoe-Darko, and Mensah 2012). Gendered power dynamics are important. Adolescent girls in Bolgatanga reported that they could not negotiate condom use where a boy insisted on non-use (van der Geugten et al. 2017). Women in Accra report that negotiations around condom use can be too complex and contested to continue where their partner has a negative perception of condom use (Osei et al. 2014). Women who were categorised as wealthier than average in the DHS reported that they had greater negotiating power over condom use than women who were less wealthy, while overall one in four women reported not being able to demand a partner use a condom (Darteh, Doku, and Esia-Donkoh 2014).

The most recent (2015) Costed Implementation Plan (CIP) in Ghana, written in alignment with Ghana's FP2020 goals, committed to the rights of both men and women to "have access to safe, effective, affordable and acceptable methods of family planning" (p.3). The plan sought to engage men to dispel "myths and misconceptions amongst men…for ensuring their support of family planning" (p. 34), including a need for a national campaign to mobilise men "in support of family planning" (p.36). Ghana's CIP had limited programmes to address men's own contraceptive use, instead framing men as partners with the overall objective of increasing women's contraception rates (Hardee, Croce-Galis, and Gay 2017).

Masculinities have a significant role in shaping men's behaviours in Ghana, including their attitudes and behaviours towards contraception (Atobrah and Ampofo 2016, Dery and Apusigah 2020, Miescher 2007, Atobrah 2017). Much of the research on condom non-/use in Ghana, however, tends to focus on prevalence and use as reported by women (Asiedu et al. 2020), through the lens of HIV prevention (Weaver et al. 2011, Adih and Alexander 1999, Agbadi et al. 2020). There is little research from Ghana that explores how masculine norms and conceptions of sex intersect with men's motivations for condom non-/use.

Methods

Sampling and research instruments

Mixed method data were collected in 2020-21 from a sample of men aged 18 and above in James Town, Accra. Mobile phones were used to administer a survey to 306 men and conduct in-depth interviews with 37 men. This mode of data collection was designed to adhere to national COVID-19 protocols at the time (for methodological detail see (Strong 2021a, Strong et al. 2022)). The survey instrument gathered quantitative and qualitative data, captured through closed and open-ended questions on relationships, sexual and reproductive health, and masculinities. Survey questions were piloted and cognitively tested for consistent understanding with a sample of men from a neighbouring similar community. The interviews captured in-depth data on men's perceptions, conceptualisations, attitudes, and behaviours towards sex, sexual and reproductive health, and masculinities. The research instruments are available in Appendix F and C.

The survey used respondent-driven sampling (RDS), in which 'seeds' – men considered to have good social networks through either their work or social lives – were invited to participate (Lattof 2018a, Salganik and Heckathorn 2004, Schonlau and Liebau 2012, Yauck et al. 2021). Each seed was then asked to refer another man by providing a mobile phone number. Compensation was given for both participating in the study as well as additional compensation for each participant referred. Referrals continued to create a chain effect. In-depth interviews were conducted with a purposeful, nested sample of men. Surveys were read and respondents were selected for in-depth interview to represent a range of ages and sexual and reproductive health experiences.

All surveys and interviews were conducted in the respondent's choice of Ga, Twi, or English, or a combination of the three, by research assistants who were from the community where the study took place. Survey data were gathered on laptops and saved to a secure cloud-based platform, and interviews were recorded, translated (where necessary), transcribed, and saved to the same platform. A member of the team fluent in all three languages read all interview transcripts to ensure consistency and accurate translation; where meaning was unclear in translation the original was kept with an explanation of the meaning in parentheses.

Ethical approval was obtained from the Research Ethics Committee at the London School of Economics and Political Science (REC ref. 000802c) and the Ghana Health Service Ethics

Review Committee (GHS-ERC0104/10/19). Approval was sought and obtained from the Ghana Health Services Regional Director for Greater Accra, and community stakeholders.

Quantitative data analysis

Explanatory variables

Socio-demographic characteristics were captured in the survey and cleaned for analysis: age, whether a respondent was religious, whether a respondent was parenting or equivalent, highest (or current) level of education, and relationship status. To create the variable "parenting" and reflect contextual norms around parental-like care, men were asked whether they were parents or cared for anyone in a father-like way to reflect realities of care work and fatherhood beyond biological parenthood.

The survey captured socio-economic variables, including whether a man was working, who was the main source of income in their household, and a wealth index. Men were asked who was responsible for the main income in their household, and responses were assigned to three categories: the respondent as the main source, the respondent and an additional member(s) of their household, or someone else in the household (e.g., a parent, partner, friend, etc.). A wealth index was created from questions on ownership of household goods and household structure and is described in detail in Appendix D (Fry K. 2014, Filmer and Pritchett 2001, Strong et al. 2022).

Knowledge of a partner's contraceptive use was coded as either knowing a partner used a contraceptive (always or some of the time), knowledge that a partner was not using a contraceptive, or don't know. This variable might not accurately capture whether a partner is using contraception but allows for analysis of whether men's belief of a partner's contraceptive non-/use impacted men's own behaviours.

Questions asked about aspects of manhood and masculinities, including an open-ended question about men's own views of the three most important characteristics a man should have. To centre men as the survey respondents, their own words were used to inductively develop categories for quantitative analysis (Timmermans and Tavory 2012). The data were categorised into four aspects of masculinities: individual, interpersonal, familial, community

and structural. Individual level responses related to men's attitudes, beliefs, physical characteristics, and mannerisms. Interpersonal factors related to sex, sexuality, and relationships. Familial / community level characteristics related to care work and the role of caregiving within the familial unit. Structural level factors related to navigation of employment, material possessions, and finances, and are connected to men's participation in the informal and formal economies.

Independent variable

Contraceptive use in the survey was conceptualised as the physical act of using (i.e., putting on) a condom. This aimed to reduce multiple conceptualisations of 'use', in which a man might frame a sexual partner using a contraceptive as him also using. Questions on contraceptive use were only asked to men who had reported ever having had sex, which means that abstinence as a method of contraception might not be captured if this was abstinence from first sex. "Never use" and "Always Use" include men who reported almost never, or almost always, using condoms.

Men were asked "When having sex, how often do you use contraception?" – categorised in the survey as never, sometimes (less than half the time), sometimes (more than half the time), always – with open text follow up for elaboration on their non-/use. Responses indicated that men understood this question to relate to condoms – as men who answered they never used contraception elaborated that they either practiced withdrawal or the rhythm method with their partner. The variable was cleaned and coded to specifically relate to condom non-/use. No men reported having a vasectomy. The four categories were condensed to three – never, sometimes, always – to reflect both the ambiguities around more / less than half the time and avoid categories too small for analytic use.

Analysis

An ordinal logistic regression was used, converting the independent variable into an ordered variable with categories 'never', 'sometimes', 'always'. Regressions were run using Volz-Heckathorn weights ("RDS-II"), which calculate the inverse probability of a respondent being selected to participate based on the recruiter's personal network size and clustering at the recruiter level was accounted for (Volz and Heckathorn 2008, Yauck et al. 2021). Seeds

(n=26) and incomplete surveys (n=10) were excluded for a final total sample of 270 (Yauck et al. 2021, Wejnert et al. 2012).

Two regression analyses were conducted using R Studio Version 1.4.1717 (RStudio Team 2020). The first included the total sample of men who were asked about their condom non-/use (n=235). This question was only asked to men who had reported ever having had sex. The second was a subsample of men (n=173) who reported having a sexual relationship of any kind at the time of the interview. These men were asked whether they would be happy if their current partner became pregnant. Due to a skip pattern error, this question was only asked to men who reported being in a relationship at the time of the survey. Thus, the second subsample allows for an analysis of the extent to which pregnancy acceptability was associated with their condom non-/use.

Qualitative data analysis

Qualitative data were drawn from open-ended survey questions and in-depth interviews. Qualitative survey data on reasons for using contraception were cleaned and thematically analysed in Dedoose (Dedoose Version 7.0.23 2016), with the condensed categories for men's reasons cross tabulated into typologies of non-/users, using RStudio (RStudio Team 2020). Open-text answers in the survey as to why men reporting using, not using, or sometimes using condoms was cleaned and constructed into themed categories for analysis.

Interview transcripts were thematically analysed using an abductive approach to operationalise critical evidence and theorising around contraceptive use, sex, reproduction, and masculinities alongside novel insights from respondents (Tavory 2014, Timmermans and Tavory 2012). Transcripts were cyclically read and re-read by the author to inform the construction of a codebook. The codebook was developed by the author to capture themes that were constructed from previous literature and theories, as well as iterated during readings to include novel themes that emerged from the interview data. Interviews were coded on Dedoose Version 9.0.46. Codes were subsequently grouped, to construct themes that related to the intersecting motivations and meanings of condom non/-use.

Reflexivity

This research was led by a researcher from and trained in the Global North, in collaboration with Act for Change, a community organisation in James Town. This collaboration included the employment of three researchers from the community, who were paid to conduct the remote data collection during COVID-19.

The survey and interview guide were designed to capture information from men on their sexual and reproductive health and their masculinities. Open text survey responses often had to be interpreted by the research team for analysis. Notes were made by research team to clarify any terminology or answers that were complex, but ultimately in the process of capturing and cleaning complex data some meaning may be missed. The author conducted the analysis and did additional cleaning of all data necessary for this study. As a researcher not based in the context, care was taken to ensure that data were linked to existing evidence and knowledge as well as through conversations with the research team. This was intended to ensure that the analysis was reflective of the realities that men described. The voices, opinions, and thoughts of men who participated in the study were centred in the construction of variables and the analysis for a more grounded research approach.

Results

The results first outline the sample descriptive statistics and prevalence of condom non-/use among men who have ever had sex. Regressions are presented to unpack the socio-demographic and socio-economic factors that are associated with condom non-/use. Locating these factors within gendered meanings of sex, the results then examine men's self-reported motivations for condom non-/use.

Sample Description

Table 11: Included survey sample description (n=270)

		N (%)
Age	18-19	42 (15.6)
	20-24	101 (37.4)
	25-29	62 (23.0)
	30-39	31 (11.5)
	40+	34 (12.6)

At least one current partner / relationship	Yes	181 (67.0)
	No	88 (32.6)
	Did not answer	1 (0.4)
Condom use	Never had sex	35 (13.0)
	Always uses	39 (14.4)
	Sometimes uses	73 (27.0)
	Never uses	123 (45.6)

Of men who had ever had sex (n=235), 41.4% reported that they either sometimes or always used a condom (Table 11). The majority of men reported that they never used condoms.

Men's Motivations for Condom Non-/Use

Table 12: Men's motivations for condom non-/use by reported use

	Never use (n=123)		**Sometimes use (n=73)**		**Always use (n=39)**	
Reason	**N**	**%**	**N**	**%**	**N**	**%**
Doesn't know about condoms	13	100	0	0	0	0
Uses other behavioural methods such as withdrawal or rhythm	5	100	0	0	0	0
Currently wanting a pregnancy	5	100	0	0	0	0
Religious reasons	4	100	0	0	0	0
Doesn't feel that he needs to	6	100	0	0	0	0
Pleasure / feeling related effects	23	85	4	15	0	0
Perceived / previous side effects	12	71	5	29	0	0
Partner motivated his decision	12	50	9	38	3	13
Decision based on relationship type	27	64	12	29	3	7
To prevent a pregnancy	0	0	22	47	25	53
Protection against STIs	0	0	14	58	10	42
Protection (unspecified)	0	0	4	44	5	56
Depends on the circumstances of sex	2	25	6	75	0	0

Did not answer / provide a reason	10	83	2	17	0	0
Other	7	78	2	22	0	0

Table 12 presents men's responses when asked why they reported always, sometimes, or never using condoms. Men who gave multiple reasons were counted more than once, meaning the total for each group are larger than the number of respondents. The percentage of people citing each motivation by their condom non-/use is also presented.

Condom non-use included lack of knowledge of condoms, reference to using behavioural methods (e.g., withdrawal), wanting a pregnancy, and religious motivations. These explanations were not cited by any men who reported sometimes or always using condoms. Condom non-use and sometimes-use were connected by motivations that centred around pleasure, perceived side effects, the involvement of their partner in the decision – including their partner making the decision for them as well as their partner using contraception – and the circumstances of sex. Sometimes and always use were connected by desires to prevent a pregnancy and STIs.

Men reported multiple motivations for condom non-/use; these were not binaries in which the motivation for non-use was the antithesis of the motivation to use. For example, while 25 of 39 men always used condoms to prevent a pregnancy, only 5 of 123 men who never used reported that they currently wanted a pregnancy. Motivations to not use condoms could be connected to positive thinking regarding partner preference, pleasure, love, and intimacy.

Factors associated with condom non-/use

Table 13: Ordinal regression models for factors associated with condom non-/use among men

	Explanatory Variable	**Model 1** **OR** **(coeff, C.I)**	**Model 2** **OR** **(coeff, C.I)**
Pregnancy Acceptable (ref No)	Pregnancy is acceptable	---	0.12 *** (-2.14, -3.43 – -0.94)
Age (ref 20-24)	18-19	1.43	1.58

		(0.36, -0.74 – 1.44)	(0.46, -1.09 – 2.03)
	25-29	1.21 (0.19, -0.59 – 0.97)	0.83 (-0.18, -1.43 – 1.02)
	30-39	0.77 (-0.26, -1.64 – 1.10)	0.53 (-0.63, -2.65 – 1.36)
	40+	2.48 (0.91, -0.62 – 2.41)	7.86 + (2.06, 0.06 – 4.09)
Religious (ref No)	Religious	5.42 + (1.69, 0.13 – 3.55)	35.20 ** (3.56, 1.35 – 6.33)
Parenting (ref No)	Parenting	0.06 *** (-2.89, -3.87 – -1.98)	0.04 *** (-3.22, -4.47 – -2.07)
Relationship Type (ref Married)	Longterm Partner / Fiancé	0.36 (-1.03, -2.67 – 0.56)	0.34 (-1.07, -3.23 – 1.02)
	Girlfriend	1.16 (0.15, -0.90 – 1.21)	1.29 (0.26, -1.14 – 1.66)
	Sexual Partner	6.78 + (1.91, 0.23 – 3.66)	5.36 (1.68, -0.30 – 3.78)
	Single	0.73 (-0.32, -1.49 – 0.85)	---
Multiple Relationships (ref No)	Multiple Relationships	1.91 (0.65, -0.28 – 1.58)	1.05 (0.05, -1.09 – 1.18)
Working (ref No)	Working	1.28 (0.24, -0.48 – 0.99)	1.83 (0.61, -0.42 – 1.68)
Education (ref Senior Secondary)	Primary	1.52 (0.42, -0.85 – 1.64)	2.30 (0.83, -1.09 – 2.85)
	Junior Secondary	0.88 (-0.13, -1.03 – 0.75)	0.52 (-0.65, -1.94 – 0.59)
	Higher	5.56 ** (1.72, 0.70 – 2.77)	4.03 (1.39, -0.23 – 3.05)
Main Income (ref Respondent only)	Respondent and others	0.95 (-0.05, -0.94 – 0.83)	1.12 (0.11, -1.12 – 1.32)
	Others	1.28 (0.25, -0.65 – 1.15)	4.49 + (1.50, 0.19 – 2.88)
Partner Using Contraception (ref No)	Yes	0.95 (-0.05, -0.94 – 0.82)	0.32 * (-1.15, -2.43 – 0.07)
	Don’t know	0.49 (-0.71, -1.58 – 0.16)	1.08 (0.08, -1.19 – 1.35)
Wealth Index (ref Lower)	Middle	1.03 (0.03, -0.77 – 0.85)	5.30 ** (1.67, 0.35 – 3.06)
	Higher	0.90 (-0,10, -1.11 – 0.92)	8.78 ** (2.17, 0.76 – 3.66)
Masculinity (ref Not Important)	Individual factors important	1.25 (0.22, -0.62 – 1.08)	0.23 (-1.45, -2.93 – -0.06)
	Interpersonal factors important	1.84	1.74

	(0.61, -0.15 – 1.38)	(0.56, -0.58 – 1.70)
Familial / community factors important	0.81 (-0.21, -0.95 – 0.52)	0.27 ** (-1.32, -2.40 – -0.30)
Structural factors important	1.61 (0.47, -0.22 – 1.18)	0.82 (-0.20, -1.27 – 0.87)

+ p<0.10,* p<0.05,** p<0.01,*** p<0.001

Table 13 shows the regression results for two models. Model 1 reports ordinal regression results for all men surveyed who had reported every having had sex. Model 2 reports ordinal regression results for currently partnered men, which includes a variable for pregnancy acceptability.

Among all men who had ever had sex (Model 1), there were significant differences in condom use between men who were parenting compared to those who weren't, and men with higher education compared to those with senior secondary education. Men who were parenting were much less likely (OR 0.06) to be using condoms than men who were not parenting, while men with higher educational attainment were more likely to be using condoms than those with secondary senior educational attainment (OR 5.56).

Model 2 reports the odds ratios of using condoms among men who were currently partnered. This subgroup of men (n=173) was also asked about the acceptability of their partner becoming pregnant. Among these men, those who thought a pregnancy would be acceptable were less likely to be using condoms than those who thought a pregnancy would be unacceptable at time of interview (OR 0.12). In addition, men who were already parenting were less likely to use condoms than men who were not parenting (OR 0.04). Men who knew their partners were using contraception were less likely to use condoms than men who knew their partners weren't using contraception (OR 0.32).

Men who reported that someone other than themselves was the main source of household income were more likely to use condoms than men who reporting being the main source of household income (OR 4.49), though this was only significant at the p<0.1 level. Men who belonged in both the middle and higher wealth categories were more likely (OR 5.20, OR 8.78) than men who belonged to the lower wealth category to be using condoms.

Men who reported being in a relationship were less likely to use condoms if they reported believing that familial and community level factors were an important component of masculinities than if they did not (OR 0.27). This variable largely centred around provision of care by men to various members of their family, including partners, children, parents, and friends. The other three levels (individual, interpersonal, structural) of masculinity attributes did not have an association with condom use, although the individual was associated at a p=0.1 significance level.

Among men with partners (Model 2), being aged 40+ (OR 7.86) and men who were religious were also associated with increased condom use (OR 35.20). The high OR, likely due to the small number of men over 40 and small number of men who report not being religious, means that these associations should be interpreted with caution.

The regression results suggest interlinking socio-economic and normative factors that shape condom non-/use, tying use to men's interactions with their broader contextual environments. Men who are less economically independent from others in their household alongside men who are more highly educated and wealthier were more likely to use a condom. Men who were already parenting or who believe a critical component of being masculine was familial and community care were less likely to report using condoms.

The qualitative analysis interrogates men's motivations for condom non-/use and locates these motivations in relation to conceptualisations of sex and gender.

Sex, reproduction, and condoms

For men who reported sometimes or always using, condoms were explicitly linked to pregnancy prevention. Frequently, these men also framed sex as inherently about reproduction. Men's motivations for condom use centred the navigation of reproductive sex. Of the 39 men who reported always using condoms, 25 did so specifically to prevent a pregnancy, and 22 of 73 men who sometimes used condoms did so to prevent a pregnancy.

> ***R:*** *Sex, sex, sex… I can't say sex is something for fun because it is through sex that we have children.*

45-year-old, always uses condoms because "I [the respondent] don't want any child now"

This respondent links sex specifically to reproduction (and, by extension, as not only 'fun') and explicitly ties his condom use to desires to avoid a pregnancy. The respondent indicates elsewhere that he does not believe his partner is using contraception, meaning that for him condoms are the main and only current contraceptive being used within his partnership. This explicit link between condom use and pregnancy and parenthood was made clear by a number of respondents:

R: *Because I am not ready to be a father yet and don't want the lady to get pregnant.*

26-year-old, always uses condoms

R: *It was in the beginning of our relationship when we did not want a child but when we were ready we stopped [using condoms]*

30-year-old, sometimes uses condoms

Both men describe (not shown here) their partner's contraceptive non-use as complementing their own condom use, illustrating the relationality of condom non-/use. They illustrate that condoms allow for the navigation of being 'ready' to be a parent, and how the acceptability of parenthood is temporal and dynamic. This includes that condom use is not consistent and can vary; while the second respondent describes stopping when ready for children, he reported that he still sometimes uses them. Boundaries between being ready or not ready for parenthood are also relational to some men's expectations and socio-economic aspirations:

R: *For me I would say you should be a university graduate… but if you are not even done and you have a skill or working fine.*

28-year-old, sometimes uses condoms to prevent a pregnancy

This respondent highlighted his expectations of the socio-economics conditions a man should meet before he is 'ready' to have children. For some men, condom non-/use was not only about pregnancy prevention but also was a means to navigate gendered, masculine norms around fatherhood and parenting expectations.

These qualitative insights intersect with the socio-economic factors significantly associated with condom use in the regression results (Table 13). Parenting is deeply embedded in provision – particularly financial provision – by men. It also contributes to understanding why men who are already parents might be less likely to use condoms (Table 13), as they are already navigating the realities of parenting and are not influenced by the perceived need to meet certain masculine ideals prior to parenthood.

Love and intimacy

Men's condom non-/use motivations were deeply relational, and references to their partners or relationships were implicated in their condom non-/use. When describing motivations to use (or not use) condoms, men frequently referred to their relationship with their sexual partner as being important. 64% of men who reported their condom non-/use was motivated by their relationship were men who reported never using, compared to 29% who reported sometimes using and 7% always using (Table 12).

> ***R:*** *I feel she's my wedded wife and there is no need. Besides, she's on a family planning method*
>
> 47-year-old, never used condoms

This man connects his decision to not use condoms to his marital status, but also how his partner facilitates this decision by using contraception herself. It suggests that for him, it is specifically condoms that become less acceptable once married. In the regression analyses, relationship type was not significantly associated with condom non-/use (Table 13). Men's quotes and own words, therefore, might contradict the quantitative results. Interrogating the relational aspect of love and intimacy, however, reveal that meanings of condom non-/use were connected to the perceived level of love and intimacy and the desire to express this, rather than any specific relationship label. For some men, sex was about building intimate connections with their partner, as well as testing their sexual compatibility linked to future reproduction:

> ***R:*** *Sex before marriage… allows you to know your partner as far as sex is concerned sometimes there is sexual incompatibility if those things arise then you know to resolve those issues, so for me sex before marriage is very important and after*

marriage too it is very important, it is a way of consummating your marriage and that is what you would use to produce babies so it is very important in marriage

40-year-old, sometimes uses condoms depending on if it is readily available at time of sex

The quote from the respondent reveals how condom non-/use is embedded in interpersonal and community factors. For him, sex is about generating connection, testing the capacity to have penile-vaginal sex. Condoms become important for being able to facilitate these meanings of sex while, critically, avoiding a pregnancy. By conceptualising the meaning of sex for unmarried people through the lens of building sexual compatibility to meet norms of fertility, condom use assumes a nuanced meaning. It is both connected to reproduction but also distinct in its capacity to prepare men for their future, partnered sexual and reproductive lives. These behaviours and expectations are deeply rooted in the study context's heteronormative, sexual, and reproductive masculinities.

Men's responses emphasised that this relationality was tied to the desire to express love, intimacy, and sexual non-monogamy:

R: *[LAUGHS] when I hear of sex for me it is enjoyment. It is all about enjoyment…She shouldn't be opening it to everyone since she trusts and believes and loves you she would give it to you for you to know she really loves you.*

28-year-old, always uses condoms as he and his partner are not ready for children

Condoms assume meanings beyond fertility regulation and towards facilitating the expression of feelings that men had towards their sexual partners. This included how condom use impacted their ability to express love to their partners:

R: *She feels detachment with the use of condoms and sometimes complains that it doesn't show love*

27-year-old, sometimes uses condoms

R: *It is because my ex-girlfriend thinks I don't love her when I use condom every time*

27-year-old, sometimes uses condoms

In both responses, men were framing their condom non-/use in consideration to what they believe or were told their partner felt. Condom non-use and sometimes-use are connected to sex, and non-use is a means to express love through sex. For these men, condom non-/use is connected to the values and characteristics of a specific relationship and the expression of feelings, not only the category of relationship.

Circumstance, trust, and STIs

The relationship that a man had to their partner intersected with how circumstances shape condom non-/use. For some men spontaneous sex was specifically the reason for their sometimes condom non-use.

> ***R:*** *…but nowadays I don't use a condom. Because most times it (sex) happens spontaneously between us*
>
> 28-year-old, sometimes uses condoms

> ***R:*** *sometimes I have sex unplanned so I don't have it on me*
>
> 23-year-old, sometimes uses condoms

For these respondents, condom non-/use was linked to the circumstances in which they had sex. For the first respondent, their partner never uses contraception (not shown here), and he reports that she thinks it is unnecessary for a monogamous relationship. By implication, therefore, condom use becomes linked to sex outside of a monogamous relationship. Trust and love highlight the relational nature of sex. For many men, their condom use was motivated by who they were having sex with; trust was relational and embedded in concerns over not knowing if a sexual partner had other partners:

> ***R:*** *It was my first time having sex with her and I didn't know her that much at that time*
>
> 20-year-old, sometimes uses condoms

> ***R:*** *If I do not trust her, I use condoms but for my girlfriend, I do not use a condom*
>
> 20-year-old, sometimes uses condoms

R: *There are some girls I do not trust so I use them but not with my girl when I had one*

30-year-old, sometimes uses condoms

The respondents highlight that contraceptive use is tied to their perceptions of their sexual partner, as well as their own sexual experience and relationship development. Concerns over STIs are not only biomedical and related to specific transmission risk but also rooted in social constructions of trust. It shows the complex and multifaceted nature of sexual relationship development that survey questions on relationship type can only partially capture. For other men, trust is specifically tied to monogamy:

R: *I don't use rubber because my girlfriend doesn't go anywhere. She is always at home.*

23-year-old, never uses condoms

R: *Because we are staying together and faithful*

24-year-old, never uses condoms

Trust, therefore, is a relational construction and bound up in gendered notions of sex. During interviews, some men described their perception of women in the community enjoying sex more than they (men) thought was appropriate. This manifested in gendered sexual stigma towards women, who become labelled as promiscuous and less trustworthy:

R: *Like I said at first when we were talking, there are some of the women that are sex maniacs [**kakapiopio**] they like having sex, if she doesn't have sex today she can't sleep*

21-year-old, sometimes uses condoms because he is in a committed relationship

Men with multiple partners reported different condom non-/use depending on who the partner was. One 27-year-old man reported that he never used condoms with his 'baby mama' [mother of his child] because "I have a kid with her", while he sometimes uses with his girlfriend because "I know when she is with me she is mine, but once she steps out, she is not

mine". His responses allude to an element of control around knowing a partner's whereabouts being tied to trust and sexuality. It also highlights the intersections between relationship type and parenting. Aligning to results in Table 13, the man's status as a father was a reason for condom non-use, but this was specifically with the partner with whom he had a child. It highlights the complexity of parenting and the relational nature of condom non-/use.

Gendered sexual stigma intersects with respondent's perceptions of the connection between certain partners and risks of STIs. It highlights that relationship type might proxy for a trusting relationship, but for many men trust is more of a motivator for their condom non-/use than the label they gave their relationship. Concerns over STIs – particularly HIV – was a key motivator for men to use condoms. This was directly linked to the relation of partner a man had sex with. Partners who were unknown to the man or women who had multiple other sexual partners were framed as people with whom condom use was desirable:

> ***R:*** *Yeah, the boys especially, you see now HIV is real so I always tell my male friends HIV is real because who don't know who also have sex with that lady [**ole mɛi babawoo in yeɔɔ lo nɛ – "you don't know whether a lot of people eat this fish / meat too"]** and you don't know where she has been before coming to you*
>
> 22-year-old, always uses condoms to protect against STIs and pregnancy

One respondent indicated that within his friendship group, contraceptive use was encouraged in specific circumstances. This included the description below, in which a man might have sex with someone they do not know well after a night of drinking with friends. These circumstances elicited specific concerns over the potential of STI transmission:

> ***R:*** *We [he and his friends] normally focus on STIs… sometimes we are tipsy with alcohol we don't follow what we are supposed to do, we may aim that I would not engage in an unprotected sex with someone I don't know very well, who is a stranger to me but when we are drunk we will not be focusing on those things, we depart from that thing… we [men] normally help each other with condoms, if one doesn't have we help out.*
>
> 40-year-old, sometimes uses condoms depending on if it is readily available at time of sex

The two respondents above highlight the role of social relationships as well as sexual relations in condom use. Condom use as a mechanism to navigate risk with specific types of partners – itself based on gendered assumptions of that partner – is constructed and communicated via friendship groups. It intersects how the circumstances of sex and the social situations in which a man might meet a sexual partner influence potential condom non-/use. It also further illustrates how condom use might be perceived within a relationship as men associating their partner with women stigmatised by men as less trustworthy or more likely to present risks.

Sex, pleasure, and happiness

Condom non-/use was connected to pleasure, sexual effects, and what men wanted to feel during sex. Pleasure was discussed between men, with interactions between men shaping masculine norms around sex for pleasure. Conversations, particularly among younger men, centred around sex as pleasure and how this can be used as a mechanism for bragging between men. This creates new meanings around condom non-use, where sexual pleasure is a marker of masculinity and communicated through interactions with friends. Condom non-use becomes the way to earn these "bragging rights":

> ***R:*** *The normal boys boys talk…* ***chale*** *[colloquialism and way of referring to a friend/acquaintance] yesterday I had sex with my girl it was so nice we enjoyed ourselves and all that, because of the pleasure…they think they have gained themselves bragging rights*
>
> 20-year-old, never had sex

> ***R:*** *So far if they [male friends] are talking [about sex] I don't pay attention to them but one thing I have seen it that they can say stupid words like what is sweeter than a vagina?*
>
> 22-year-old, sometimes uses condoms as he doesn't enjoy sex with it

23 of 123 men who reported never using condoms reported doing so because of reasons relating to pleasure and other sexual effects that they associated to condoms (Table 12). Meanings of condom non-/use that centre around pleasure are tied to conceptualisations of sex as a pleasurable activity:

R: *…like, let's do something enjoyable, so I see it to be something that we enjoy example when two young people eat together it is more enjoyable than one person eating alone.*

22-year-old, sometimes uses condoms as he doesn't enjoy sex with it

I: What is your opinion about sex?
R: Sex is happiness / pleasure [**minshɛɛ**]

21-year-old, sometimes uses condoms because of the relationship type

Condom use was associated with 'sweetness' – in which men saw condom use as antithetical to pleasurable sex:

R: *It is not sweet at all using condom*

28-year-old, never uses condoms

R: *Because doing it raw [condomless] is much sweeter than using condom*

22-year-old, never uses condoms

Both these respondents reported that their partners use contraception. This might indicate that motivations to not use condoms, driven by desires for more pleasurable experiences, are facilitated by the partner assuming the responsibility of avoiding a pregnancy. Men privilege their pleasure and their partners are potentially left to navigate pregnancy avoidance. This implies an inherent gendered power dynamic in which men's capacity to decide the type of sex they want and their decisions to not use condoms place a burden on their partners to navigate their own (non-reproductive) desires.

A number of men acknowledged women's sexual pleasure, with fewer mentioning that contraceptive decisions included what their partner found more pleasurable:

R: *Because my girlfriend says I come [ejaculate] early when I use condom and she doesn't enjoy it. Therefore, sometimes I don't use contraceptives.*

32-year-old, sometimes uses condoms

While the respondent had a conversation with his partner around not using condoms, this man was not sure whether his partner uses contraception. This suggests that conversations around pleasure and contraception do not necessarily include discussion of contraceptive use by both sexual partners.

Discussion

Interrogating men's motivations for their condom non-/use provides insights into the varied meanings that they ascribe to condoms, as well as the personal, interpersonal, and community factors embedded in their decisions. Condom non-/use was shaped by complex factors and motivations located in gendered sexual expectations, behaviours, beliefs, and constructs. Men's perceptions of ideal masculine attributes and the role of masculine norms and expectations were particularly significant, and emphasises the importance for SRH policies and services to recognise men as gendered and reproductive beings (Daniels 2006). Men's desired outcomes of sex – pleasure, reproduction, to convey love and intimacy – were intertwined with their motivations for condom non-/use which were simultaneously relational. Men's experiences and perceptions illustrate the ways in which interactions and perceptions of trust and risk were tethered to the type of relationship(s) a man was in as well as their perceptions of their sexual partner(s).

Pregnancy prevention was a significant motivator among men who reported using condoms, especially those who reported 'always' using condoms. Interview data highlight how pregnancy prevention was tied to gendered expressions, meaning that condom use became tied to masculine norms. This connects men's socio-economic conditions to their condom non-/use, including significant associations depending on whether men were the main earner in their household, their relative wealth, and their educational attainment. These factors are tied to constructions of 'readiness' (Strong et al. 2022, Ouedraogo, Senderowicz, and Ngbichi 2020), which men describe in interviews. These socio-economic conditions that shape condom non-/use are also tied to contextual masculine norms around the 'breadwinner' model of being able to provide financially for a family (Dery and Apusigah 2020, Ganle et al. 2016).

Understanding constructions of masculinities, including men's own views on what are critical attributes, characteristics, and behaviours for a man to have, provide novel and important

insights into condom non-/use. The findings illustrate the linkages between condom non-use and masculine ideals that centred around providing care for partners, children, and family. Men who felt these masculine norms were important to them were less likely to use condoms than those men who may perceive these masculine expectations as less important. Men's lower use of condoms may be indicative of their desire to create a context in which they can display these masculine qualities. Not using condoms might be a form of expressing care to a partner's emotional wellbeing and relationship desires, while having children provides a way in which men are able to prove their capacity to care for their families and meet the masculine expectations that they identify as critically important. Evidence of the intertwining nature of masculine ideals and reproduction has been highlighted elsewhere in Ghana, as well as Nigeria, and this study develops how this specifically and directly intersects with motivations to use condoms among men (Dery and Apusigah 2020, Smith 2020, Atobrah 2017). Including the role of masculinities and the relationship these have to broader systems and structures is therefore a critical component of a comprehensive, holistic, and positive SRHR agenda (Ganle 2015).

Sex had different meanings, connected to condom non-/use, and reflected different desires among men. The qualitative analyses presented further masculine norms not captured in the quantitative variables that influenced condom non-/use. For many men, sex was tied to pleasure, and condom non-/use was located within navigations of pleasure. Men's constructions of condoms as preventing the pleasure-focused sex they desired align to existing evidence and reinforce the need to incorporate pleasure in SRH policies and programming (Higgins and Hirsch 2008, Shai et al. 2012). Pleasure was also embedded in sexual partnerships; for some men, their decisions to not use condoms were associated with their partner's pleasure. For other men, their decisions to not use condoms to enhance their sexual pleasure was facilitated by their partner using contraception to prevent a pregnancy, thereby assuming the task and burden of pregnancy prevention. Novel male contraceptives are critical in offering alternative contraceptives that can alleviate this gendered burden.

Men's motivations were informed by gendered sexual stigma, in which women who were perceived as more sexually active were framed negatively. These represent critical 'myths and misconceptions' around family planning that could be addressed in future Costed Implementation Plans or similar SRH policies (Ministry of Health 2015). Condoms became connected to expressions of stigmatising beliefs and attitudes within sexual relationships

(Marston and King 2006). These meanings are distinct from believing that there is an absence of STI risk; they also speak to a navigation of stigmatising assumptions around women's sexual promiscuity. Condoms assume a meaning beyond their biomedical function and towards expressing (or undermining) signs of love and commitment. Condoms are conceptualised by some men as a barrier to expressing love, and condom non-use has important implications for men's navigation of their relationships. The continued framing of condoms only through a public health lens, in relation to HIV, means that critical meanings of condoms are missed, which limits the potential to understand motivations behind condom non-/use (Greene and Biddlecom 2000).

Relationships were an important component of men's condom non-/use. This includes whether a man knew about his partner's contraceptive use, and norms and expectations around condom non-use within marriage. Where the unit of analysis focuses on whether a sexual couple are protected from pregnancy (Becker and Costenbader 2001, Greene and Biddlecom 2000, Hook et al. 2018), critical power dynamics might be minimised. This study illustrates that relationship type may be a limited proxy for understanding motivations for condom non-/use, which are shaped by trust, love, pleasure, intimacy, and control. These meanings were developed through interactions both with partners and with friends and other men in the community. The findings advance existing evidence from Ghana on the role of relationship quality – measured through commitment, trust and communication – in shaping contraceptive use and acceptability (Cox et al. 2013). Existing condom advertising – e.g., Trust Condoms and the associated Good Man campaign in South Africa (PSI 2023)– offer effective ways to engage men more meaningfully in their decisions around condom non-/use by meaningfully engaging in the language and motivations men themselves cite.

Limitations

This study utilised methods designed to ensure the safety of respondents and researchers in response to COVID-19. The sample survey is not able to be generalised to the community, regional, and national levels. Despite cognitive testing during the survey development stage, there is the potential that respondents' answers differ from question intentions. For example, one respondent answered that he was using contraception but listed his partner's contraception as explanation. Thus, there may be some variation in the proportions of men self-reporting their contraception use. Nearly all men gave responses that explicitly and

implicitly referred to condom use, suggesting that the question had broad consistent understanding across respondents. Responses were cleaned to ensure all responses were in relation to condom non-/use. A skip pattern error within the survey meant that men who were not currently in relationships were not asked about their attitude towards pregnancy. This provides a pathway for future studies to explore attitudes towards pregnancy among men who are sexually active outside of a relationship.

Conclusion

Men's reasons to use condoms are plural and linked to the performances of their masculinity, the acceptability of a pregnancy, and their socio-economic circumstances. By locating condom use with different conceptualisations of sex, this study highlights the multiple motivations for contraceptive non-/use that are currently under explored in the literature. This study demonstrates the generative potential of understanding condom non-/use through a combined lens of masculinities and holistic understandings of sex.

Demographic and public health survey research provides critical and important macro-level data on condom non-/use. Grappling more with men as gendered and reproductive within survey design and questions will advance the detail and nuance of data and analyses. Condom non-/use should be understood more holistically and located within sex as pleasure, love, intimacy, trust, and spontaneity. It is important that data collection tools gather evidence on non-risk-based attitudes and behaviours towards condoms. While pregnancy prevention and STI-risk reduction are important factors, incorporating broader motivations could contribute to iterating and generating more effective and relevant policies and programmes. Attitudes and meanings around condoms are not static or singular, but rather reflect personal, interpersonal, and community interactions, expectations, and norms. Where survey data captures information on attitudes and behaviours, ensuring that this is relational and asked for each sexual partner a person has could help illuminate how condom non-/use manifests differently across relationships.

Ghanaian policy continues to commit to comprehensive access to sexual and reproductive health services and grapple with meaningfully involving men in provision. Acknowledging the reasons that men seek sex and the meanings that condom non-/use have allow for discussions around how, for example, to have pleasurable sex that includes condom use.

Tackling gendered sexual stigma can be important in mitigating the association between condoms, trust, and men's ideas of women's unacceptable sexuality. Though comprehensive sexuality education is currently a fraught policy topic in Ghana, ideas of wellbeing and pleasurable sex are important to include in CSE content (Singh, Both, and Philpott 2021). In the absence of alternative biomedical contraceptives for men, it might also be necessary to incorporate the need for men to adopt more positive masculinities that centre on sharing the burden of pregnancy prevention, and complementary ways to express love, intimacy, trust, and to create pleasure.

Future research on men's motivations to use or not use contraception will benefit from better understanding the interplay between gender, masculinities, and conceptualisations of sex. As male-centred reproductive technologies continue to be developed, grappling with the sexual desires of individuals will allow for the development of different types of contraceptives that can meet these desires. Examining how men conceptualise their condom use in relation to their sexual lives and their gendered realities is necessary to create more meaningful SRH programmes and policy that meets men where they are.

Chapter 7: Conclusion

This thesis interrogated men's roles in sexual and reproductive health and rights, seeking to address the 'missingness' of men in both policy and research. A mixed method study, it engaged theoretically, methodologically, and empirically with policy debates in global health and international development, as well as epistemological contestations in demography. The thesis develops an interdisciplinary conceptual framework that integrates masculinities into a feminist approach to demographic research through the lenses of Reproductive Justice, intersectionality, and stigma. Through this framework, the thesis is able to examine and understand the varied and significant roles that men have in SRH. Currently, there are limited policies, programmes, and interventions grappling with men and masculinities that are aimed at improving access to SRHR, particularly abortion (Ruane-McAteer et al. 2019, Ruane-McAteer et al. 2020). This thesis offers evidence that can help inform the development of future policies, programmes, and interventions aimed at men and gender transformational change.

The analyses show how men's perceptions, conceptualisations, and experiences provide meaningful and critical insights into their motivations and involvement in SRH. Specifically, this thesis emphasises how men's understandings of sex, sexuality, and reproduction tie to their gendered identities, their constructions of masculinities, and the broader gendered normative expectations around them. Experienced and enacted stigma, alongside desires to meet dominant masculine norms, boundary un/acceptable sexual and reproductive behaviours among men. Men's SRH decisions, therefore, become motivated by the need to navigate these boundaries, which includes the perceived need and desire to involve themselves in the SRH of others which can create conditions of reproductive injustice.

Summary of findings

The findings in this thesis link to three critical areas of SRH that men are involved in: abortion, emergency contraception, and male condoms. Through interrogating men's roles in each of these, the complexities, variations, and nuances of their perceptions, motivations, and behaviours were uncovered.

Grappling with men and abortion is complex. Abortions are, fundamentally, a decision for a pregnant person to make, and abortion-related care should meet the wants and needs of that person. To meaningfully engage with existing research and on men's involvement in this thesis, Chapter 3 maps existing evidence on men and abortion. Chapter 3 operationalised the abortion-related care trajectories framework (Coast et al. 2018) to examine men's roles in abortion and develop on existing evidence reviews on the topic (Altshuler et al. 2016). The assembled literature illustrates the often significant direct and indirect ways in which men shape abortion-related care trajectories.

The studies mapped in Chapter 3, primarily drawing on qualitative data, highlight how men shape abortion-specific experiences, individual contexts, and the broader community contexts in their roles as partners, family members, friends, and community leaders. Studies report on the ways in which men's reactions, including denial or rejection of a pregnancy, shape the decisions that women felt were available to them. This chapter emphasises that men could shape the choices and decisions that women are able to make around their abortions, including whether they are able to access the care they want, in the way they want, with the support they want. The review illustrates men's roles in abortions across different contexts and the need for further evidence aimed at critically understanding the mechanisms driving these roles.

Chapter 4 uses empirical data to analyse the motivations that drive men's involvement in abortion. Using mixed method data and operationalising the conceptual framework, the chapter highlights how constructions of masculinities are tethered to and entangled in expectations and norms around sex, sexuality, reproduction, and fatherhood. Critical tensions are made visible; sex was an important part of becoming a man, as was reproduction. Yet, for men to become fathers they first needed to meet masculine norms connected to 'breadwinner' and provider models of manhood. An inability to meet these expectations was perceived to result in interpersonal and community shaming. Thus, analysing men's constructions of masculine ideals and their descriptions of expectations provides essential insights into the internalised and externalised mechanisms that drive men's gendered expressions and behaviours.

Reproduction threatens dominant masculine norms as well as helps fulfil them. Masculinities are constructed both on what men's bodies do and on what other bodies (specifically women's) can do for men. Women's bodies are simultaneously embodied spaces where men can express their masculinity through sex and reproduction and represent a threat to masculinities. Such constructions of masculinities and the notion of 'readiness' were embedded in men's rationales for their involvement in abortions, both actual experiences and men's perceptions about hypothetical abortion involvement.

Men's involvement in and attitudes towards pregnancies and abortions were deeply relational. The empirical data analysed in Chapter 4 illustrates the utility of novel survey data that embeds a relational understanding of gender and behaviour in its design. This design was shaped by the conceptual framework, which necessitated a deeper interrogation of men through a feminist approach to their gendered lives. Men's involvement in abortions was pregnancy-specific, shaped by their relationship to the pregnant person and how a continued pregnancy or abortion would impact their masculinity. Research methods that provide insights into this relational space between men and women are essential for analysing the manifestations of gendered power. The chapter illustrates the role that theory can play in critical understandings of men's SRHR within demographic research.

Chapter 5 reveals how the assumptions and language within global health, international development, and demography are mal-aligned to the realities of people's SRH lives. It achieves this by examining men's involvement in and differing conceptualisations of emergency contraception (EC). The chapter highlights the disconnect between knowledge of the biomedical language of 'emergency contraception' and the language and information used and shared among men, which focuses on the practicalities of ECP use and brand names. While some men conceptualised ECPs in ways that aligned to recommendations by healthcare providers and SRH policies, many men did not incorporate notions of 'emergency' and instead considered ECPs as part of a broader mix of contraception with unique benefits. Within this framing, men highlighted that ECPs had specific benefits, including as a contraceptive that facilitated spontaneous, pleasurable, and condom-less sex. The analysis highlights the need for global health and international development policies to grapple more explicitly with lived contextual realities, and the potential information that is missed when men are minimalised within or excluded from SRH research and evidence production.

Emergency contraception was conceptualised as a material object through which men enacted gendered and sexual stigma. Some men viewed ECPs as highlighting 'responsibility' among men and women seeking to avoid pregnancy. Yet, some men also saw women's use of ECPs as indicative that women had been irresponsible, reckless, or that they were promiscuous, conceptualising ECPs as a means through which women can have enjoyable and frequent sex. The visible nature of ECPs, compared to other contraceptives such IUDs, implants, and injectables, meant that for some men its utility was as an observable contraceptive. Within this frame, men discussed pressuring their partner to take ECPs, to secure their desired (pleasurable, condom-less) sex and avoid a pregnancy. The chapter highlights the need for data collection instruments to use language that holds contextual relevance, as well as the critical importance of men's involvement that is missed where they are minimised or excluded from research altogether. The analysis presented in this chapter provides insights into how women's reported ECP use might be dictated and controlled by men and may reflect gendered power.

The final empirical chapter (Chapter 6) examines men's condom non-/use and critically engages with current efforts towards the incorporation of a broader, more holistic understanding of sex in global health and international development (Starrs et al. 2018, Higgins and Hirsch 2008). The analysis interrogates the different ways that men conceptualise sex and the outcomes they desire from sex and how these intersect with their motivations for condom non-/use. Sex was more than simply a mechanism to reproduce; for men, sex also related to pleasure, intimacy, love, trust, and power. The type of sex men sought and the meaning that they wished to convey through sex with their partner was tied to their motivations around condom non-/use. Reasons for non-/use were not antitheses; where men's use was driven by pregnancy and STI prevention, non-use was rarely driven by desires for a pregnancy. When condoms are framed simply as a tool for pregnancy or STI avoidance in global health and international development, motivations to for non-use are invisibilised. This has important implications for engaging men as users of SRH services, meeting their needs and desires, and for developing alternative male contraceptives to accommodate these.

Chapter 6 includes a novel set of masculinities variables within the quantitative analysis to better understand condom non-/use. Developed through qualitative responses, the variables are rooted in a constructivist understanding of masculinities. This process was informed by the feminist conceptual framework, which centres the nuance and depth provided by a

contextually grounded and mixed method approach to research (Levtov et al. 2014, Culley, Hudson, and Lohan 2013). Thematic categorisation of masculinities into individual, interpersonal, familial / community, and structural factors showed that men who considered familial / community forms of masculinity as important were less likely to use condoms. Alongside this, other significant factors shaping condom non-/use included men's financial, educational, and wealth-based circumstances. The chapter emphasises the potential significance of relational factors in condom non-/use, alongside gendered contextual and normative factors. It offers a way for future research to consider a broader understanding of gendered relationality from the interpersonal to a man's relationship with his community, and how constructions of masculinities are located in that relational space.

Theoretical and methodological contributions to research

This thesis troubles positive and atheoretical traditions within demographic research (Presser 1997, Williams 2010, Sigle 2016, Strong et al. 2023). It does so by creating a conceptual framework that draws on multiple disciplines and critical thinking within academic and activist spaces. Reproductive Justice, stigma, and intersectionality provide the necessary lenses to understand sexual and reproductive health and rights within their broader environments, making visible how social, political, economic, and gendered systems and structures can shape the conditions of access, choice, and autonomy. With this understanding of sexual and reproductive health, a feminist approach, grounded in African feminism and the politics of context and location, exposes the role of Global North epistemological hegemonies in shaping research. It provides the conceptual tools to centre constructivist approaches to better understand sex, sexuality, relationships, gender, and power.

A feminist approach challenges many of the assumptions within demographic research (Williams 2010). This thesis further develops these by interweaving the theoretical work on hegemonic masculinities as a mechanism through which to better grapple with men within research. This draws on Critical Studies of Men and Masculinities (Hearn 2013, Lohan 2015). The conceptual framework created for this thesis, therefore, necessitates that research tools be designed in a way that capture men as gendered beings, who both internalise and externalise gendered expectations, and whose constructions of masculinities were built in relation to the world around them.

Critical to this conceptual framework was its application throughout the research project; it was not simply a tool through which to approach the analysis after data collection. The framework allowed for the collection of empirical data that emphasised the role of masculinities within men's involvement in sexual and reproductive health, and critically engaged with assumptions both in research and global health and international development policy and programming. The following section outlines how this framework was integral to the development of research tools that could generate more nuanced data with a greater capacity to capture the role of interactions and constructed gendered ideals. The final component of this section describes how adaptations to COVID-19 provide new methodological considerations for future demographic research.

Implications of the conceptual framework on the research design and implementation

The implications of the conceptual framework developed in this thesis can contribute to research design and implementation both within demographic research and beyond. In particular, it offers insights into how future quantitative work across disciplines can be grounded in constructivist, feminist thinking. This includes the development of research tools better able to capture nuances and unanticipated responses. This can (re)shape the closed nature of the data commodity chain in global health and international development, making it more possible for novel or unexpected data to inform policy and programmes and iterate research tools (Coast, Randall, and Leone 2009).

The conceptual framework in this thesis required meaningful collaboration with community-based organisations and partners, to ensure that the aims and objectives, research instruments, and implementation were contextually relevant and grounded. This process meant that the research project could be designed in a way that not only met the needs of the PhD thesis, but also produced relevant and useful data for organisations working within the community, moving towards a model of co-production. The partnership with Act for Change, which was further solidified through the employment of researchers who had also worked at the organisation for data collection, both helped when iterating the research tools (see Chapter 2) and was critical in the knowledge exchange and community engagement after data collection was completed (see later in the Conclusion).

The conceptual framework generated a critical rethinking of survey design, with learning that can inform future survey instruments. Iterating the survey with the research team, including prioritising first the Ga-language survey and then translating this back into England and Twi, foregrounded contextually relevant linguistic nuances (Chapter 2). Piloting the survey with men in the community and incorporating their voices and input in the questions allowed for iterations that would better capture contextual nuances and further emphasised how knowledge and understandings around SRH among men were connected and divergent (Chapter 5).

In contrast to most quantitative research, the survey design in this thesis centred voice through open-ended questions and avoided reliance on categorical questioning. By understanding gender, power, and behaviour as relational, the survey's approach to repeat questioning for different partners illuminates how men's attitudes and behaviours were not static or consistent across different partners and types of relationships. The analytic potential of relational questions and repeat questions for men with multiple partners was demonstrated in Chapter 4 and should be considered for larger scale quantitative research in the future.

Centring the voices of men in the survey design facilitated a mixed method approach to understanding men, gender, and SRH. The conceptual framework prioritised understanding men's own constructions and perceptions of masculine norms, which led to the creation of quantitative measures from qualitative responses to open-text survey responses (Chapter 6). This blended qualitative and quantitative approach generated nuanced and grounded evidence. It shows how the examination of men's own perceptions and conceptualisations of sex, sexuality, reproduction, and masculinities, deepens our understanding of their SRH attitudes, behaviours, roles, and involvement (Chapters 4 and 6). The overall survey and interview design (re)emphasises the central importance of mixed method approaches to understanding gender and power within demographic research, developing on the central importance of mixed methods work within the field of masculinities (Levtov et al. 2014, Culley, Hudson, and Lohan 2013).

Use of mobile phone-based methods

The evidence included in this thesis shows how the use of mobile-phones as a tool for conducting research with men can work effectively, which is important as technological

advances continue to increase mobile-phone ownership and usage globally (Zupork Dome, Adu Duayeden, and Armah-Attoh 2020). Mobile phones allow for a shifting of temporal and spatial power dynamics that provide respondents greater control over the interview process. The tools used for data collection, including headsets that allowed the research team to work 'hands free', facilitated the written capture of any further information that was relevant and important. This provided data that generated more detailed understandings of both men's understandings of questions (for example, the conflation of contraception with male condoms in Chapter 6) and the nuance in their attitudes and behaviours. It highlights the potential for the development of surveys that can capture large scale mixed methods data in one interview, which has implications for not overburdening respondents by repeated data collection.

While it was not possible to assess the counterfactual (using face-to-face methods), there were no significant or clear indications that men disliked mobile phones for data collection. It is important, however, to consider that these methods are inherently exclusionary, and that they would ultimately be best used in conjunction with other differently accessible methods (see Considerations).

Implications and contributions to community, national, and global policies and programmes

The empirical findings of this thesis offer contributions to policy and programme development and implementation at the community, national, and global level. The following section outlines how different components of this thesis offer potentially useful considerations and implications for different stakeholders at different structural levels.

Community implications: Transforming Men Movement

A critical component to this thesis was developing a meaningful partnership with community-based organisations for whom the research and evidence should be useful, relevant, and beneficial. After data collection was completed, I was awarded a competitive Knowledge, Exchange, and Impact grant through the LSE. In collaboration with Act for Change (see Chapter 2 on this partnership), we used this funding to develop a series of workshops with men called *Transforming Men Workshops*.

35 men participated in a series of six fortnightly workshops that were divided by age, with men aged 18-24 in one workshop and 25-30 in another. The workshops were developed using evidence from the empirical findings in this study and aimed to create a safe space for men to discuss their masculinities, as well as to engage men on issues of violence and sexual and reproductive health and rights and equality. The community-based work drew on evidence during the pilot phase of this study of men's desires to talk about issues relating to their sexual and reproductive lives (Chapter 2), the pressures and normative expectations they felt as fathers (Chapter 4), and the ways in which they conceptualised their partners and expressed socialised and gendered expectations of partner behaviours (Chapters 4-6).

Workshops included several different activities and discussions, including around fatherhood and parenting, sex, sexuality, and reproduction, and workshops on preventing violence as well as tackling men's own feelings towards violence. The workshops were facilitated by Samuel Lamptey, who worked as a researcher on this thesis and is also an employee at Act for Change. They also included the facilitation support of Nii Kwartei Owoo and Nii Kwartelai Quartey, also researchers on this thesis and all three were co-authors on Chapter 4.

A major component of the workshops was to support men share their gendered experiences around SRH and violence. Men shared examples of their sex lives, the pressures that they felt to meet masculine expectations, their reflections on their fathers and the types of fathers they sought to be, and on violence (particularly intimate partner violence). Participants at the workshops reported finding the space extremely valuable, particularly commenting on the significance of having a safe environment to discuss these concepts:

> *Organizations should focus on men, create awareness and go to men or make available space like we have here – workshop participant*

With the completion of the workshops, Act for Change are now using the combined evidence from this thesis, the workshops, and their other community-based programmes to apply for longer-term funding. This funding would be used to develop the *Transforming Men Movement*, a community-wide programme that seeks to engage men around the topic of masculinities and develop tools and mechanisms through which to (re)construct masculinities with feminist and equality principles.

The development of the *Transforming Men Movement* speaks not only to the hard work and commitment of Act for Change towards social justice, but also the important role that research-activist collaborations can have. It was critical from the beginning of this thesis that the research was able to be relevant and useful beyond meeting the requirements for a PhD. This is possible, and collaboration and the creation and production of research instruments that are iterated to reflect contextual realities are a critical mechanism for this meaningful work.

Implications for Ghanaian Policy and Programming

The overarching implication of the empirical findings is that sexual and reproductive health policies and programmes in Ghana must explicitly grapple with gendered power dynamics. The following section outlines current policies and how the empirical findings might contribute to further developing these, alongside programmatic engagement with non-profit SRHR service providers. Policy and programme briefs designed from this thesis that were shared among key stakeholders within Ghana can be found in Appendix L.

Currently, governmental efforts to improve sexual and reproductive health are spread across different policies within different ministries, including the Ministry of Health, Ministry of Education, and Ministry of Gender, Children, and Social Protection. Greater alignment of the intricate relationship between gender and healthcare means that these policies and government ministries should be more critically responsive to each other and develop a clear and consistent understanding of the centrality of power, particularly gendered power, within SRHR. Importantly, greater funding through the health budget, produced by the Ministry of Finance, is necessary for better provision of SRHR services and programmes (UNICEF 2022).

The National Health Policy only references SRHR in relation to promoting "safe and responsible sexual behaviour" (Ministry of Health 2020, p. 13). The policy sub-objective does recognise the

> *…broader context of personal lifestyle, the economic circumstances, employment, living conditions, family environment and gender relationships including traditional and legal structures in which individuals live – (Ministry of Health 2020, p. 13).*

The policy's recognition of the broader context corresponds to findings in this thesis, in which both men, their relationship with their sexual partner, and their location within their gendered contexts could play a significant role in SRHR. However, the policy should also emphasise individuals own gendered sense of self and broader gender norms, not only gender relationships. Acknowledging the community-level gendered expectations and the role that these play on shaping masculine expectations and ideals has been shown to be significant among men in this thesis.

Moreover, the policy focuses on "safe" behaviour within a framing of "unplanned" pregnancies among youth and risks of HIV infection. The empirical evidence from this thesis suggests that approaching sex as 'risk' – of a pregnancy or STI transmission – might be limited in engaging men around why they make certain SRH decisions. As highlighted in this thesis, sexual behaviours are in part determined by desires for intimacy, pleasure, the fulfilment of masculine expectations, love, and more. For example, men might conceptualise "safe and responsible behaviour" to mean condom non-use, where being a responsible partner is tied to expressing love, intimacy, and trust (Chapter 6). Acknowledging a more holistic notion of sex within policy is critical and ensuring that subsequent service provision and information engage these different desires around sex.

Within the National Gender Policy, there is very little recognition of the intersections between gender and sexual and reproductive health and rights (Ministry of Gender Children and Social Protection 2015). The policy references the importance of "maternal mortality and reproductive health", including "unsafe" abortion (Ministry of Gender Children and Social Protection 2015, p. 17). However, there is little engagement with men's roles within SRHR and the significance of masculinities within this. Limited grappling with how embedded masculinities and gendered power are in sexual and reproductive health and rights might reduce the effectiveness of policies and programmes achieving their aims of universal SRH.

The National Gender Policy references broader sexual and reproductive health in related to aiding girls' educational outcomes and as a tool for women's empowerment, highlighting the:

> *…need to enforce the teaching of age-appropriate education to girls and boys on sexuality and reproductive health and rights in school curricula, including issues of*

> *gender relations and responsible sexual behaviour, focused on preventing teenage pregnancies – (Ministry of Gender Children and Social Protection 2015, p. 25)*

The most recent Guidelines for Comprehensive Sexuality Education in Ghana (Government of Ghana 2018) provide a proposed outline for CSE. It emphasises that:

> *[CSE] for young people should cover a broad range of issues relating to their physical, biological, emotional and social development, as well as the development positive decision making, self-esteem and the building of health relationships skills – (Government of Ghana 2018, p. 7)*

The guidelines include grappling with gender roles and norms for 'older adolescents' (aged over 15), including bodily autonomy and empowerment. Prior to this age, proposals include teaching primary school students aged 8 about 'gender roles' in the form of "maleness and femaleness" (p. 11), teaching gender "norms, roles and stereotyping" to 11-year-olds, and "gender and power relations" to 13-year-olds (p. 12). Recent efforts to implement a revised CSE curriculum were met with resistance by reactionary stakeholders and negative publicity that ultimately curtailed its implementation (Peyton 2019). Should CSE be implemented in the future, there are a number of additional considerations that would be important based on the findings in this thesis.

The evidence in this thesis highlights the important role of gender and gendered norms and expectations within sexual and reproductive health. This affirms that the current focus on gender within the proposed CSE guidelines are necessary and important. Further to an exploration of gender roles in relation to 'maleness' and 'femaleness', this thesis highlights the role of masculinities in SRHR and the importance of incorporating this in CSE. Taking a gender transformational approach within CSE would assist in creating more critical engagement not just with how gender is constructed but the ways in which it can be reconstructed towards equitable, healthy, and positive sexualities. As highlighted by the community work above, creating space for conversations between boys could be a practical, cost-effective, and significant mechanism to generate discussions around age-related masculine norms, expectations, and pressures.

Sexual pleasure and the positives of sex remain elusive in CSE policies. These continue to be minimised and also point to the need for better training and sensitisation for educators as well as for young people (Singh, Both, and Philpott 2021). Within this thesis, the role of stigmatising perceptions of women's sexuality (Chapter 5) and men's assumptions of expectations of their sexual and married partners to meet men's own pregnancy and abortion desires (Chapter 4) indicate critical areas of socialisation that might begin to be approached in early education and social media campaigns. The empirical findings highlight the important ways that men are responsive and supportive partners, as well as how their attitudes might be more supportive towards certain types of SRH care depending on their relationship to the person. Further exploration around how masculinities might be reconstructed towards broader levels of support to all relationships would be extremely useful.

A further contribution is to SRHR programmers, particularly for non-governmental, non-profit service providers. During the dissemination period of this thesis, policy and programme briefs were shared with MSI Ghana and Planned Parenthood Association of Ghana, both of which provide key SRHR services in Accra. Meetings with MSI Ghana focused on the empirical findings that showed how different services – abortion, emergency contraception, condom provision – were intersecting with gendered norms in ways that could limit the choice and autonomy particularly of women.

Highlighting the potential role of men in abortion (Chapter 3 and 4), for organisations that provide abortion services it is necessary to consider the different types of information sharing and care provision that would allow women to navigate their gendered environments. Campaigns to address men's roles could be useful, particularly in challenging their masculine identities and their perceptions of pregnancies within those gendered norms. Further developing on the insights in Chapter 4 about men's varying support for abortions among different relations of women / girls could be useful, as it offers insights into positive attitudes towards abortions that might be advanced further. However, the time sensitive nature of abortion means that short term solutions might include provision of medication abortion for at home use and discreet clinics, allowing women to access care privately or in secret without necessarily navigating the norms, expectations, and behaviours of their partners or of other men.

The provision of information on emergency contraception needs to be carefully considered to recognise the role of language and more limited knowledge of biomedical terms and phrases (e.g., 'emergency contraception'). The Government's restrictions on emergency contraception advertising are likely to exacerbate this and are fundamentally antithetical to better SRHR. For providers, both governmental, non-governmental, and private, work should be done to create more positive spaces for people seeking ECPs who might feel uncomfortable, embarrassed, or stigmatised. ECPs should be understood as safe to use (including multiple use) (World Health Organization 2021a), and located within people's sexual lives as an important component of their fertility regulation. This means challenging associations between ECPs and irresponsibility or sexual stigma. Men's roles in ECP use, including buying, might be a helpful place to create provider-purchaser conversations around the importance of bodily autonomy and their partner's choice, particularly where men may have intentions to pressure their partner into taking the pills. Furthermore, easier provision and reduced barriers for women's access can reduce the reliance on a man or partner who might then be able to shape a decision.

Finally, male condom provision should seek to meet men where they are and be framed within their sex lives. Focusing on the role of condoms with regards to pregnancy prevention and STIs is useful for its biomedical function but might minimise its social and sexual function. There are men for whom condom non-/use is embedded in relational and sexual desires. Linking condom provision with, for example, other modes of pleasure enhancement (e.g., lubricants), education around non-penetrative sexual pleasure, and tools and information for alternative, meaningful, contextually relevant expressions of love and pleasure could be particularly useful. Importantly, this should not seek to increase condom uptake specifically, but rather provide better conditions that might facilitate condom use for men who want to use them.

Implications and considerations for Global policy and programming

Global health and international development is increasingly focused on meeting the universal sexual and reproductive health and rights of all people (United Nations Population Fund 2019). The empirical findings in this thesis illustrate the importance of research with men to better understand a population's SRH needs. This includes the motivations, mechanisms, and needs of men themselves, including for contraceptives that meet their conceptualisations of

positive sex and wellbeing. Such evidence will have significant implications for the development of contraceptives that will meet the needs of men and provide a greater range of choice for an individual to meet their pregnancy and reproductive desires. This can be extended to all people so that future contraceptives should be developed to allow people of all bodies and genders the ability to have the fulfilling sex life they desire.

By critically understanding men's roles in SRH, policy can better understand the needs of women and other people by mapping the gendered environments and power dynamics they must navigate. The thesis reaffirms the need to grapple with masculinities in sexual and reproductive health and rights, as highlighted in political commitments stemming from the International Conference for Population and Development in 1994. In focusing on women and the need for increased modern contraceptive use and lowering fertility in the Global South, global SRH policies continue to exacerbate gendered power inequalities. Through the marginalisation of men, these policies are also at risk of inadequately addressing a key group that can shape reproductive injustices. Men should neither be taken as having no needs nor being framed only in relation to their role as supportive stakeholders in SRH (Wentzell and Inhorn 2014, Hook et al. 2018). Rather, specific policies on masculinities are needed and such policies should not be limited to the Global South.

The empirical findings in this thesis highlight the generative potential for SRH policies to operationalise broader holistic understandings of sex, sexuality, and reproduction, in line with the Guttmacher-Lancet Commission and advocacy around pleasure and well-being (Starrs et al. 2018, Philpott et al. 2021). Through this holistic lens, sexual and reproductive health, attitudes, and behaviours can be better understood, and the meanings and conceptualisations of contraception and abortion can be more carefully considered in ways that reflect lived contextual realities. This also includes understanding SRH technologies beyond their biomedical purpose, to consider how policies might reflect the languages and meanings of individuals and communities and offer comprehensive services and care that centre choice, wellbeing, and autonomy.

Finally, global SRH policies around abortion must include gender transformative programmes that tackle men's roles in abortion trajectories. Men can have a significant impact on the ability of a woman to make decisions relating to her body and her pregnancy. This might include decisions over whether and where to obtain abortion care, that could have

implications for the biomedical safety of the care they receive. Commitments that call for abortion to be made available where legally permissible will only perpetuate reproductive injustices and endanger women. It is fundamentally important that commitments are focused on overcoming the social, cultural, political, economic, and contextual barriers to abortions. This includes meaningfully engaging with masculinities and transforming dominant and often reproductively oppressive masculinities.

Considerations

This thesis has a number of considerations that are important to contextualise the empirical findings and future thinking.

The Sample

This thesis was unable to incorporate evidence from adolescents who could provide assent with parental consent, as well as people with particularly audio or cognitive disabilities, and anyone who did not have access to a mobile phone. The intention had been to include these groups, including to partner with disability rights organisations and through hiring of research support personnel to facilitate access e.g., sign language. The inability to include people from these groups, who are often made marginal in research, reflected the necessary methodological decisions made during COVID-19. These groups have critical SRH needs (World Health Organization and UNFPA 2009, Starrs et al. 2018), and their experiences are especially important to consider. Moreover, their experiences of gender and masculinities might be different due to the intersections of their age, ability, and access to technologies, which contribute to their interactions with their community and contextual environments. Ensuring the ethical and meaningful participation of these communities was not possible for this thesis.

The research almost exclusively sampled cis-gendered and heterosexual men. Due to the open-ended survey questions, 6 respondents did discuss their gender fluidity and non-heterosexuality. With the anti-LGTBQ+ politics that were (and are) current at the time of this research in Ghana, it was significant that both the survey questions and the mode of data collection created a space in which some respondents felt comfortable sharing this information without being asked to. It offers considerations for how future surveys might be

able to gather more nuanced insights into people's gender and sexuality without explicit questions, in contexts where such questions might elicit push-back. However, the research does not explicitly include the experiences of people of other genders, including women. This would have required ensuring that there was a team of researchers who had diverse genders, sensitively trained, and with the necessary support to refer people to if necessary; all beyond the financial, time, and methodological constraints of this thesis. Future inclusion of these groups would allow a necessary look at multiple conceptualisations of masculinities, in order to further engagement with the role of gendered pluralities within the conceptual framework.

Measurements

This thesis focused on capturing constructions of the contextually dominant masculine ideal. The sample size and methodological instruments meant that it was not possible to generate data on multiple different constructions of masculinities that all interrelate to one another and might have different relationships to sexual and reproductive health (Connell 2005, Connell and Messerschmidt 2005). However, by mapping how men perceived and constructed the contextually dominant masculine ideal, it does provide useful insights into how other masculinities might then be located in relation to this. Moreover, the survey did ask men for the three most important characteristics that they believed a woman should have, in order to produce data on men's gendered expectations on women. However, the data were frequently incomplete, with men only offering one or two responses. This limited the analytical value available, and whilst it offers potential for future research to qualitatively assess those answers that were provided, it was not analytically strong enough for integration into the three empirical chapters of this thesis.

The survey design included multiple ways to capture a measure of masculinities among respondents, including scales that were iterated with the research team and through the piloting process. The original intention was to use these to explore the development of a 'masculinities' scale. However, when a preliminary analysis was run of these variables results indicated that the scale did not have strong internal validity or analytic utility. The final set of masculinities variables, which were produced through qualitative data captured in the survey (Chapter 6), were analytically valuable. The analysis of the open-ended questions was generative but time-consuming and is likely to be of limited utility for quantitatively understanding masculinities in larger sample surveys. Moreover, the scale that was produced

focuses on what men considered to be important characteristics for men. This makes the relational nature of masculinities implicit; it has to be assumed that men are answering this question in relation to the world around them. However, it might not necessarily capture the full extent of how men construct and understand masculinities against alternative masculinities and femininities.

A skip pattern error as a result of human error meant that men who were currently unpartnered were not asked whether they would be happy if their partner(s) became pregnant now (at the time of survey). This means that the data failed to capture that men who are not partnered can still be sexually active and, therefore, have attitudes towards pregnancies. To navigate this, multiple regressions were run to include the broader sample and the partnered sample (Chapter 4); inclusion of a broader question for all respondents would have mitigated the need for this.

The abortion supportability matrix (used in Chapter 4) was not able to disentangle clearly where support was not given due to attitudes towards an abortion or a perception of the respondent's place to become involved in that person's abortion care. Qualitative data indicated that it was frequently the latter, but further exploration as to why men responded differently to different relationships would be beneficial. The use of a sumscore meant that increments between "no", "it depends", and "yes" were the same (0, 1, 2), which might not capture the expansive nature of what "it depends" might mean. Over-dispersion within the sumscore indicates that for future iterations of the matrix, a Negative Binomial regression might be a more effective choice than a standard Poisson regression.

Future Research

The theoretical implications, empirical findings, methodological innovations and experimentations, and lessons learned all contribute to my future research aspirations. I aim to continue to develop on the methodological considerations within this study to think about how to scale up the survey and include a broader sample of men. This would include examining and testing how open-ended questions and relational questions can be effectively used for a larger sample. This entails considering how masculinities operate in different contexts to better understand how research and policies can be designed in ways that are adaptable and reflective of the role of context.

The findings of this research highlight some of the critical and complex ways masculinities shape and are shaped by sexual and reproductive health. The open-ended questions emphasise specific themes that might be important and are currently under-interrogated or not included in surveys, such as pleasure, well-being, love, and multiple conceptualisations and linguistic understandings of different reproductive technologies and methods. Grappling with the different types of sex men have, the meanings of this sex, and more detailed information on types of involvement and the nature of that involvement – including behavioural methods such as withdrawal that require men's participation – would be critical and fascinating. This includes ensuring that questions are specific as to whether they are referring to penile-vaginal sex or other forms of sex.

As highlighted in this thesis, friends and the community at large can have an important role in the policing and boundarying of acceptable masculine behaviours, whether around fatherhood or acceptance of sexual partners and condom use. Given the role of interactions in shaping norms and perceptions of acceptable behaviours, focus group discussions would be a way to delve further into understanding men's constructions of masculinities (as per the original research intentions outlined in Chapter 2). I aim to bring the lessons learned from trying to measure masculinities in quantitative surveys forward, conceptualising novel ways that masculinities – and femininities – might be captured. This includes developing a process that allows for scales to be reflective of their cultural context but also for methods to be applicable across contexts. Creating, testing, and validating such a scale would allow for tangible interventions in global SRH measurement through the inclusion of men and masculinities in data collection.

Finally, there remains data collected that have not been analysed as part of the empirical chapters presented in this thesis. This includes data on people's sexualities (volunteered and self-reported) as well as the perceptions of queerness that emerged in interviews (similarly volunteered and not responding to any specific questions on sexuality). Further exploration of these expressions of sexualities within the context of masculinities and gender would be important, particularly for ensuring that data that are provided by men, for which they gave up their time, are not left unused. It would also be able to further advance quantitative survey epistemologies by considering how to better develop research tools and instruments to meet queer / LGBTQ+ populations.

Broader Research Implications

This thesis also provides learnings and considerations that can be adopted in broader research on SRHR. The methodological innovations in this thesis and the critical approach to demographic research can be employed in future critical survey design development and implementation. Through a partnership with the Institute National d'Études Démographiques (INED), awarded through their visiting researcher scheme at the invitation of Dr Heini Väisänen, I have been working on a project that examines how sexual and reproductive health and rights are captured in Anglophone and Francophone surveys across the Global North and South. This critically examines how surveys can replicate assumptions around what components of sexual and reproductive health 'matter' to different populations in different contexts and provides insights into the areas of SRHR that are minimised.

The qualitative survey instrument in this thesis has been used by an ongoing project by the Guttmacher Institute (USA) and BRAC (Bangladesh), which explores abortion attitudes and behaviours among forcibly displaced Rohingya communities in Bangladesh. The instruments from this thesis were used in the development of the research tools for that project, which included a qualitative research component with men in the community.

These future research agendas and implications for other research projects highlight the theoretical generalisability of the project (Cornish 2020). The empirical findings are inherently embedded in their context, which was a critical aim of the research design. However, the employment of a critical approach to men, masculinities, and demography can be generalisable to research in other contexts.

So, what about men?

This thesis is emphatic that men cannot, should not, and must not be ignored within sexual and reproductive health and rights. They are critical, both as users of SRH services and technologies, and in shaping the conditions, choices, and access the other people must navigate. The minimal research with men and their marginalised roles in global health and international development means that women continue to carry the burden of SRHR. This replicates gendered roles and continues ideologies that centre on controlling women's bodies.

Interrogating the roles of masculinities within SRHR is crucial for critically examining how policies and programmes can more meaningfully consider gender utopic futures. This would include the development of further methods of fertility regulation that centre the wellbeing of individuals and the sex that they hope to have with their partner(s). Masculinities must be constructed away from controlling the body of someone else; sexual and reproductive rights can never and must never include the right to control another person's body. Ultimately, it is through the full, radical transformation of gendered systems and structures and the deconstruction of power inequalities and injustices that universal SRHR can and will be achieved.

Appendix A: Published Research Protocol

Open access Protocol

BMJ Open

Exploring the roles of men and masculinities in abortion and emergency contraception pathways, Ghana: a mobile phone-based mixed-methods study protocol

Joe Strong

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ABSTRACT

Introduction Global commitments have established goals of achieving universal sexual and reproductive health and rights (SRHR) access, but critical obstacles remain. Emergency contraception and induced abortion are overlooked in policy and research. Men's roles in the SRHR of others are significant, particularly as obstacles to universal SRHR. Evidence on gender, masculinities and SRHR is essential to understand and reduce the barriers faced by individuals seeking to avoid the conception or continuation of a pregnancy.

Methods and analysis This study aims to understand men's masculinities and their relationships with emergency contraception and abortion. The protocol presents a multimethod study of men aged over 18 years in James Town, Accra, Ghana. In response to the COVID-19 pandemic, the research will use two mobile-based methods: a survey and in-depth interviews. Using respondent-driven sampling, an estimated 789 men will be recruited to participate in the survey, asking questions on their knowledge, attitude, behaviours and roles in emergency contraception and abortion. In-depth interviews focused on constructions of masculinity will be conducted with a purposive sample of men who participated in the survey. Data will be analysed concurrently using multiple regression analyses of quantitative data and abductive analysis of qualitative data.

Ethics and dissemination Ethical approval has been granted by the London School of Economics and Political Science and the Ghana Health Service. The findings in this study will: engage with emerging research on masculinities and SRHR in Ghana and elsewhere; offer methodological insight for future research; and provide evidence to inform interventions to reduce obstacles for emergency contraception and abortion care seekers. Dissemination will occur at all levels—policy, academic, community—including multiple academic articles, policy briefs, workshops and presentations, conference papers, and theatre/radio-based performances of key messages.

Strengths and limitations of this study

- ► Transferring methods to mobile phones allows for research to be conducted in changing environments due to COVID-19, where movement and social contact are problematic.
- ► A mixed-methods approach strengthens the ability for the study to unpack critical constructions that relate to emergency contraception and induced abortion and increases the richness of the data.
- ► Mobile-based methods are limiting in terms of only reaching those with access to the technology.
- ► Mobile phones reduce non-verbal cues and lack of observable confirmation of privacy and consent do not allow for the inclusion of participants who have gatekeepers (eg, young people).

INTRODUCTION

Postcoital pregnancy avoidance methods, the most effective of which are emergency contraception and induced abortions, are under-represented in global and regional policy and research.[1 2] Despite critical international milestones such as the International Conference on Population Development and Sustainable Development Goals 3 and 5[1] and regional commitments (eg, Maputo Protocol[3]) calling for universal access to sexual and reproductive health and rights (SRHR), political, social and economic barriers have restricted progress, particularly in relation to postcoital pregnancy avoidance.[1 4–8]

Emergency contraception is most frequently provided in pill form. Though there is a copper IUD emergency contraceptive, evidence from high-income countries indicates extremely low uptake.[9] There are various types of emergency contraception pills (ECPs) with varying efficacies—the most effective estimated to prevent up to 95% of pregnancies if taken within 5 days of sex that would lead to conception.[10] Abortions are essential healthcare, categorised by the WHO as safe, less safe and least safe.[11] The safety levels depend on the method choice and

the environment where the abortion occurs. However, the advent of medical abortions—misoprostol/mifepristone combinations—has radically reshaped conceptions of safety, with pregnant people able to induce abortions safely outside of facilities, delineating the conflation of safety and overmedicalisation.[11 12]

Abortions and emergency contraception are both legally permissible in Ghana.[13 14] ECPs have been included in health policy since 1996.[15] Knowledge of ECPs is increasing; the 2008 Ghana Demographic Health Survey found 35.4% of women had heard of emergency contraception when asked.[16] More recently, Performance Monitoring for Action (PMA2020) data estimated that 52% of women aged 15–49 had heard of emergency contraception.[17] ECPs are part of the mix of contraceptives that women in Ghana use,[18] with one-third of young women attending pharmacies in Greater Accra reporting ECPs as their main method of contraception.[19]

Abortions have been decriminalised in Ghana since 1985 for three criteria: fetal abnormality; maternal health; and rape/incest.[20] However, knowledge of the law remains low,[21] with only 11% of survey respondents in the 2017 Ghana Maternal Health Survey knowing abortions were legally permitted.[22] Estimates of the abortion rate in Ghana vary from 13.4 per 1000 women aged 15–49 in 2017,[22] to 26.8 per 1000 in the same year,[21] many of which are less and least safe, with significant associated risks to pregnant people's health.[23 24]

Globally, studies since the 1990s have shown that men have direct and indirect roles in emergency contraception[25–28] and abortion-related care.[29–37] Research on emergency contraception and men's roles in Ghana has been limited.[18 19] Abortion-related studies in Ghana indicate that men insert themselves in the autonomous decision-making of others via their role as partner or father,[38 39] including controlling the finances for seeking care,[39] and providing medicines and materials for care (eg, procuring methods).[35 40] In addition, men's responses to (potential and confirmed) pregnancies,[41] including denial of pregnancy,[42] have a significant role in a person's postcoital pregnancy avoidance decision-making. While evidence indicates that men do support abortions, for example, in instances of birth spacing and to finish school, such support continues to decentre pregnant people from their own autonomous reproductive decision-making.[39]

Few studies analyse the mechanisms that drive men's roles in reproduction.[43 44] Critical studies of men and masculinities (CSM) has emerged as a response to this. CSM examines masculinities and femininities in order to understand men as gendered individuals and provide an explanation of the mechanisms that drive social behaviours.[45–47] CSM draws heavily on the notion of 'hegemonic masculinity', which is the contextually idealised form of masculinity.[48 49] Hegemonic masculinities must be understood in the context of intersectional power relations, in which race, nationality, sexuality and ability all impact its construction.[50 51] Complex systems of power mean that masculinities might be hegemonic in one context but made marginal in another.[51–55] In Ghana, the destructive role of colonialism shaped masculinities by imposing Euro-American normative values, resulting in a complex system of masculinities embedded within a globalised white supremacist power system.[56]

Constructions of masculinities are not static, and new forms emerge and become intertwined in social structures—such as health and legal systems—and used to justify social control and dominance over other forms of masculinities and femininities.[57 58] Understanding masculinities is a mechanism through which to explore power and the potential ways in which these constructions operationalise power over reproductive decision-making. Investigating the characteristics of hegemonic and relational masculinities allows a better understanding of men's roles in postcoital pregnancy avoidance. As a constantly evolving construct, greater evidence on how masculinities operate presents the opportunity to consider how men's masculinities can be engaged with in policy and rights-based activism.

A note on terminology: 'Postcoital pregnancy avoidance' is evolving terminology. It was importantto indicate that this research would not be focused on methods of contraceptionthat could be used before or during intercourse (eg, intrauterine devices(IUDs) or condoms). Instead, the focus is methods that occur 'post-coital',particularly after a sexual encounter that risks pregnancy. Emergency-contraception and abortion are separate but linked forms ofreproductive healthcare. Emergency contraception prevents a pregnancy fromoccurring, whereas abortions are healthcare for people already pregnant. Thisdistinction is important. 'Avoidance' was used as an abbreviation of thesemethods that avoid either the conception or the continuation of a pregnancy.

METHODS/DESIGN

Aims and objectives

This protocol outlines a funded, multiyear research project, expected to finish in March 2022. The aim of this research is to generate extensive data exploring the relationships between masculinities and postcoital pregnancy avoidance in a study site in Accra, Ghana. It has the following objectives:

1. To identify and explore the factors associated with men's knowledge, attitudes and behaviours towards postcoital pregnancy avoidance.
2. To generate and analyse new knowledge on how men's constructions of masculinities, sex and abortion interact with abortion-related care pathways.
3. To investigate the relationship between men and pathways to obtaining ECPs and to explore the constructions of masculinities within these.

Abortion and ECPs, while linked, are kept distinct in the objectives. This is to reflect the very different purposes each has within a person's reproductive life course, as well as variations in current knowledge and evidence about the two.

Data will be collected through a multimethod, concurrent design. A mixed-methods approach is methodologically most appropriate to achieve these aims and objectives, allowing for both breadth of information through a larger survey and depth of information through qualitative interviews.[59 60] These data will be used to produce substantial outputs, including peer-reviewed papers, blogs, policy briefs and art.

The methods will be triangulated by looking at how masculinities are constructed and relate to abortions within each method and between each method, exposing complexities and narrative devices[61] that will allow for a generative exploration of the objectives.[62]

Objective 1: Quantitative data on sources of knowledge and the association between knowledge, attitudes and behaviours, and sociodemographic factors will be analysed alongside an interrogation of qualitative data on the emergent mechanisms that drive these, with the intention of using uncovering broad trends and exploring the potential mechanisms behind these.

Objectives 2 and 3: Interview data will explore the constructions and operationalisation of 'manhood' or 'masculinities' within discussions of sex, emergency contraception and abortion. Emergent themes will then be used to interrogate the responses men provide when asked about masculinities within the survey and to unpack any broader trends around the construction of masculinities and emergency contraception and abortion pathways, respectively. The data are designed to allow for an exploration of the links in surveys between men's involvement in emergency contraception and abortion pathways, their constructions of their masculinities and the mechanisms emergent in qualitative data that might explain these.

Formative research and study site selection

This project had two phases of formative research: a scoping trip in January 2019 and a piloting phase in February to March 2020. The formative phase involved conversations with expert professionals working in SRHR, particularly abortion, including activists, advocates, academics and practitioners.[63] Such conversations resulted in the inclusion of ECPs into the research project. An important component of the scoping trip was to identify a relevant area to locate the study.

James Town, a neighbourhood in Accra, was chosen as the study site. Expert conversations indicated that it would be an area where the research topic could be useful for local activists as well as the Ghana Health Service and key stakeholders. Key stakeholders in the community, including the Secretary to the Paramount, a key figurehead in the Ga community in James Town, expressed approval for the research to be conducted.

The majority of residents are ethnically Ga, with largely internal migration meaning that there is an increasing mix of cultural representation from across Ghana.[64] Ga communities have been historically patrilineal, compounded by the imposition of patriarchal British values during colonialism. While relations between genders afford women certain autonomies, pregnancy and childbirth remain important and are linked to men's performance of masculinities.[57] The changing dynamics of the area, for example, from economic internal migration from elsewhere in Ghana,[64] allows for explorations of how constructions of masculinities might vary within and between groups of men.

Access to healthcare remains inequitable, with the Accra Metropolitan Assembly reporting 'inadequate coverage' across of the entire submetro.[65] This includes challenges in both accessing healthcare and in public health, with recent incidences of diarrhoeal disease[66] and cholera[67] outbreaks. Despite a number of maternity-based clinics in James Town,[68] the largest of which is Ussher Polyclinic, it was observable that abortion services are not advertised. Evidence indicates that rates of less and least safe abortions remain high, with pregnant people preferring to self-manage their abortions outside of facilities, often with less safe methods such as herbs, toxins and pharmaceuticals.[38] In addition, the study indicated that partners, predominantly men, created barriers to abortion-related care through withholding moral support or financial resources.[38]

Prior to the second formative research phase, three research assistants (RAs) were hired. The researcher position was advertised on social media and through WhatsApp, with a selection of applicants interviewed. Following a week-long paid training workshop on methods and value clarification on SRHR, the three researchers were asked to join the team. All are from the research context and the research tools were iteratively developed as a team.

During the piloting stage, 39 men aged 18 and above were purposively sampled from Ussher Town, a neighbourhood next to James Town. This aimed to reduce the likelihood of these men being resampled during the data collection phase. The survey instrument was iterated based on cognitive interview feedback from participants to ensure questions were understood consistently. The survey and interview guides are available at the project website: https://www.masculinitiesproject.org/.

Mobile methods

Data collection will be conducted using mobile phones. The original research plan was to conduct the survey and interviews—alongside focus groups—face to face. However, the COVID-19 pandemic, declared 11 March 2020, necessitated a review of these methods. Mobile phones were the most appropriate option due to the high proportion—94%—of shared and individual mobile phone ownership in urban Ghana.[69] The research team can be distanced from respondents and research can feasibly continue in the event of restricted movements.

Evidence suggests that mobile phone-based data collection can provide rich and quality responses, though can require more reflexivity of how the mode might shape the data.[70 71] Interviews and surveys will be administered by the research team over the call. Self-administered surveys

using smart technologies (eg, mobile apps/web-based apps), and audiovisual platforms, were rejected, as they require a level of literacy and internet/data connectivity inappropriate for the context.[38]

Quantitative survey

Respondent-driven sampling

Respondent-driven sampling (RDS) was first conceptualised as an alternative to snowball sampling for populations less likely to participate in research, for whom there was no reliable sampling frame to conduct a simple random sample.[72 73] As there are no appropriate existing mechanisms to identify men through social distanced, mobile phone means, RDS was considered suitable. It relies on a peer-referral system in which pre-existing relationships are used to create chains, with the intention being referrals from peer to peer eventually spread to the point that the final respondents are not known to the initial respondents.

The outcomes of interest are the factors associated with men's knowledge, attitudes and prior behaviour relating to postcoital pregnancy avoidance. Independent variables will include a composite socioeconomic index, which combines questions on employment, residence type and resource availability. In addition, a composite score will be created based on responses to questions on the construction of masculinity. This novel approach will attempt to understand masculinities using quantitative data, which can subsequently be compared with qualitative findings.

Sample size

The sample of interest in this research are men aged 18 and over, who live in James Town. The survey asks respondents their gender in an open-ended format; this research includes anyone reporting that they are a man.

Estimating a sample size is important to provide a useful target minimum for the data to be statistically useful, although sample size estimation is difficult to do accurately for RDS.[74] The most frequently used method for calculating estimated sample size is to take the simple random sample size and multiple by a design effect (*deff*)[75]:

$$n = deff \quad \frac{P \quad 1 \quad P)}{\left(se\left(P\right)\right)^2}$$

$P_A$represents the proportion of the population of interest. This was taken as 0.73, which is the proportion of men aged 15–59 who believed that men should be involved in some aspect of SRHR.[76] The assumption is made that this holds true for a population of men aged 18+. The standard error (*se*) is set at 0.05.

Debate continues about an appropriate *deff* value for RDS. The initial use of a *deff* value of 2 has been shown to be too low for most RDS studies, and even a revised value of 4 might be lower than necessary.[77] To minimise the risk of having a *deff* value too low for meaningful analysis, this survey assumes a *deff* of 10, as used in recent RDS studies[74]:

Table 1 Sampling matrix for RDS seeds and interview respondents

Age group	James Town North		James Town South	
18–25	Ga	Non-Ga	Ga	Non-Ga
26–39	Ga	Non-Ga	Ga	Non-Ga
40–59	Ga	Non-Ga	Ga	Non-Ga
60+	Ga	Non-Ga	Ga	Non-Ga

RDS, respondent-driven sampling.

$$n = 10 \quad \frac{0\ 73\ 1\ \ 0\ 73)}{0\ 05)^2} = 788\ 4$$

The study should reach an estimated 789 individuals to achieve a minimum estimated sample size.

Seeds and recruitment

Initially, RDS requires 'seeds' who are ideally individuals with known networks within the sample of interest and become the first in the chain of peer referral. The identification of seeds for this project will use the following matrix (table 1):

The decision was made to stratify the seeds based on age, ethnicity (Ga/non-Ga) and location (James Town North and James Town South) within the community in response to existing evidence,[57] and observations and reflections from the research team of the most common factors affecting relationship networks.

Respondents will be compensated via mobile credit transfer of GHC5 (Ghana cedi, currency in Ghana. GHC5.8:US$1. Exchange rate true on 24 June 2020, per www.exchange-rates.org) for responding and an additional GHC2 per referral. Each respondent will be asked to find a maximum of three referrals. Respondents will be asked to provide potential referrals with the mobile number of the RA or provide the RA with the details to then call and arrange an interview time. Each respondent will be given a short code (said verbally and sent via short message service) to pass onto their referral, in order to track the peer-referral process.

Remote data checks

Mobile methods and the need for physical distancing mean that survey interviews cannot be checked in person by the principal investigator (PI). A random respondent within each complete set of 10 surveys will be selected per RA to be data checked by a data assessor unaware of the original responses.

A selection of questions will be asked to assess for inconsistencies in questions and to ensure that the respondent had been interviewed. Reinterviewed respondents will receive additional compensation of GHC3 for responding to the data check questions.

Conceptualising men's masculinities

The survey consists of seven sections: sociodemographics, household and socioeconomics, relationships, emergency

contraception, abortion, masculinity and the abridged Washington Group Questions.[78]

The masculinity section was the most complex to design and benefited from the collaborative approach to this research design.[49 79] Through conversations with men during the preparation phases, piloting the survey with men in similar neighbourhoods around James Town, and workshop discussions with research team, a list of factors that were frequently associated with masculinities was created. Men are asked whether they believe that these factors are important for a man their age, as well as asked open-ended questions of what factors make a 'good' man and a 'good' woman. The language of these questions was tested during the formative stages to ensure consistent comprehension.

Data processing and analysis

Data will be processed onto RDSAT, a software designed specifically for RDS, to map networks and chains and to process the necessary weights. These weights will be identified by a series of questions in the survey that relate to the personal network size (PNS) of the individual.[74 80] The assumption is that the larger the network size, the greater likelihood of the respondent being selected to participate. Thus, weights are inversely proportional to the PNS.

Data will be cleaned and linear and logistic regressions run to explore these associations between the outcomes of interest and the independent variables.

Qualitative sampling

In-depth interviews will be conducted from a subsample of the survey. This will be a non-probability sample, with respondents selected to populate the same matrix as that used for the seeds. The aim of this is to maximise obtaining a breadth of different experiences and responses. This will take place concurrently alongside the survey and, if necessary, will continue after the survey has completed, to allow for all respondents to be considered as part of the sample.

Sampling will be assumed to be complete once 'saturation' is reached; when no new data are emerging from the selected sample.[60 81] This project understands saturation as when no new themes or codes emerge.[82] As this research aims to be generative and exploratory, aligning approximately with inductive research, such an approach is recommended.[82]

If reaching saturation requires a significant volume of surveys, there may be financial constraints as well as time constraints. Predictive sample sizes are difficult to estimate, though research using inductive approaches to saturation suggests that much can be established in the earliest interviewers.[83] The budget for interviews is not expected to be spent before saturation is reached.

All survey respondents will be asked if they would be willing to participate in an interview at the end of the survey. The PI will select candidates purposively to populate the sample matrix (table 1). Survey responses will be reviewed to ensure the diversity of individuals within each metric, until data are saturated. RAs will conduct the interviews and respondents will be compensated an additional GHC10.

In-depth interview instruments

A semistructured topic guide[84] will be used to explore conceptions of masculinities and elaborate on attitudes and behaviours around postcoital pregnancy avoidance. With consent, interviews will be recorded using devices that can plug into the RA's mobile phone, so that the audio is direct to the recorder and not audible for anyone but the interviewer, who will use headphones.

Interviews will be translated and transcribed. Transcribers with experience and fluency in Twi, Ga and English will be hired through an advertised, paid position in the study site. A random selection of 10% of interviews will be back translated by a separate transcriber, to assess for quality. Significant difference in meaning will result in translations and transcriptions being redone by a third transcriber. All documents will be stored on encrypted software and transferred through a secure platform between the PI and the RAs.

Qualitative analysis

Interviews are expected to generate a substantial and rich volume of data. As such, abductive analysis is appropriate, in which the analysis focuses on new and innovative findings, in order to test the evidence against existing theories of masculinities.[85] Emerging qualitative data will then be analysed concurrently with the outcomes from the survey. Qualitative data will be analysed using the RQDA platform, allowing integrated qualitative and quantitative data analysis on R.[86]

Participant and public involvement

Key experts (activists, advocates, practitioners, academics working in the field of SRHR) were involved in the scoping phase of this study to elaborate on critical areas that could then be included in the development of the research question.[63] It was during this phase that emergency contraception was discussed as an important emerging contraceptive, warranting inclusion. Participants were included in the piloting phase of this study to provide feedback during surveys on the relevance of questions and to test the consistency of how questions are understood.

Local organisations provided support in the design phase, such as helping disseminate job advertisements and providing informal conversations about specific contextual factors relating to the research. This study intends to collaborate with local arts-based organisations to produce radio/theatre/other arts-based outputs for dissemination and engagement of the research findings.

DISCUSSION

Considerations and limitations

There are methodological and practical considerations and limitations to this research. RDS assumes that

respondents will randomly select referrals from their network, and that subpopulations are not isolated to the point of exclusion.[73] In reality, this is not likely to be the case, and while it is argued this is not necessarily a problem because skewed and non-symmetric responses can be weighted accordingly,[73] it may impact the ability to make generalised population inferences.[74]

Individuals without access to mobile technology are likely to be missed, even if they have access to a shared mobile. Certain populations, such as adolescents and people with disabilities that impact their communication over technology, are excluded. This reflects the inability to use non-verbal cues to minimise the survey impact and to assess the role of gatekeepers during the interview.

Evidence indicates that the role of the interviewer has a direct relationship with the quality of answers relating to abortion. Men in this project might wish to provide what they perceive to be socially desirable answers, which are difficult to mitigate. The pilot survey offered little indication that this would be significant, evidenced by the number of men who offered additional information pertaining to 'sensitive' questions on SRHR. It is important, however, that the role of the interview be central in all the data analysis.

Moreover, one of the benefits of mobile phone use is that there is increased confidentiality, as only the respondent can hear the questions,[87] and men have control over when they would like to call and can choose the location they call from. This provides an interesting opportunity to consider the potential balancing of power that mobile phone methods could provide.

Ethics

Most important is the safety of the researchers and the respondents during the COVID-19 pandemic. This research will not require any face-to-face contact, nor any movement by RAs that could expose them to unnecessary risk. A guaranteed salary ensures that payment will continue regardless of ability to collect data, until the end of the data collection period (estimated September 2020).

Informed consent will be sought verbally from all respondents and recorded by interviewers onto a document. All data will be stored securely on personal devices and transferred to the PI via secure networks, before being destroyed from any non-PI devices.

The topic could also elicit discomfort in triggering experiences relating to sexual and reproductive health. Information and phone numbers to specialist helplines (Marie Stopes Ghana) will be provided to participants, and all participants will be given the contact of the research team, who will be using specific mobile phones and sim cards bought solely for project use, and the GHS Secretariat on their informed consent sheets for any follow-up necessary, relating to the research.

Ethical approval for this project has been granted by the London School of Economics and Political Science (REC ref 000802c). Ethical approval for the amended research was granted by the GHS Ethics Review Committee (GHS-ERC 008/11/19). Approval was also sought and obtained from the GHS Regional Director for Greater Accra, and community stakeholders and leaders.

Dissemination

This research expects to produce a significant volume of rich data and diverse outputs. These data will be analysed and published into peer-reviewed papers, expected to be a minimum of three (per research aims and objectives) as well as additional papers reflecting on the methodological innovations.

Policy briefs will be created for dissemination among key stakeholders, particularly the GHS. Community dissemination will include written and non-written mediums, in addition to partnering with local arts organisations to produce radio/ theatre-based dissemination.

The research team already has extensive experience in these areas within James Town. As these outputs can be time consuming, this experience, alongside the direct involvement in data collection, will be beneficial and create a more efficient process conceptualising feasible outputs, reliant on the successful application of funds.

Twitter Joe Strong @JoeStrongDemog

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Contributors This research protocol was written in full by JS.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

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Appendix B: Informed Consent and Information Sheets

Information Sheet and Consent Form (English)

Exploring the relationship between men, masculinities and post-coital pregnancy avoidance, Ghana

Researcher: Joe Strong
Department of Social Policy, LSE

Information for participants

Thank you for considering participating in this study which will take place March-August 2020. This information sheet outlines the purpose of the study and provides a description of your involvement and rights as a participant, if you agree to take part.

What is the research about?
The research is looking at men's perceptions of masculinity and manhood, and men's perceptions of emergency contraception, abortion and abortion decision-making in Ghana. The research will involve a survey, focus group discussions (where there are multiple people in a group with the researcher) and in-depth interviews (where there is just one person and the researcher). The research was funded by the Economic and Social Research Council.

Do I have to take part?
It is up to you whether or not to take part. You do not have to take part if you do not want to. If you do decide to take part, I will ask you to sign a consent form which you can sign and return either before or at the meeting.
Information will be provided in case you might feel uncomfortable. You are not expected to share any personal stories unless you feel comfortable doing so.

What will my involvement be?
You will be asked to take part in a survey, interview or focus group about your knowledge and perceptions of emergency contraception, abortion-related care and activities exploring perceptions of manhood and womanhood in Ghana. It should take maximum 1 hour. You will be thanked for the cost of your time with a five cedi mobile phone voucher / bar of soap.

How do I withdraw from the study?
You can withdraw from the study at any point, without having to give a reason. If any of the questions during the focus group make you feel uncomfortable, you do not have to answer them. Withdrawing from the study will have no effect on you. If you withdraw from the study we will not retain any information you have given us thus far, unless you are happy for us to do so.

What will my information be used for?
I will use the collected information to publish articles and a PhD thesis. This will be published and available for the public, so that you can read the outcomes. There will also be dissemination activities where possible for you to hear the outcomes of the study.
Key findings will be presented to the Ghana Health Service and the James Town community. It is hoped that these findings will be able to contribute to the continued progress in healthcare provision in James Town.

Will my taking part and my data be kept confidential? Will it be anonymised?
The records from this study will be kept confidential. Only myself and my supervisor will have access to the files and any audio tapes. Your data will be anonymised – your name will not be used in any reports or publications resulting from the study. All digital files will be given codes and stored in protected files.
The audio-recordings will be kept for a minimum of five years in secure online location, in accordance with UK law.

What if I have a question or complaint?
If you have any questions regarding this, please contact Joe Strong (the researcher), on 0209789813 or joe.strong.lse@gmail.com (email).

You can also contact the Ghana health Service Ethics Review Committee at [details to be added].

Consent form

Exploring the relationship between men, masculinities and women's abortion related care in Ghana

PARTICIPATION IN THIS RESEARCH STUDY IS VOLUNTARY

I have read and understood the study information, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	YES / NO
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time, without having to give a reason	YES / NO
I agree to the focus group being audio recorded	YES / NO
I understand that the information I provide will be used for the researcher's PhD thesis and published articles, and that the information will be anonymised.	YES / NO
I agree that my information can be quoted in research outputs	YES / NO
I understand that any personal information that can identify me – such as my name, address, will be kept confidential and not shared with anyone	YES / NO
I give permission for the (anonymised) information I provide to be deposited in a data archive so that it may be used for future research	YES / NO

Participant codename:

Interview name:

Information Sheet and Consent Form (Ga)

Yitso: Yitsoŋkpaa yɛ shinamɔ ni yɔɔ nuu, nuufeemɔ Kɛ bɔlɛnamɔ-sɛɛ hɔnaasamɔ, yɛ Ghana

Niiashikpalɔ: Joe Strong

Social Policy gbene yɛ LSE

Miŋda bo shi akɛ ojwɛŋ akɛ kuɛ ohe baawo nikasemɔ ni baaba nɔ kɛjɛ wɔsɛɛ afi (2020) Otsokrikri kɛya shi Manyɛawale nyɔŋ lɛ mli. Wolo nɛɛ tsɔɔ oti krɛdɛɛ hewɔ ni afeɔ nikasemɔ nɛɛ ni egblaa ogbɛnaa Kɛ bɔni obafee ni okɛ ohe baawo nikasemɔ mli oha, kɛji okplɛ akɛ obafee.

Mɛni nikasemɔ pɔtɛɛ nɛ?

Nikasemɔ nɛɛ baakwɛ bɔni hii naa nuufeemɔ ahaa, Kɛ bɔni amɛ naa hɔnaasamɔ tsofai, hɔkpɔmɔ Kɛ susumɔi ni boteɔ hɔkpɔmɔ mli yɛ Ghana. Nikasemɔ nɛɛ baabi sanebimɔi ni akɛ damɔ wojii ahiɛ, kutuu sanegbaa (nɔni aabua mɛi anaa akɛ kuu ni amɛ Kɛ nikasemɔ hiɛnyiɛlɔ lɛ aana sanegbaa) Kɛ mɔkome-mɔkome sanegbaa (nɔni mɔ kometoo Kɛ nikasemɔ hiɛnyɛlɔ lɛ aana sanegbaa fitsofitso).

Esa akɛ mikɛ mihe woɔ nikasemɔ nɛɛ mli tsiŋtsinaa?

Fɛɛ baa damɔ ono kɛji oosumɔ. Kɛji osumɔɔ akɛ okɛ ohe woɔ mli'ɛ bele gbɛ ka aha bo. Kɛji ofee oyiŋ akɛ obaafee'ɛ mabi bo ni okɛ onine awo nɔkplɛmɔ wolo shishi ohami dani wɔbaa kpe aloo yɛ wɔ kpee lɛ shishi.

Mɛni mafee kɛji mikɛ mihe wo nikasemɔ nɛɛ mli?

Akɛ bo baa so kuu mli ni obaatsɔɔ ojwɛŋmɔ, nilee Kɛ osusumɔ yɛ bɔni onaa hɔkpɔmɔ, hɔkpɔmɔ kwɛmɔ mliŋ saji Kɛ nifeemɔi ni kɔɔ wɔshishinumɔ yɛ nuu loo yoofeemɔ he yɛ Ghana. Nifeemɔ nɛɛ baaye tamɔ ŋmɛjii 2. Abaada bo shi yɛ odeka namɔ mli Kɛ sidii enumɔ krɛdit aloo samla tso kome.

Te mafee tɛŋŋ maje nikasemɔ nɛɛ mli?

Obaanyɛ oje nikasemɔ nɛɛ mli bee fɛɛ bee ni otaoɔ, ni okɛɛɛ moko nohewɔ ni ojie mliŋ. Kɛji sanebimɔ ko aagba onaa yɛ wɔ kutuu sanegbaa mliŋ lɛ, obaanyɛ ni ohaaa no hetoo. Kɛji oshi nikasemɔ nɛɛ mli lɛ wɔkɛ onaa wiemɔ ko fataa wɔ nikasemɔ lɛ he, ja ohawɔ hegbɛ daŋ.

Mɛni akɛ minaa wiemɔi loo nilee nɛɛ baafee?

Mabua wiemɔi lɛ anaa ni maŋmala nilee ni yɔɔmli kɛha nikasemɔ Kɛ mi PhD woloŋmaa. Abaa gbɛ nikasemɔ nɛɛ ashwa kɛtsɔ adafitswaa mli bɔni aafee ni mɔfɛɛmɔ nine aashɛ nilee ni yɔɔ mliŋ Kɛ yɔsemɔi. Abaa gbɛ nikasemɔ nɛɛ ashwa kɛtsɔ nifeemɔi srɔtoi anɔ ni abaafɔ nine atsɛ bo ni oba bo toi.

Ani akɛ mihe sajii Kɛ mi wiemɔi yɛ nikasemɔ nɛɛ mli aato heko kpakpa? Ani abaa ŋma migbɛi Kɛ kpɛtɛ mi wiemɔi he lo?

Akɛ mɛi ahe saji Kɛ amɛ naawiemɔi fɛɛ aato jogbaŋŋ. Mi Kɛ mi nukpa nɔkwɛlɔ pɛ baa na hegbɛ wɔkwɛ mɛi anaawiemɔi ni wɔbo amɛ gbee toi. Aŋmaaa ogbɛi Kɛ kpɛtɛɛ owiemɔ ko ni okɛ mi a'gba he sane yɛ wɔ nikasemɔ nɛɛ mli aloo adifi ni abaatswa sɛɛmliŋ kɛji wɔ gbenaa. Wɔbaa kadi naawiemɔi ni wɔ Kɛ tsɔne baa rikɔdi lɛ fɛɛ Kɛ okadii srɔto ko ni wɔkɛ baato jogbaŋŋ.

Ni Kɛji Miyɛ sane ko bimɔ hu loo naagba ko lɛ hu?

Kɛji oyɛ sane ko bimɔ aloo ko lɛ, Ofainɛ tswaa Joe Strong (Niiashikpalɔ) yɛ 0209789813 aloo ŋmaa lɛ kɛtsɔ joe.strong.lse@gmail.com (email)

Obaanyɛ hu ni otswa Ghana Health Service Ethics Review Committee yɛ Nana Abena Apatu 0503539896 (To be contacted on ethical issues and rights to participation from Monday-Friday between 8:30am and 5pm)

Nɔkplɛmɔ Wolo

Yitsoŋkpaa yɛ shinamɔ ni yɔɔ hii, nuufeemɔ Kɛ yei ahɔkpɔmɔ saji yɛ Ghana

NIKASEMƆ NƐƐ ANYƐƐ MOKO NƆ AKƐ EFEE

Mi kane ni minu nikasemɔ nɛɛ shishi, aloo akane fɛɛ atsɔɔ mi. Mi na hegbɛ mi bi sajii ni agbla mi sanebimɔ mliŋ fitsotso aha mi.
Hɛɛ/Daabi

Mi kplɛ ni mɔko enyɛɛɛ minɔ akɛ mi Kɛ mihe baawo nikasemɔ nɛɛ mli ni minushishi akɛ minyɛ ni mihaaa sanebimɔ ko hetoo ni manyɛ maje nikasemɔ nɛɛ bee ni mi sumɔɔ, ni mi tsɔɔɔ mɔko nohewɔ
HƐƐ/ DAABI

Mi kplɛ nɔ akɛ arikɔdi mi naawiemɔ yɛ kutuu nikasemɔ lɛ mliŋ
HƐƐ/ DAABI

Mi nuɔ shishi akɛ wiemɔi ni ma wie lɛ niiashikpalɔ lɛ kɛbaa ŋma e PhD wolo Kɛ nilee adafi, ni akɛ mi gbɛi hu kpɛtɛɛ mi naawiemɔ ko he.
HƐƐ/DAABI

Mi kplɛ nɔ akɛ abaanyɛ atsi mi nilee ta yɛ nikasemɔ nɛɛ sɛɛ
HƐƐ/DAABI

Mi nushishi akɛ mihe sane fɛɛ ni akɛ baayoomo- tamɔ mi gbɛi, heni mijɛ, ejeŋ kpo yɛ heko ejaakɛ akɛ baato jogbaŋŋ ni mɔko nine nyɛɛ nɔ ashɛ
HƐƐ/DAABI

Miha hegbɛ ni akɛ mi naawiemɔi (ni mi gbɛi kpɛtɛɛ he) ato yɛ nikasemɔ toohe lɛ bɔni afee ni akɛ tsu nikasemɔ henii wɔsɛɛ
HƐƐ/DAABI

Nikasemɔnyo okadi:

Sanegbaa gbɛi:

Information Sheet and Consent Form (Twi)

Nhwehwɛ mu a ɛfa nkabom a ɛda mmarima, mmarima ho su ne nyinsɛn a yɛnhwɛ kwan ho banbɔ, Ghana

Nhwehwɛni: Joe Strong
Department of Social Policy, LSE
Nimdeɛ ma Adesuafo

Yɛda wo ase sɛ wopɛ sɛ wo bɛka kwankyerɛfo adesua yi ho a ɛbɛ hyɛ aseɛ wɔ bosome Ɔbɛnim kɔsi August, 2020. Krataa yi fa botayɛ a ɛda adesua yi ho na ɛsan ma wo hu wo dwumadie ne won so akwanya a ɛda ho ma woso sɛ adesua ni, sɛ wo penee so a gye tum.

Nhwehwɛmu no fa dɛn ho?
Nhwehwɛmu no hwɛ mmarima adwen mu pɔ wɔ mmarima ho su ne mmarima yɛ mu ne mmarima adwen mu pɔ a ɛfa ɛnnamu ahobanbɔ a ɛhia sɛ yani kɔ ho, nyinsɛn ne nyinsɛn yi guo ho nhyehyɛ biara wɔ Ghana. Nhwehwɛ mu no bɛfa sra hwɛ, nnipa kuo adwen toatoa (abraa nnipa pii wo kuo baako mu ne nhwehwɛmu ni no) ne nsemmisa a emu dɔ (sɛ nipa baako ne nhwehwɛmu ni no). Economic ne Social Research Council na wɔde fotoɔ hyɛɛ nhwehwɛmu no mu.

!wɔ sɛ mede mehohyɛ mu bi anaa?
!wɔ wo ara wo hɔ sɛ wode woho bɛhyɛ mu anaa wommfa woho nhyɛmu. !nsɛ sɛ wo yɛ bi, sɛ wompɛ a. sɛ wo si gyina sɛ wode woho bɛhyɛmu a, me bias wo ama wo de wonsa ahyɛ nkrataa ase sɛ wo gye tom a wo bɛba ansa na yɛ ahyɛ nhyiamu no ase anaa sɛ wo bɛba nhyiamu no ase.

!deɛn na me de meho nyɛ mu bia ɛbɛyɛ?
Yɛ bɛ bisa wo ama wo de wo ho ahyɛ ekuo nkɔmmɔ die afa wo nimdeɛ ne wo adwen mu pɔ ɛfa nyinsɛn yi guo, adwene a ɛfa nyinsɛn yi guo ne dwumadie a yɛde hwehwɛ adwen mu pɔ a ɛwɔ barima yɛ ho ne ɔbaa yɛ ho wɔ ghana. !wɔ sɛ ɛfa dɔnhwere mmienu. Yɛde cedis aduonum a ɛyɛ kasa woma akyedeɛ anaa semena dua baako.

Ɔkwan bɛn so na metumi agyae adesua yi?
Wobɛtumi afri adesua no mu berɛ biara, wɔ berɛ a ɛni kwan sɛ woma nkyerɛ mu sɛ asɛmmisa bi mma wo a nyi won ano. Wo firi adesua no mu no, mmfa ɔhaw biara mmerɛ wo firi adesua no mu. Yɛ kora woho nsɛm biara a wode ama yɛn mprenprensoɔ yi, gye sɛ wanigye ho sɛ yɛ nyɛ saa ara.

Deɛn Ade na wɔde me ho nsɛm bɛyɛ?
Mede nsɛm a megye no bɛ to dwa wɔ krataa mu ne PhD thesis. Wɔde bɛ to dwa ama aman no a hu, sɛdeɛ ɛbɛyɛ a wo bɛtumi a kenkan deɛ ɛbɛsi. Afei nso dwumadie a ɛtrɛ bɛ wɔ hɔ a wobɛ te deɛ ɛbɛsi wɔ adesua no ase.

Ɔde meho nsɛm ne sɛ mede meho hyɛ mu no bɛ hinta anaa?
Ɔde ntwerɛ a ɛfa adesua yi ho hinta. Me nkoa ne nea ɔhwɛ meso na ɔwɔ kwanya sɛ ɔtumi hwɛ me nkrataa mu na ɔtie me kasayɛ mu. Woho nsɛm bɛyɛ deɛ wo din mmata ho – ɔfa wo din nto amanneɛ anaa biribiara a wɔatintim ɛfa adesua no ho. Wɔde ntwerɛdeɛ bi a nnipa kakraa bi pɛ na wɔte aseɛ bɛto abɛɛfo nwoma biara so na wɔde asie wɔ nwoma a woabɔ ho ban.

Na sɛ mewɔ asɛmmisa biara anaa sɛ nwiinwii?
Sɛ wowɔ asɛmmisa a ɛfa wɔ yi ho a, mepa wo kyew frɛ Joe Strong (Nhwehwɛmu ni no), wo anoma trofoɔ yi so 0209789813 anaa abɛɛfo ntentan yi so joe.strong.lse@gmail.com

Wobɛtumie afrɛ ghana apɔmuden nnipa nneyɛɛ ho adesua mpensɛmpɛnsɛmu agyinatukuo wɔ Nana Abena Apatu 0503539896 (To be contacted on ethical issues and rights to participation from Monday-Friday between 8:30am and 5pm)

Gye tom nsɛmmisa krataa

Sɛ wode wo ho hyɛ adesua yi mu yɛ atuhoakyɛ

Ma kenkan na ma te adesua no ase anaa w'akenkan akyerɛ me. Ma tumi abisa nsɛmmisa na woayi ano ama me ho atɔ me.	Aane/Daabi
Mefiri mepɛ mu n'agye atom sɛ mɛka ho adesua ne ho na mate aseɛ sɛ metumi apo nsɛmmisa na metumi ayi me ho afiri adesua no mu berɛ biara wɔ aberɛ a me ma nkyerɛmu biara.	Aane/Daabi
Megye nnipa kuo adwen toatoa tom sɛ wɔ bɛ	Aane/Daabi
Mate aseɛ sɛ meho nsɛmmisa a mede bɛma no, wɔ bɛtumi de ayɛ nhwehwɛmu ni no PhD thesis ne nwoma a w tintim ne sɛ meho nsɛm no bɛyɛ deɛ medin mmata ho	Aane/Daabi
Me te aseɛ sɛ meho nsɛm a ɛbɛyi me apue bi te sɛ, medin, makyiriakwan bɛ hinta na wɔn kyɛ ma obiara	Aane/Daabi
Mema ho kwan sɛ (wɔ hinta) meho nsɛm a me de mema wɔ no nto nsɛm korabia sɛdeɛ bɛyɛ a wɔde bɛ yɛ nhwehwɛmu daakye.	Aane/Daabi

Mobile phone verbal consent form

Additional consent verification for research assistants to use (based on GHDS 2014)

Please read the following to the respondent:

Now that you have been provided the information sheet and asked your comprehension and consent, can I confirm whether you have any remaining questions for me before we continue the mobile phone survey / interview. I would like to make sure you know that your participation is voluntary and if you don't want to answer any questions, that is okay. I have read you the contact details of the PI for this study, in case you have any further questions.

Please can you clearly indicate if you consent to continuing with this survey / interview:

Interview code:

Signature of interviewer _____ Date: _____

Respondent consents to be interviewed [Please tick]:
CONTINUE

Respondent does not consent to be interviewed [Please tick]: THANK AND END

Any other notes:

Appendix C: Survey Instrument

Survey Instrument in English

Instruction 1: Go to File and 'Save As' and save this document with the file codename for the participant you are about to interview. Make sure that they file is saved to your secure location.

Please take your time to read through this survey, making sure that you are familiar with it.

Make sure to ask the respondent what language they would like to answer the survey is in. Offer them Ga, English or Twi.

Reassure the respondent throughout that all their information is secure and will be anonymous.

At the end of this survey is some information on sexual and reproductive health and also on COVID-19. If people ask you questions, please refer them to these services.

Remember: Try to ask the questions in the same way each time, for consistency.

Unless instructed, try to avoid reading out the categories for questions. Instead pick the category that fits their answer best.

Before we start the survey, I would like to check that you are somewhere that you feel comfortable speaking freely. I will be asking you questions that relate to your personal life. If you would like to move somewhere more private, please do.

Start the survey:

Where do you currently sleep?

Do you sleep anywhere else?

How do you know the person who recruited you?

Have you seen them and spoken to them in the past two weeks?

[Please continue with the interview regardless. If you are unsure about what the respondent answers above, message Joe straight after the interview].

Can you confirm what gender you identify as?

[If the respondent answers that they identify as a woman, please thank them and end the survey].

SECTION 1 – SOCIO DEMOGRAPHICS

I now going to ask you some questions about yourself.

1.1.How old are you?

1.2.What year were you born?

1.3.Do you have a birth certificate?
- Yes
- No (Go to 1.4)
- Don't know (Go to 1.4)

1.3.1. Do you know where it is?
- Yes
- No
- Don't know

1.4.What ethnic group / tribe do you belong to?
- Ga
- Akan
- Fante
- Asante
- Ewe
- Guan
- Mole-Dagbani
- Grusi
- Gurma
- Mande
- Other
- Don't know

1.5.Do you have a religion?
- Yes
- No (Go to 1.6)

1.5.1. What is your religion?
- Tsetseetse
- Iam
- Christian (unknown denomination)

Catholic
Anglican
Methodist
Presby
Pentecostal / charismatic
Other Christian
Islam
Individual
Other
Don't know

1.5.2. Are you currently practising your religion?
Yes
No
Don't know

1.6.What is the highest level of schooling you attended or are currently attending?
Never attended
Primary
Middle / JSS
Secondary / Technical
Higher
Don't know
Other

1.7.Are you currently in work?
Yes
No (Go to 1.9)

1.7.1. What is your work?

1.7.2. Do you receive payment for this work?

1.7.3. How long have you been doing this work for?

1.7.4. Is your work affected by coronavirus? If YES, how has it been affected?

1.8.Are you currently doing any other work?
Yes
No (Go to 1.9)

1.8.1. What is this work?

1.8.2. Do you receive payment for this work?

1.8.3. How long have you been doing this work for?

1.8.4. Is your work affected by coronavirus? If YES, how has it been affected?

1.9.Is there anyone else in your household who is working?

Yes
No (go to 1.10)

1.9.1. Who?

1.10. Who is the main source of income for your household?

SECTION 2 – YOUR HOUSEHOLD

I am now going to ask you a few questions about the place where you currently are sleeping.

2.1.What **working** items does this household contain? **[read out the categories]**

- Electricity
- Wall clock
- Radio / Speaker
- TV
- TV Decoder
- DSTV
- Computer / Laptop
- Non-smart mobile phone (yam)
- Smart phone
- Coal pot
- Gas stove
- Fridge
- Freezer
- Sofa
- Table
- Bed
- Fan
- Air-conditioning
- Flushing toilet
- Livestock
- Canoe / net
- Bicycle
- Motorcycle
- Car

2.2.In your room, what is the main material of the floor?

- Earth/Sand
- Wood planks
- Palm / Bamboo
- Polished Wood
- Vinyl / Asphalt
- Cement
- Tiles
- Other (please type what)

2.3.What is the main material on the roof of this building

- No roof
- Thatch

Wood
Metal
Cement
Tiles
Slate
Azar
Other

2.4.Where do you get your main source of water

Commercial domestic
Private domestic
Commercial shared
Private shared
Other

SECTION 3 – RELATIONSHIPS

I am going to ask you some questions about your relationships. Please remember that everything you say is confidential and you do not have to answer if you do not want to.

3.1. Are you currently in a relationship?

Yes
No (Go to 3.3.)
Don't know

3.1.1. Can you describe that relationship to me?

Instruction: If the person indicates they are in a relationship with a man, please explain to them that you are interested in pregnancy and sexual and reproductive health, and you would like to know whether the person they are in a relationship was born male.

Explain that everything said is confidential and private and if they do not wish to answer, they don't need to.

3.1.2. Is it a sexually active relationship?

Yes
No
Don't know

3.1.3. Do you live with this person?

Yes
No
Don't know

3.1.4. Has this relationship been affected by coronavirus?

Yes
No
Don't know

3.1.4.1. If YES, how has it been affected?

3.2. Are you in any other relationship? **Ask them to describe ALL the other relationships they are in.**

Yes

No (Go to 3.3)
Don’t know

3.2.1. Can you describe that relationship to me?

3.2.2. Is it a sexually active relationship?
Yes
No
Don’t know

3.2.3. Do you live with this person?
Yes
No
Don’t know

3.2.4. Has this relationship been affected by coronavirus?
Yes
No
Don’t know

3.2.4.1. If YES, how has it been affected?

3.3. Have you ever had sex?
Yes
No (Go to 3.8)
Don’t know (Go to 3.8)

3.4.When having sex, how often do you use contraception / family planning?
Always
Sometimes (more than half the time)
Sometimes (less than half the time)
Never
Don’t know

3.4.1. Why do you always / sometimes / never use contraception?

3.5.When having sex, how often does the person you are having sex with use contraception / family planning?
Always
Sometimes (more than half the time)
Sometimes (less than half the time)
Never
Don’t know

3.5.1. In your opinion, why do they always / sometimes / never use contraception

3.6. In your opinion, who should make the decision about whether someone uses contraception / family planning?

3.7.Would you be happy if [insert relationship] becomes pregnant now?

Instruction: Repeat question 3.7. for all the relationships that the person says that they are in. In your answers, make sure you note which relationship you are talking about.

3.8.Do you have any children or are you caring for any children like a father?

Yes
No
Don't know

3.8.1 Could you tell me about these?

3.9.In your opinion, who should decide when to have children

3.10. In your opinion, who should decide how many children to have

3.11. Is coronavirus having an impact on your attitude towards pregnancy? If YES, how?

SECTION 4 – EMERGENCY CONTRACEPTION

I am now going to ask you some questions about emergency contraception.

4.1.Have you heard of emergency contraception?

Yes
No (Go to 4.2.)
Don't know (Go to 4.2.)

4.1.2. Can you tell me what emergency contraceptive is used for?

4.2. Emergency contraception is commonly used within 72 hours of having sexual intercourse, in order to avoid pregnancy. Have you heard of that?

Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.3.How did you **first** hear about it?

Relationship partner
Female friend
Male friend
Mother
Father
Male relative
Female relative
Internet
Radio
TV
Public advertising
Pharmacist
Other healthcare professional (specify)
School
Don't know
Other (please type)

4.4.Have you ever seen emergency contraception?

Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.4.1. Can you describe it to me?

4.4.2. Have you ever bought it?
Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.4.3. Who did you last buy it for?

4.4.4. Have you ever bought it for another person?
Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.4.5. Who were they?

4.4.6. How much did it cost?

4.5.In your opinion, who should be the person to go and buy these pills

4.6.Would it be okay if [insert partner] used these pills?
Yes
No
It depends

4.6.1. If it depends, what does it depend on

4.7.Would you buy these pills for [insert partner]?
Yes
No
It depends

4.7.1. If it depends, what does it depend on

Instruction: Repeat 4.6. and 4.7. for as many partners as they have and write the partner next to each response

4.8.Is coronavirus having an impact on your attitude towards emergency contraceptives? If YES, how?

SECTION 5 – ABORTION

I am now going to ask you some questions on abortion. As always, there are no right or wrong answers, and everything we discuss is private.

5.1.Do you know what an abortion is?

Yes
No (Go to 5.3.)
Don't know (Go to 5.3.)

5.2.What is it?

5.3. An abortion is an intervention which ends a pregnancy / stops it from continuing. Have you heard of this?

Yes
No (Go to 5.5.)
Don't know (Go to 5.5.)

5.4.How did you **first** hear about it?

Relationship partner
Female friend
Male friend
Mother
Father
Male relative
Female relative
Internet
Radio
TV
Public advertising
Pharmacist
Other healthcare professional (specify)
School
Don't know
Other (please type)

5.5.What ways have you heard of that women use to have abortions?

5.5.1. Do you think some ways of aborting are safer than others?

Yes
No (Go to 5.6.)

Don’t know (Go to 5.6.)

5.5.1.1.Which are safer

5.5.1.2.Which are less safe

5.6.Is it lawful / allowed in the law to have an abortion in Ghana?
Yes
No
Don’t know

5.6.1. Can you tell me what the law is?
Yes
No
Don’t know

5.7.Have you supported someone obtain an abortion?
Yes
No (Go to 5.8.)
Don’t know (Go to 5.8.)

5.7.1. Have you supported more than one person?
Yes
No
Don’t know

5.7.1.1.For the most recent, what relationship / relation was this person to you?

5.7.1.2.Do you remember what type of abortion it was?

5.7.1.3.Who decided on this way?

5.7.1.4.How did you support them?

Instruction: Repeat section 5.7. for all the people they say they have supported having an abortion. In your answers, make sure to note which person you are writing about.

5.8.Would it be okay if [insert relationship] had an abortion?

Instruction: Repeat 5.8. for all the relationships they say they are in. In your answers, make sure to note which person you are writing about.

5.9.Would you support the following to obtain an abortion if they wanted one?

	Yes	No	Don't know	It Depends
Wife				
Second wife / girlfriend				
Girlfriend				
Sister				
Sister-in-law				
Daughter				
Other female relative				
Female friend				
School girl				
Sex worker				
Female colleague				

5.10. Is coronavirus having an impact on your attitude towards abortion? If YES, how?

SECTION 6 – MASCULINITY

6.1. What are the three key things you would want to see in a man your age?

6.2. What are the three key things you would want to see in a woman your age?

6.3. For you, who should make or did make the final decision regarding…

When you should / did marry?

What profession you should / did take?

When to start having sex for the first time?

Currently whether to have sex or not?

The continuation of your education?

What clothes you wear?

Where you currently live now?

6.4. In the household, who should make the final decision regarding…

Spending money on food

Spending money on bills + rental

Spending money on electrical items

Spending on furniture

Spending on school fees

How to care for children

How to discipline children

Who a child should live with

What to name a child

Who should inherit the household

The division of household chores?

6.5. Are there people in your household who are more important than others?

Yes
No (Go to 6.6.)
Don't know (Go to 6.6.

6.5.1. Who are they?

6.6. For men, do you believe that it is important for man to:

	Yes	No	Don't know	It depends
Show emotion?				
Not be disabled?				
To want to have sex with women?				
To have more sons than daughters				
To be the main cook for his family?				
To grow muscles?				
To want to have sex with men?				
To defend his honour				
To have multiple sexual relationships at the same period of time				
To have children				
To beat his partner				
To beat his children				
For a husband to share household duties with his wife				
A man to report when a woman beats him to the police				

SECTION 7 – ABILITY QUESTION

7.1. Do you have difficulty seeing, even if wearing glasses?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.2. Do you have difficulty hearing, even using a hearing aid?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.3. Do you have difficulty walking or climbing steps?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.4. Do you have difficulty remembering or concentrating?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.5. Do you have difficulty with self-care, such as washing all over or dressing?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.6. In your usual language, do you have difficulty communicating, for example understanding or being understood?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.7. Do you have difficulty performing sexual intercourse?

No – no difficulty

Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.8. Do you have any challenges affecting your mind?

QUESTIONS AFTER SURVEY

Instruction: Replace the [age category] with the group that you are interested in

How many [age category] do you know in Jamestown?

How many [age category] do you know in Jamestown that know you?

How many [age category] do you know in Jamestown that know you and that you have seen in the past two weeks?

How many [age category] do you know in Jamestown that know you and that you have seen and talked to in the past two weeks?

Please read: Thank you for taking part in this survey. Do you have any questions for me?

Please read: Recruitment instructions

I am now going to ask you to recruit a **maximum** of three people who identify as men to take part in this survey. These should be people you are friends with, who you know and have talked to in the past two weeks.

The people you speak to have **one week** to take part. If they decide to take part, you will be sent an additional 2 cedis **for each person**. They will also get compensation for taking part.

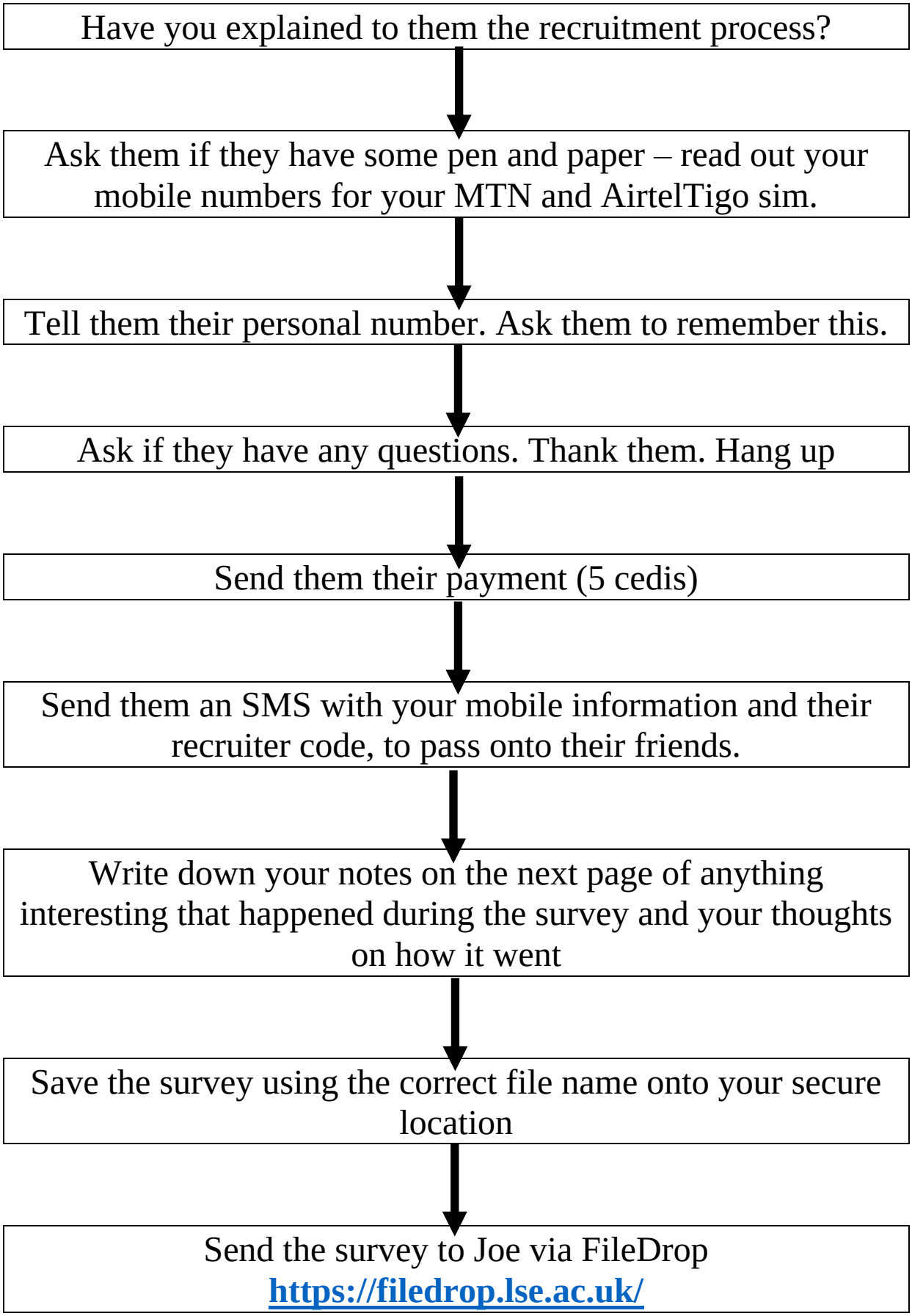
I am going to tell you my MTN and AirtelTigo numbers. Please pass these onto your friends to call me on. If they call me, I will arrange to return their call.

Here is your personal number [tell them their interview number – the first column of your table]. Tell your three friends this number, because I will ask for it when they call.

I will also send you an SMS message with these details. Is this the best number to message? If this is not the best number, please can you tell me the best number to message you. I will also use this number to transfer mobile credit.

Do you have any questions about what I have just said?

To finish the interview


Have you explained to them the recruitment process?
Ask them if they have some pen and paper – read out your mobile numbers for your MTN and AirtelTigo sim.
Tell them their personal number. Ask them to remember this.
Ask if they have any questions. Thank them. Hang up
Send them their payment (5 cedis)
Send them an SMS with your mobile information and their recruiter code, to pass onto their friends.
Write down your notes on the next page of anything interesting that happened during the survey and your thoughts on how it went
Save the survey using the correct file name onto your secure location
Send the survey to Joe via FileDrop
https://filedrop.lse.ac.uk/

NOTES

Add any notes here from this survey, including how you thought it went, whether there were any challenges, whether anything interesting occurred.

Information on abortion and emergency contraception

Filedrop

TO ACCESS GMAIL: go onto www.gmail.com . Log into account below:

masculinitiesproject@gmail.com
Password: Menshealth123

TO ACCESS FILEDROP: go onto **https://filedrop.lse.ac.uk/** . Log in with the details below:

Username: masculinitiesproject@gmail.com
Password: Menshealth123.

Send your filedrop emails to j.strong3@lse.ac.uk

Abortion + EC FACT SHEET

Abortion is allowed in Ghana under the following cases:

- In cases of rape, incest or defilement of the female idiot
- If the life or health of the woman is in danger
- If there is risk of fetal abnormality

The Ghana Health Service has provisions for safe abortion services, and safe abortions at public clinics should cost between 50-100 cedis.

Safe abortions are those which are provided by a trained doctor, nurse or midwife using manual vacuum aspiration, dilation and curettage, or misoprostol (Cytotec), and which are performed in a government or private hospital, health centre or clinic.

There are clinics that will say they are heath facilities but are not safe for abortions. Make sure to confirm that the clinic is government or has proof that it is an official provider.

For more information:

Call Marie Stopes toll-free for a confidential talk on
0800 20 85 85 OR WhatsApp them on 0556489090

Covid-19 Facts

Covid-19, or ‘Coronavirus’, is a virus that spreads from person to person. The best response to it is to wash your hands whenever possible, limit your social interactions, and wear a cloth over your mouth and nose in public.

Please follow the advice provided by the Ghana Health Service and the World Health Organisation.

Survey Instrument in Ga

Instruction 1: Go to File and 'Save As' and save this document with the file codename for the participant you are about to interview. Make sure that they file is saved to your secure location.

Please take your time to read through this survey, making sure that you are familiar with it.

Make sure to ask the respondent what language they would like to answer the survey is in. Offer them Ga, English or Twi.

Reassure the respondent throughout that all their information is secure and will be anonymous.

At the end of this survey is some information on sexual and reproductive health and also on COVID-19. If people ask you questions, please refer them to these services.

Remember: Try to ask the questions in the same way each time, for consistency.

Unless instructed, try to avoid reading out the categories for questions. Instead pick the category that fits their answer best.

Remember to assure people that everything is anonymous and confidential

Before we start the survey, I would like to check that you are somewhere that you feel comfortable speaking freely. I will be asking you questions that relate to your personal life. If you would like to move somewhere more private, please do.

Start the survey:

Where do you currently sleep?

Do you sleep anywhere else?

How do you know the person who recruited you?

Have you seen them and spoken to them in the past two weeks?

[Please continue with the interview regardless. If you are unsure about what the respondent answers above, message Joe straight after the interview].

Can you confirm what gender you identify as?

[If the respondent answers that they identify as a woman, please thank them and end the survey].

SECTION 1 – SOCIO DEMOGRAPHICS

I now going to ask you some questions about yourself.

1.11. Afii enyɛ oye?

1.12. Mɛi afimli afɔ bo?

1.13. Ani oye fɔmɔ wolo?
Yes
No (Go to 1.4)
Don't know (Go to 1.4)

1.13.1. Ole heni eyɔɔ?
Yes
No
Don't know

1.14. Mɛni nyo jib o?
Ga
Akan
Fante
Asante
Ewe
Guan
Mole-Dagbani
Grusi
Gurma
Mande
Other
Don't know

1.15. Oyɛ jamɔ ko mli?
Yes
No (Go to 1.6)

1.15.1. Mɛi jamɔ mli oyɔɔ?
Tsetseetse
Iam
Christian (unknown denomination)
Catholic
Anglican
Methodist
Presby
Pentecostal / charismatic
Other Christian

Islam
Individual
Other
Don’t know

1.15.2. Ani ojaa amrɔ nɛ?
Yes
No
Don’t know

1.16. Nɛgbɛ okɛ skul ya shɛ aloo nɛgbɛ oshɛ yɛ skul?
Never attended
Primary
Middle / JSS
Secondary / Technical
Higher
Don’t know
Other

1.17. Ani otsuɔ nii amrɔ nɛɛ?
Yes
No (Go to 1.9)

1.17.1. Mɛni nitsumɔ otsuɔ?

1.17.2. Ani awoɔ bo nyɔmɔ kɛha nɛkɛ nitsumɔ nɛɛ?

1.17.3. Afii enyie oye yɛ nɛkɛ nitsumor nɛɛ mli?

1.17.4. Is your work affected by coronavirus? If YES, how has it been affected?

1.18. Ani otsuɔ nitsumɔ kroko hu?
Yes
No (Go to 1.9)

1.18.1. Mɛni nitsumɔ ni?

1.18.2. Ani awoɔ bo nyɔmɔ kɛha nɛkɛ nitsumɔ nɛɛ?

1.18.3. Afii enyie oye yɛ nɛkɛ nitsumor nɛɛ mli?

1.18.4. Is your work affected by coronavirus? If YES, how has it been affected?

1.19. Ani moko yɛ tsu nɛɛ mli ni tsuɔ nii?
Yes
No (go to 1.10)

1.19.1. Namɔ?

1.20. Namɔ haa/jieɔ shika yɛ tsu nɛɛ mli?

SECTION 2 – YOUR HOUSEHOLD

I am now going to ask you a few questions about the place where you currently are sleeping.

2.5. Mɛɛ nibii nitsuɔ nii yɔɔ tsu nɛɛ mli? **[read out the categories]**

- Electricity
- Wall clock
- Radio / Speaker
- TV
- TV Decoder
- DSTV
- Computer / Laptop
- Non-smart mobile phone (yam)
- Smart phone
- Coal pot
- Gas stove
- Fridge
- Freezer
- Sofa
- Table
- Bed
- Fan
- Air-conditioning
- Flushing toilet
- Livestock
- Canoe / net
- Bicycle
- Motorcycle
- Car

2.6. Mɛɛ nii ni akɛ fee otsu lɛ shikpɔn?

- Earth/Sand
- Wood planks
- Palm / Bamboo
- Polished Wood
- Vinyl / Asphalt
- Cement
- Tiles
- Other (please type what)

2.7. Mɛɛ nii ni akɛ fee otsu lɛ yiteng?

- No roof
- Thatch
- Wood
- Metal
- Cement
- Tiles
- Slate
- Azar

Other

2.8. Nɛgbɛ onaa nu kɛjɛɔ?

Commercial domestic
Private domestic
Commercial shared
Private shared
Other

SECTION 3 – RELATIONSHIPS

I am going to ask you some questions about your relationships. Please remember that everything you say is confidential and you do not have to answer if you do not want to.

3.1. Ani okɛ moko nyiɛ amrɔ?

Yes
No (Go to 3.3.)
Don't know

3.1.1. Te obaa tsɛ nɛkɛ nyiɛmɔ nɛɛ tɛnn?

Instruction: If the person indicates they are in a relationship with a man, please explain to them that you are interested in pregnancy and sexual and reproductive health, and you would like to know whether the person they are in a relationship was born male.

Explain that everything said is confidential and private and if they do not wish to answer, they don't need to.

3.1.2. Ani bɔlɛ namɔ yɛ nyɛ nyiɛmɔ nɛɛ?

Yes
No
Don't know

3.1.3. Ani okɛ yoo nɛɛ yɔɔ?

Yes
No
Don't know

3.1.4. Has this relationship been affected by coronavirus?

Yes
No
Don't know

3.1.4.1. If YES, how has it been affected?

3.2. Ani okɛ mɔ kroko hu nyiɛ? **Ask them to describe ALL the other relationships they are in.**

Yes
No (Go to 3.3)
Don't know

3.2.1. Te obaa tsɛ nɛkɛ nyiɛmɔ nɛɛ tɛnn?

3.2.2. Ani bɔlɛ namɔ yɛ nyɛ nyiɛmɔ nɛɛ?

Yes
No
Don't know

3.2.3. Ani okɛ yoo nɛɛ yɔɔ?

Yes
No
Don't know

3.2.4. Has this relationship been affected by coronavirus?

Yes
No
Don't know

3.2.4.1. If YES, how has it been affected?

3.3. Ani okɛ moko ena bɔlɛ naa

Yes
No (Go to 3.8)
Don't know (Go to 3.8)

3.12. Kɛji oona bɔlɛ, shii enyiɛ ni okɛ contraceptives bɛjeɔ ohe?

Always
Sometimes (more than half the time)
Sometimes (less than half the time)
Never
Don't know

3.12.1. Mɛni hewɔ ni okɛ contraceptives bɛjeɔ ohe daagbi/ bei komɛi/ kwraa?

3.13. Kɛji oona bɔlɛ, shii enyiɛ ni mɔni okɛ wɔɔ bɛjeɔ ehe kɛ contraceptives/ family planning?

Always
Sometimes (more than half the time)
Sometimes (less than half the time)
Never
Don't know

3.13.1. Kɛji okwɛ, mɛni hewɔ ni ekɛ contraceptives bɛjeɔ ehe daagbi/gbii komɛi/kwraa

3.14. Kɛji okwɛ, namɔ nɔ edamɔ kɛji abaa bɛje he kɛ contraceptive/family planning?

3.15. Ani ebaa gɔɔ onaa kɛji [ashimashi] gɔ hɔ bianɛ?

Instruction: Repeat question 3.7. for all the relationships that the person says that they are in. In your answers, make sure you note which relationship you are talking about.

3.16. Oye bi ko aloo ookwɛ gbekɛ ko tamɔ etsɛ ji bo?
Yes
No
Don't know

3.8.1 Could you tell me about these?

3.17. Kɛji okwɛ, namɔ ni sani esusu beni akɛ afɔɔ bi(iɔ

3.18. Kɛji okwɛ, namɔ ni sani esusu bii abɔ ni abaa fɔ

3.19. Is coronavirus having an impact on your attitude towards pregnancy? If YES, how?

SECTION 4 – EMERGENCY CONTRACEPTION

I am now going to ask you some questions about emergency contraception.

4.9.Ani onu emergency contraceptive he dan?

Yes
No (Go to 4.2.)
Don't know (Go to 4.2.)

4.1.2. Obaanyɛ otsɔɔ mi nɔ ni Emergency cotrceptive fe)?

4.10. Emergency contraception is commonly used within 72 hours of having sexual intercourse, in order to avoid pregnancy. Onu he dan?

Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.11. Nɛgbɛ onu he yɛ klɛnklɛn?

Relationship partner
Female friend
Male friend
Mother
Father
Male relative
Female relative
Internet
Radio
TV
Public advertising
Pharmacist
Other healthcare professional (specify)
School
Don't know
Other (please type)

4.12. Ani ona emergency contraceptive nɛɛ eko dan?

Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.12.1. Obaanyɛ ni otsɔɔ mi bɔni eyɔɔ?

4.12.2. Ani ohe eko dan?

Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.12.3. Namɔ ji naagbee mɔ ni ohe eko eha?

4.12.4. Ani ohe eko eha mɔkroko hu dan?
Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.12.5. Namɛi ni?

4.12.6. Enyiɛ ni ohe lɛ?

4.13. Kɛji okwɛ, namɔ ji mɔni sa akɛ eya ni ayahe nɛkɛ tsofa nɛɛ

4.14. Ani ebaa gɔɔ onaa akɛ ashimashi akɔ nɛkɛ tsofa nɛɛ?
Yes
No
It depends

4.14.1. Kɛji okɛɛ ebaajɛ, mɛni nɔ edamɔ

4.15. Ani obaahe tsofa nɛɛ oha ashimashi?
Yes
No
It depends

4.15.1. Kɛji ebaajɛ, mɛni nɔ edamɔ?

Instruction: Repeat 4.6. and 4.7. for as many partners as they have and write the partner next to each response

4.16. Is coronavirus having an impact on your attitude towards emergency contraceptives? If YES, how?

SECTION 5 – ABORTION

I am now going to ask you some questions on abortion. As always, there are no right or wrong answers, and everything we discuss is private.

5.11. Ani ole nɔni ji abortion?
Yes
No (Go to 5.3.)
Don't know (Go to 5.3.)

5.12. Mɛni ni?

5.13. An abortion is an intervention which ends a pregnancy / stops it from continuing. Ani onu da?
Yes
No (Go to 5.5.)
Don't know (Go to 5.5.)

5.14. Nɛbgɛ onu klɛnklɛn yɛ?
Relationship partner
Female friend
Male friend
Mother
Father
Male relative
Female relative
Internet
Radio
TV
Public advertising
Pharmacist
Other healthcare professional (specify)
School
Don't know
Other (please type)

5.15. Mɛɛ gbɛi srɔtoi anɔ onu ni yei kɛ jeɔ musu?

5.15.1. Kɛji okwɛ, ayɛ gbɛi komɛi ni yɛ shweshweeshe/safe fe ekomɛi?
Yes
No (Go to 5.6.)
Don't know (Go to 5.6.)

5.15.1.1. Te nɔni yɔɔ shweshweeshwe/safe

5.15.1.2. Te nɔni bɛ shweshweeshwe/safe

5.16. Ani Ghana mla gmɛɔ gbɛ kɛha musujiemɔ
Yes
No
Don't know

5.16.1. Obaanyɛ ni okɛɛ mi nɔni mla kɛɔ yɛ he?
Yes
No
Don't know

5.17. Ani owa moko efite musu dan?
Yes
No (Go to 5.8.)
Don't know (Go to 5.8.)

5.17.1. Ani owa mɛi fe ekome?
Yes
No
Don't know

5.17.1.1. Onaagbe wamɔ nɛɛ, mɛni shinamɔ yɔɔ okɛ mɔ nɛɛ ten? [what relationship was this person to you]

5.17.1.2. Okaiɔ gbɛnɔ ni akɛ jie aha lɛ?

5.17.1.3. Namɔ ni tsɔɔ gbɛ nɛɛ?

5.17.1.4. Mɛni wamɔ okɛ ha nɛkɛ mɔ nɛɛ?

Instruction: Repeat section 5.7. for all the people they say they have supported having an abortion. In your answers, make sure to note which person you are writing about.

5.18. Ebaa gɔɔ onaa kɛji ashimashi ya fite musu

Instruction: Repeat 5.8. for all the relationships they say they are in. In your answers, make sure to note which person you are writing about.

5.19. Ani obaa wa mɛi nɛmɛi ateng moko afite musu kɛjɛ eetao [would you support the following]

	Yes	No	Don't know	It Depends
Wife				
Second wife / girlfriend				
Girlfriend				
Sister				
Sister-in-law				
Daughter				
Other female relative				
Female friend				
School girl				
Sex worker				
Female colleague				

5.20. Is coronavirus having an impact on your attitude towards abortion? If YES, how?

SECTION 6 – MASCULINITY

6.1. Mɛni ji nibii otii etɛ ni obaasuma akɛ ona yɛ nuu he?

6.2. Mɛni ji nibii otii etɛ ni obaasuma akɛ ona yɛ yoo he?

6.3. Kɛ ka bo'ɛ, namɔ ni tsɔɔ aloo naagbee susumɔ/hewale damɔ enɔ kɛji eba lɛ

Bei ni okɛ baa bote gblashihilɛɛ?

Nitsumɔ ni obaa tsu/ kase?

Bei ni okɛ yoo baaje bɔlɛnamɔ shishi?

Amrɔnɛɛ kɛji okɛ yoo baa wɔ aloo okɛ yoo wɔɔɔ?

Onikasemɔ/skul nɔtsamɔ?

Ataade ni obaa wo?

Heni obaa hi bianɛ?

6.4. Namɔ nɔ naagbee susumɔ damɔ yɛ tsu mli kɛ ebalɛ?

Shikajiemɔ kɛha niyenii

Shikajiemɔ kɛha bills/ tsu nyɔmɔwoo

Shikajiemɔ kɛha electrical items

Shikajiemɔ kɛha furniture tamɔ sɛi kɛ okplɔ

Shikajiemɔ kɛha skul nyɔmɔwoo

Bɔni akwɛɔ gbekɛbii

Bɔni akwɛɔ Gbekɛbii ahaa

mɔ ni masɛi bi baahi

Gbɛi ni akɛ baawo gbekɛ

Mɔni abaa shi tsu aha

Shianitsumɔ jaa

6.5. Ani mɛi komɛi he hia fe mɛi komɛi yɛ otsu lɛ mli

Yes
No (Go to 6.6.)
Don't know (Go to 6.6.

6.5.1. Namɛi ni

6.6. Kɛ ka hii, ani oheɔ oyeɔ akɛ ehia akɛ nuu

	Yes	No	Don't know	It depends
Ajie eyaafo kpo?				
Aka tsɔ kpajelɔ/helatsɛ lo?				
Esumɔ akɛ ekɛ yei baawɔ?				
Ena bii hii pii fe yei				
Eji mɔni pɔtɛnn ni hoɔ shia niyenii?				
Ebɔ egbɔmɔtso				
Ekɛ hii ana bɔlɛ?				
Efa ejakuman he				
Ekɛ yei pii awɔ yɛ				
Efɔ bii				
Eyi ega				
Eyi ebii				
Ni nuu kɛ ega aja shia nitsumɔ				
Nuu aya report ega kɛha police Kɛ ega yi lɛ				

SECTION 7 – ABILITY QUESTION

7.1. Do you have difficulty seeing, even if wearing glasses?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.2. Do you have difficulty hearing, even using a hearing aid?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.3. Do you have difficulty walking or climbing steps?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.4. Do you have difficulty remembering or concentrating?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.5. Do you have difficulty with self-care, such as washing all over or dressing?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.6. In your usual language, do you have difficulty communicating, for example understanding or being understood?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.7. Do you have difficulty performing sexual intercourse?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.8. Do you have any challenges affecting your mind?

QUESTIONS AFTER SURVEY

Instruction: Replace the [age category] with the group that you are interested in

How many [age category] do you know in Jamestown?

How many [age category] do you know in Jamestown that know you?

How many [age category] do you know in Jamestown that know you and that you have seen in the past two weeks?

How many [age category] do you know in Jamestown that know you and that you have seen and talked to in the past two weeks?

Please read: Thank you for taking part in this survey. Do you have any questions for me?

Please read: Recruitment instructions

I am now going to ask you to recruit a **maximum** of three people who identify as men to take part in this survey. These should be people you are friends with, who you know and have talked to in the past two weeks.

The people you speak to have one week to take part. If they decide to take part, you will be sent an additional 2 cedis for each person. They will also get compensation for taking part.

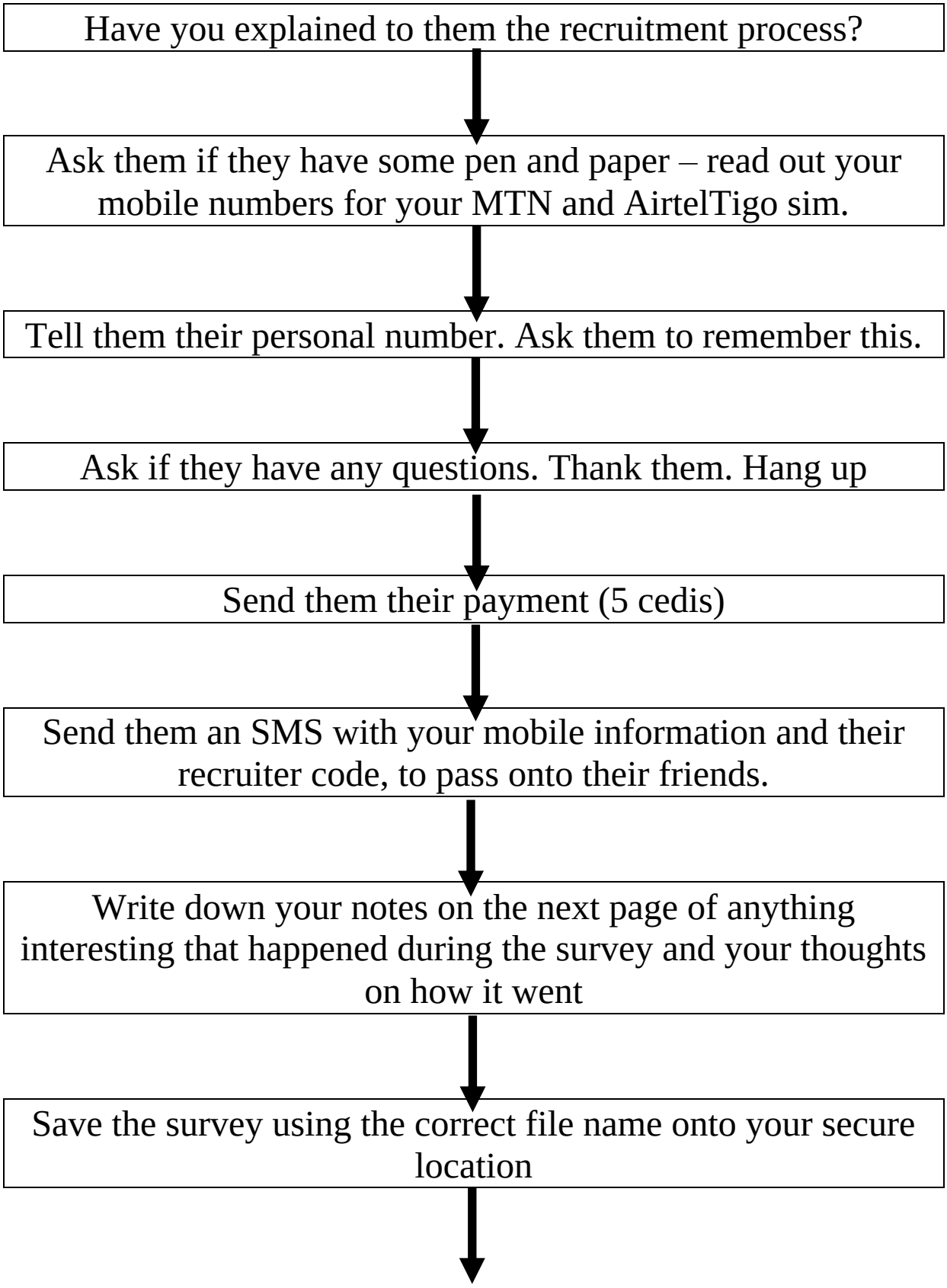
I am going to tell you my MTN and AirtelTigo numbers. Please pass these onto your friends to call me on. If they call me, I will arrange to return their call.

Here is your personal number [**tell them their interview number – the first column of your table**]. Tell your three friends this number, because I will ask for it when they call.

I will also send you an SMS message with these details. Is this the best number to message? If this is not the best number, please can you tell me the best number to message you. I will also use this number to transfer mobile credit.

Do you have any questions about what I have just said?

To finish the interview



Send the survey to Joe via FileDrop
https://filedrop.lse.ac.uk/

NOTES

Add any notes here from this survey, including how you thought it went, whether there were any challenges, whether anything interesting occurred.

Filedrop

TO ACCESS GMAIL: go onto www.gmail.com . Log into account below:

masculinitiesproject@gmail.com
Password: Menshealth123

TO ACCESS FILEDROP: go onto **https://filedrop.lse.ac.uk/** . Log in with the details below:

Username: masculinitiesproject@gmail.com
Password: Menshealth123.

Send your filedrop emails to j.strong3@lse.ac.uk

Abortion + EC FACT SHEET

Abortion is allowed in Ghana under the following cases:

- In cases of rape, incest or defilement of the female idiot
- If the life or health of the woman is in danger
- If there is risk of fetal abnormality

The Ghana Health Service has provisions for safe abortion services, and safe abortions at public clinics should cost between 50-100 cedis.

Safe abortions are those which are provided by a trained doctor, nurse or midwife using manual vacuum aspiration, dilation and curettage, or misoprostol (Cytotec), and which are performed in a government or private hospital, health centre or clinic.

There are clinics that will say they are heath facilities but are not safe for abortions. Make sure to confirm that the clinic is government or has proof that it is an official provider.

For more information:

Call Marie Stopes toll-free for a confidential talk on
0800 20 85 85 OR WhatsApp them on 0556489090

Covid-19 Facts

Covid-19, or 'Coronavirus', is a virus that spreads from person to person. The best response to it is to wash your hands whenever possible, limit your social interactions, and wear a cloth over your mouth and nose in public.

Please follow the advice provided by the Ghana Health Service and the World Health Organisation.

Survey Instrument in Twi

Instruction 1: Go to File and 'Save As' and save this document with the file codename for the participant you are about to interview. Make sure that they file is saved to your secure location.

Please take your time to read through this survey, making sure that you are familiar with it.

Make sure to ask the respondent what language they would like to answer the survey is in. Offer them Ga, English or Twi.

Reassure the respondent throughout that all their information is secure and will be anonymous.

At the end of this survey is some information on sexual and reproductive health and also on COVID-19. If people ask you questions, please refer them to these services.

Remember: Try to ask the questions in the same way each time, for consistency.

Unless instructed, try to avoid reading out the categories for questions. Instead pick the category that fits their answer best.

Remember to assure people that everything is anonymous and confidential

Before we start the survey, I would like to check that you are somewhere that you feel comfortable speaking freely. I will be asking you questions that relate to your personal life. If you would like to move somewhere more private, please do.

Start the survey:

Where do you currently sleep?

Do you sleep anywhere else?

How do you know the person who recruited you?

Have you seen them and spoken to them in the past two weeks?

[Please continue with the interview regardless. If you are unsure about what the respondent answers above, message Joe straight after the interview].

Can you confirm what gender you identify as?

[If the respondent answers that they identify as a woman, please thank them and end the survey].

SECTION 1 – SOCIO DEMOGRAPHICS

I now going to ask you some questions about yourself.

1.21. W'edi nfie sɛn?

1.22. Afe bɛn na yɛ wo wu?

1.23. Wu wɔ awuo krataa?
Yes
No (Go to 1.4)
Don't know (Go to 1.4)

1.23.1. Wonim bebɛa ɛwɔ?
Yes
No
Don't know

1.24. Wo yɛ dɛn ni?
Ga
Akan
Fante
Asante
Ewe
Guan
Mole-Dagbani
Grusi
Gurma
Mande
Other
Don't know

1.25. Wo wɔ ɛsum bi mu?
Yes
No (Go to 1.6)

1.25.1. ɛsum bɛn na wo wɔ?
Tsetseetse
Iam
Christian (unknown denomination)
Catholic
Anglican
Methodist
Presby
Pentecostal / charismatic
Other Christian

Islam
Individual
Other
Don't know

1.25.2. Sesia, wu daso sum anaa?
Yes
No
Don't know

1.26. Wo kɔ skul ɛkɔ pim hifa anaa sesia we du hi ɛwɔ skul mu?
Never attended
Primary
Middle / JSS
Secondary / Technical
Higher
Don't know
Other

1.27. Sesia wu yɛ ajuma anaa?
Yes
No (Go to 1.9)

1.27.1. Ajuma bɛn na wu yɛ?

1.27.2. Yɛ tua wo ka ɛfa saa ejumaa ni mu?

1.27.3. Wedi afie sɛn ewor saa ejuma yi mu?

1.27.4. Is your work affected by coronavirus? If YES, how has it been affected?

1.28. Wu yɛ ajuma fufro bi anaa?
Yes
No (Go to 1.9)

1.28.1. ɛyɛ ajuma bɛn?

1.28.2. Yɛ tua wo ka ɛfa saa ejumaa ni mu?

1.28.3. Wedi afie sɛn ewor saa ejuma yi mu?

1.28.4. Is your work affected by coronavirus? If YES, how has it been affected?

1.29. Obi wɔ wu dain mu na ɔyɛ ajuma anaa?
Yes
No (go to 1.10)

1.29.1. W’ana?

1.30. W'ana na ɛma/yi sika ɛwɔ wu dain ni mu?

SECTION 2 – YOUR HOUSEHOLD

I am now going to ask you a few questions about the place where you currently are sleeping.

2.9.Dɛn enuama na ɔmu yɛ ajuma ɛwɔ wu dain ni mu?**[read out the categories]**

Electricity
Wall clock
Radio / Speaker
TV
TV Decoder
DSTV
Computer / Laptop
Non-smart mobile phone (yam)
Smart phone
Coal pot
Gas stove
Fridge
Freezer
Sofa
Table
Bed
Fan
Air-conditioning
Flushing toilet
Livestock
Canoe / net
Bicycle
Motorcycle
Car

2.10. Nuama bɛn na yɛ di ayɛ wu dain nu fem?

Earth/Sand
Wood planks
Palm / Bamboo
Polished Wood
Vinyl / Asphalt
Cement
Tiles
Other (please type what)

2.11. Nuama bɛn na yɛ di ayɛ wu dain nu esoro?

No roof
Thatch
Wood
Metal
Cement
Tiles
Slate
Azar

Other

2.12. ɛhifa na wu nya nsuo ɛfre?
Commercial domestic
Private domestic
Commercial shared
Private shared
Other

SECTION 3 – RELATIONSHIPS

I am going to ask you some questions about your relationships. Please remember that everything you say is confidential and you do not have to answer if you do not want to.

3.1. Odi obi nante sesɛa?

Yes
No (Go to 3.3.)
Don't know

3.1.1. Dɛn na wobɛ frɛ wɔ ni obaa nu nante nu

Instruction: If the person indicates they are in a relationship with a man, please explain to them that you are interested in abortion and sexual and reproductive health, and you would like to know whether the person they are in a relationship was born male.

Explain that everything said is confidential and private and if they do not wish to answer, they don't need to.

3.1.2. Ndamu agoro wɔ mu nanteɛ ni mu anaa?
Yes
No
Don't know

3.1.3. Wode obaa nu tena faako?
Yes
No
Don't know

3.1.4. Has this relationship been affected by coronavirus?
Yes
No
Don't know

3.1.4.1. If YES, how has it been affected?

3.2. Wode obaa fufro su nante? **Ask them to describe ALL the other relationships they are in.**
Yes
No (Go to 3.3)
Don't know

3.2.1. Dɛn na wobɛ frɛ wɔ ni obaa nu nante nu?

3.2.2. Ndamu agoro wɔ mu nanteɛ ni mu anaa?
Yes
No
Don't know

3.2.3. Wode obaa nu tena faako?
Yes
No
Don't know

3.2.4. Has this relationship been affected by coronavirus?
Yes
No
Don't know

3.2.4.1. If YES, how has it been affected?

3.3. Wode obi ada da?
Yes
No (Go to 3.8)
Don't know (Go to 3.8)

3.20. Sɛ wode obaa da, dowdo sɛn na wode contraceptives bɔ wohu ban?
Always
Sometimes (more than half the time)
Sometimes (less than half the time)
Never
Don't know

3.20.1. Adɛnti na wode contraceptives bɔ wohu ban dabia/ sometimes/ kwraa

3.21. Sɛ wode obi da'a, dowdo sɛn na nipa nu di contraceptives/family planning bɔ nehu ban?
Always
Sometimes (more than half the time)
Sometimes (less than half the time)
Never
Don't know

3.21.1. Sɛ wo hwɛa, adɛnti na odi contraceptives bɔ nehu ban dabia/sometimes/kwraa

3.22. Sɛ wo hwɛa, wana su na egyina sɛ ɛfa banbɔ ɛwɔ contraceptive/ family planning mu?

3.23. ɛbɛ yɛ wo dɛ sɛ [insert relationship] nya nyinsɛn sesia?

Instruction: Repeat question 3.7. for all the relationships that the person says that they are in. In your answers, make sure you note which relationship you are talking about.

3.24. Wu wɔ ba anaa wohwɛ akwadaa bi tisɛɛ woyɛ ne agya?
Yes
No
Don't know

3.8.1 Could you tell me about these?

3.25. Sɛ wo hwɛa, wana na ɛda ni su ɛfa ɛmmere yɛ di bɛ wu ba?

3.26. Sɛ wo hwa, wana na ɛkyɛrɛ akwadaa ahi na yɛ bɛ wo

3.27. Is coronavirus having an impact on your attitude towards pregnancy? If YES, how?

SECTION 4 – EMERGENCY CONTRACEPTION

I am now going to ask you some questions about emergency contraception.

4.17. Wati emergency contraceptive da?
Yes
No (Go to 4.2.)
Don't know (Go to 4.2.)

4.1.2. Wobɛ tumi akyɛrɛ mi nea yɛ di emergency contraceptive yɛ?

4.18. Emergency contraception is commonly used within 72 hours of having sexual intercourse, in order to avoid pregnancy. Wati da?
Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.19. ɛhifa na wote nu first?
Relationship partner
Female friend
Male friend
Mother
Father
Male relative
Female relative
Internet
Radio
TV
Public advertising
Pharmacist
Other healthcare professional (specify)
School
Don't know
Other (please type)

4.20. Wahu emergency contraceptive nu bi da anaa?
Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.20.1. Wobɛ tumi akyrɛ mi sɛna eti?

4.20.2. W'atɔ bi da anaa?
Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.20.3. Wana na ɛyɛ nipa last na wotɔ abi ama?

4.20.4. W'atɔ bi ɛma nipa fufro su da anaa?
Yes
No (Go to 4.5.)
Don't know (Go to 4.5.)

4.20.5. ɔmu yɛ wan?

4.20.6. Ahi na wotɔ nu?

4.21. Sɛ wohwɛa, wana na ɛda ne su sɛɛ ɔnkɔ tɔ saa edoro nu?

4.22. ɛbɛ yɛ wo dɛ sɛ X fa saa edoro nu?
Yes
No
It depends

4.22.1. Sɛ it depends, dɛn su na egyina

4.23. Wobɛ tɔ saa edoro nu bi ama X?
Yes
No
It depends

4.23.1. Sɛ it depends, dɛn su na egyina?

Instruction: Repeat 4.6. and 4.7. for as many partners as they have and write the partner next to each response

4.24. Is coronavirus having an impact on your attitude towards emergency contraceptives? If YES, how?

SECTION 5 – ABORTION

I am now going to ask you some questions on abortion. As always, there are no right or wrong answers, and everything we discuss is private.

5.21. Wonim bibiaa yɛ frɛ no abortion?
- Yes
- No (Go to 5.3.)
- Don't know (Go to 5.3.)

5.22. ɛyɛ dɛn

5.23. An abortion is an intervention which ends a pregnancy / stops it from continuing. W'ati da?
- Yes
- No (Go to 5.5.)
- Don't know (Go to 5.5.)

5.24. ɛhifa na wote nu first?
- Relationship partner
- Female friend
- Male friend
- Mother
- Father
- Male relative
- Female relative
- Internet
- Radio
- TV
- Public advertising
- Pharmacist
- Other healthcare professional (specify)
- School
- Don't know
- Other (please type)

5.25. ɛkwan bɛn na w'ati sɛɛ obaa mu di yi nyinsɛn?

5.25.1. Sɛ wohwɛa, yɛ wɔ ɛkwan bi na ɛyɛ safe kyɛn ebi?
- Yes
- No (Go to 5.6.)
- Don't know (Go to 5.6.)

5.25.1.1. Dɛn n'ɛyɛ safe

5.25.1.2. Dɛn na ɛnyɛ safe

5.26. Ghana mra ma kwan ɛfa nyinsɛnguo
Yes
No
Don't know

5.26.1. Wobɛ tumi akyɛrɛ mi deɛ ɛmra nu sii?
Yes
No
Don't know

5.27. Wabua obi eyi nyinsɛn da?
Yes
No (Go to 5.8.)
Don't know (Go to 5.8.)

5.27.1. Wabua nipa ɛtra baako?
Yes
No
Don't know

5.27.1.1. Wo last no, dɛn nshinamu na eda wu ne nipa nu ntɛm?

5.27.1.2. ɛkwan bɛn so na yɛ di yi, sɛ wo kae'a?

5.27.1.3. Wana n'ɛkyɛrɛ ɛkwan nu?

5.27.1.4. Ebua bɛn na wode bua no?

Instruction: Repeat section 5.7. for all the people they say they have supported having an abortion. In your answers, make sure to note which person you are writing about.

5.28. ɛbɛ yɛ wo dɛ sɛ X kɔ yi nyinsɛn

Instruction: Repeat 5.8. for all the relationships they say they are in. In your answers, make sure to note which person you are writing about.

5.29. Wobɛ tumi abua nipa ni bi eyi nyinsɛn sɛ ɔpɛ sɛɛ obɛ yi?

	Yes	No	Don't know	It Depends
Wife				
Second wife / girlfriend				
Girlfriend				
Sister				
Sister-in-law				
Daughter				
Other female relative				
Female friend				
School girl				
Sex worker				
Female colleague				

5.30. Is coronavirus having an impact on your attitude towards abortion? If YES, how?

SECTION 6 – MASCULINITY

6.1. Dɛn adeɛ pɔtii miensa na wo bɛ pɛ sɛɛ wobɛ hu ɛwɔ barima hu?

6.2. Dɛn adeɛ pɔtii miensa na wo bɛ pɛ sɛɛ wobɛ hu ɛwɔ obaa hu?

6.3. Anka wo'a, wana na egyina ne so sɛ ɛba no sɛɛ?

ɛmmerea wo di bɛ kɔ awareɛ mu?

Ajuma'a wobɛ yɛ/sua?

ɛmmere'a wo di bɛ hyɛ nda ase?

Sesia sɛ wo di obaa bɛ da anaa wo di nu nda?

Sɛ wo bɛ twa wo edisua?

Atadea wobɛ hyɛ?

Bebia wobɛ ti sesia?

6.4. Wana na final decision gyina ne so ɛwɔ ɛdain mu ɛfa

Sikadie ɛfa aduane

Sikadie ɛfa bills+ rental

Sikadiemu efa electrical items

Sikadie ɛfa furniture

Sikadie ɛfa school fees

Akwadaa hwɛmu

Akwadaa titiemu

Nea ɔdi akwadaa bɛ tena

Edin'a yɛdi bɛ to akwadaa

Nea yɛ bɛ gya edain ɛma

Efiejuma kyekye

6.5. Obi mu hia kyen obi ɛwɔ wo dainimu

Yes
No (Go to 6.6.)
Don't know (Go to 6.6.

6.5.1. ɔmu yɛ wana

6.6. Anka barima, wogye di sɛɛ ehu hia sɛɛ obarima

	Yes	No	Don't know	It depends
Bɛ su?				
ɔnyɛ yareni anaa?				
ɔpɛ sɛɛ ɔdi ɛmaa bɛ da				
ɔnya mmaa barima pii ɛkyɛn obaa				
ɔnyɛ nea onua aduane ɛma ne fie?				
ɔyɛ macho				
ɔdi barima nda?				
ɔyɛ agyeman				
ɔdi mbaa bebiree ada				
ɔnya ba				
ɔnbu ne yere				
ɔnbu ne ba				
ɔdi ne yere akyekye efiajuma				
Obarima ɛreportu ne yere ɛma police sɛ ne yere bu nu				

SECTION 7 – ABILITY QUESTION

7.1. Do you have difficulty seeing, even if wearing glasses?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.2. Do you have difficulty hearing, even using a hearing aid?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.3. Do you have difficulty walking or climbing steps?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.4. Do you have difficulty remembering or concentrating?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.5. Do you have difficulty with self-care, such as washing all over or dressing?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.6. In your usual language, do you have difficulty communicating, for example understanding or being understood?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.7. Do you have difficulty performing sexual intercourse?

No – no difficulty
Yes – some difficulty
Yes – a lot of difficulty
Cannot do at all

7.8. Do you have any challenges affecting your mind?

QUESTIONS AFTER SURVEY

Instruction: Replace the [age category] with the group that you are interested in

How many [age category] do you know in Jamestown?

How many [age category] do you know in Jamestown that know you?

How many [age category] do you know in Jamestown that know you and that you have seen in the past two weeks?

How many [age category] do you know in Jamestown that know you and that you have seen and talked to in the past two weeks?

Please read: Thank you for taking part in this survey. Do you have any questions for me?

Please read: Recruitment instructions

I am now going to ask you to recruit a **maximum** of three people who identify as men to take part in this survey. These should be people you are friends with, who you know and have talked to in the past two weeks.

The people you speak to have one week to take part. If they decide to take part, you will be sent an additional 2 cedis for each person. They will also get compensation for taking part.

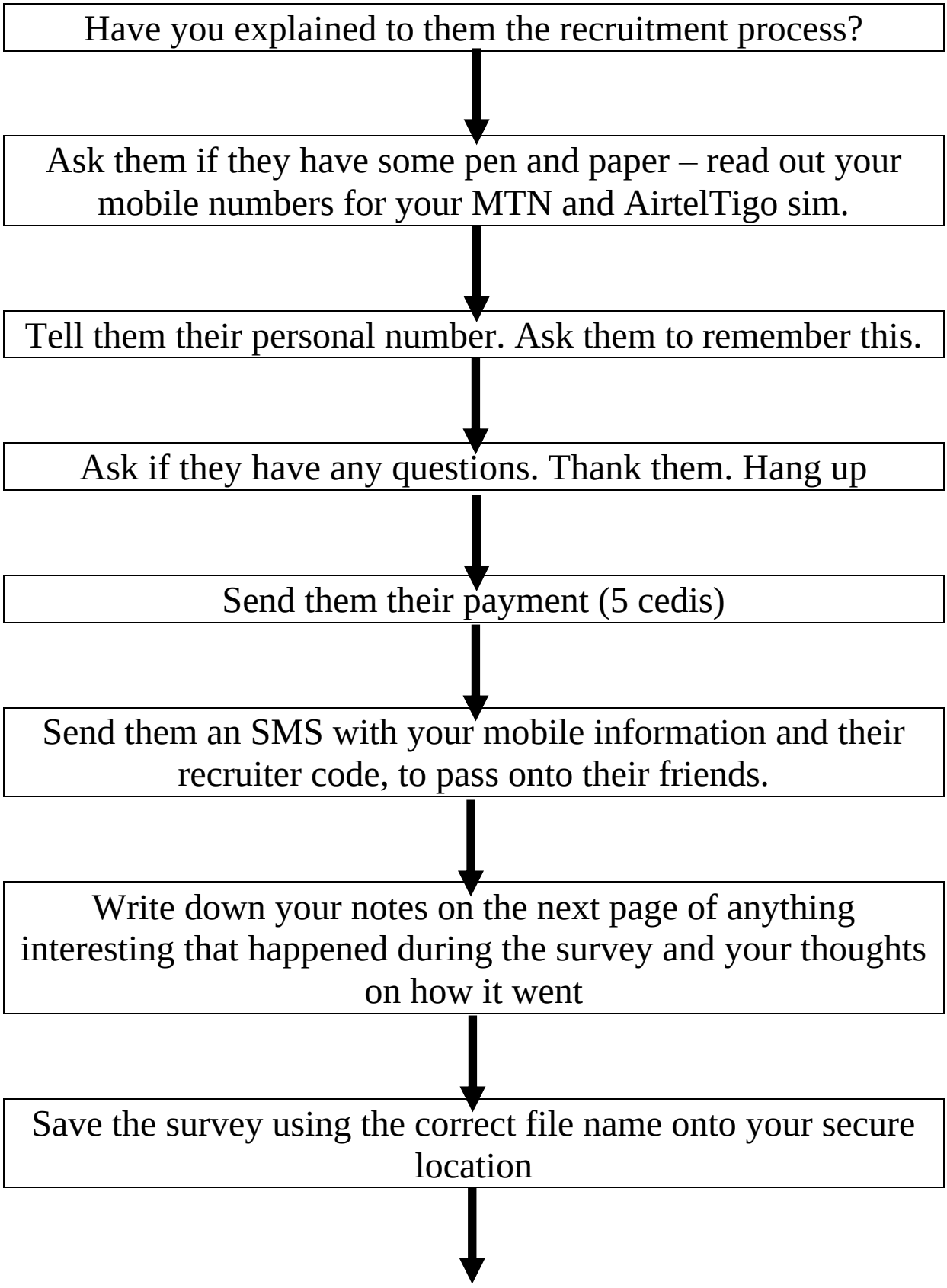
I am going to tell you my MTN and AirtelTigo numbers. Please pass these onto your friends to call me on. If they call me, I will arrange to return their call.

Here is your personal number [**tell them their interview number – the first column of your table**]. Tell your three friends this number, because I will ask for it when they call.

I will also send you an SMS message with these details. Is this the best number to message? If this is not the best number, please can you tell me the best number to message you. I will also use this number to transfer mobile credit.

Do you have any questions about what I have just said?

To finish the interview



Send the survey to Joe via FileDrop
https://filedrop.lse.ac.uk/

NOTES

Add any notes here from this survey, including how you thought it went, whether there were any challenges, whether anything interesting occurred.

Filedrop

TO ACCESS GMAIL: go onto www.gmail.com . Log into account below:

masculinitiesproject@gmail.com
Password: Menshealth123

TO ACCESS FILEDROP: go onto **https://filedrop.lse.ac.uk/** . Log in with the details below:

Username: masculinitiesproject@gmail.com
Password: Menshealth123.

Send your filedrop emails to j.strong3@lse.ac.uk

Abortion + EC FACT SHEET

Abortion is allowed in Ghana under the following cases:

- In cases of rape, incest or defilement of the female idiot
- If the life or health of the woman is in danger
- If there is risk of fetal abnormality

The Ghana Health Service has provisions for safe abortion services, and safe abortions at public clinics should cost between 50-100 cedis.

Safe abortions are those which are provided by a trained doctor, nurse or midwife using manual vacuum aspiration, dilation and curettage, or misoprostol (Cytotec), and which are performed in a government or private hospital, health centre or clinic.

There are clinics that will say they are heath facilities but are not safe for abortions. Make sure to confirm that the clinic is government or has proof that it is an official provider.

For more information:

Call Marie Stopes toll-free for a confidential talk on
0800 20 85 85 OR WhatsApp them on 0556489090

Covid-19 Facts

Covid-19, or 'Coronavirus', is a virus that spreads from person to person. The best response to it is to wash your hands whenever possible, limit your social interactions, and wear a cloth over your mouth and nose in public.

Please follow the advice provided by the Ghana Health Service and the World Health Organisation.

Appendix D: Description of Wealth Index

The wealth index was created through a Principal Components Analysis of survey variables that captured the material assets in a household (developed from variables used in the DHS) as well as to the structure of a person's household (floor material, roof material, water source). The following variables related to men's material assets:

If the household has one of the following (and it is working):
Electricity
Wall clock
Radio / speaker
TV
TV Decoder
Computer / Laptop
Non-smart mobile phone
Smart phone
Coal pot
Gas Stove
Fridge
Freezer
Sofa
Table
Bed
Fan
Air-conditioning
Flushing toilet
Livestock
Canoe/net
Bicycle
Motorcycle
Car

Variables relating to household structural factors were changed to binaries, necessary for the PCA analysis. It was decided that the binary should be based on what different materials would indicate about the structural quality of a household, acting as a proxy for the wealth of the person living within that household. Assumptions around what constituted higher quality and lower quality were developed with the entire research team, based on context knowledge of the typical households in James Town. These were defined as follows:

Roof materials
Higher quality: slate, cement
Lower quality: metal, wood, azar, no roof

Floor materials
Higher quality: tiles, carpet, wood planks / polished wood
Lower quality: cement

Source of water was similarly changed to a binary to reflect more contextual assumptions around the type of water source typical of a wealthier household and a less wealthy household:

Water source
Higher quality: private shared, private domestic
Lower quality: commercial shared, commercial domestic

A PCA analysis was run to create a score that could be attributed to each respondent. This score was then cut into thirds, proportional to the score. Each respondent was then assigned a wealth third based on scores and not based on creating equal proportions of men in each wealth category.

Appendix E: Focus Group Discussion Topic Guide and Vignettes

Focus Group Discussion Topic Guide

1. **Introductions and informed consent and the FGD expected behaviour**

Start with introductions – who I am

- PhD researcher from the London School of Economics, researching abortion in Ghana.
- Take all participants through the informed consent sheet, ensure that everyone has understood this and that it is signed.
- Ensure that participants are happy being voice recorded
    - Plan B is that JS will write up notes during the focus group discussion
- Reiterate anonymity of this and explain that it is a pilot focus group – their names and any identifying features will not be included.
- Participants are expected to show respect to each other and behave in ways that are respectful – failure to do so will lead to ejection from the focus group.

2. **Introductory questions**

Remind participants that no information about them or their families are being collected – it is all in the strictest confidence

Begin with questions about:

- Where are people from / how long have they live in Accra, etc (niceties).
- What is the current situation in Ghana regarding work and their lives?
    - What's troubling them? Are times good / bad / hard / okay etc.

3. **Gender exercise**

We want to first start with an exercise. There is some cut up piece of paper and some pens. Here are two circles, one for men and one for women. We want you to write down what types of things that make a good man and a good woman. There is no right or wrong answer. Spelling is not important, and if you prefer to say it out loud, we can write it down.

[do exercise]

4. **Abortion and introductory questions**

Today we are going to discuss the topic of abortion, as well as family planning and emergency contraception.

- First, I would like to know if you know many people who practice family planning, e.g. use condoms, or women who use contraceptives? Why do people in your friendship groups choose to use or not use family planning?
- Have you ever heard of the emergency contraceptive pill?
    - If yes, from where? Do you know where to get it

What is abortion? What are peoples' understandings of abortion? Are people aware if there are different types of abortions in Ghana?

- If so, what are these?
- Are some better than others? Why?
- Are there different clinics to get abortions in? Are some better than others? Why?

Are people aware of what the law on abortion is in Ghana?

- Could they elaborate on these?
- Do people know if there are any limits (e.g. gestational age) for when an abortion is allowed?

How might a man in Accra get hold of their information on abortion?

- Do they have any preferred sources to find out (e.g. in the future)
    - Where would a man go if they needed to obtain an abortion for their daughter/ wife / girlfriend (as the answers might be different for different relationships?)?
    - What are the main reasons for seeking an abortion in Ghana? Why?

5. Vignettes

We are now going to go through some stories. For each of them, imagine that you or someone you know is in that situation. What should the boy / man do in each situation? Why? How would he feel / react? Why?

6. Any other thoughts / questions?

Wrap up – thank for coming. Re-explain the informed consent and where they can contact about the focus group.

Example Vignettes

Kwame is 16 years old and is in school. His girlfriend is 15 years old and is at the same school. They have been together for 3 months. Kwame's girlfriend tells him that she is pregnant. They are afraid to tell their parents and about what to do with the pregnancy.

Kojo and his wife have three children aged under 5. The wife gave birth to their third child six months ago and is still breastfeeding. Because she is still breastfeeding, they do not use contraception. The wife finds out she is pregnant again

Samuel has been together with his girlfriend for three years. They are both 24 years old. She tells him that she is pregnant, and he tells her to get an abortion. Samuel gives her money to go to the drug store, but the girlfriend does not want an abortion. She takes the money but keeps the pregnancy

Joseph has three children. His daughter is 17 years old and is still in school. She is the first child, very intelligent and religious. She is always the reference point for the other children in terms of good behaviour. She tells him that she is pregnant, but she is not in a relationship with the boy.

Isaac has been married to his wife for 1 year. He is 20 years old and she is 19. She is a market seller and he is an artisan who has just completed his apprenticeship. They are trying to save money. Isaac's wife becomes pregnant and gets an abortion. She does not tell Isaac until after the pregnancy has been ended

Abraham is 31 years old. He is having an affair with a woman who is 22 years old. The woman becomes pregnant because they do not use any contraception.

Kofi is a barber and has five children. His eldest daughter is 15. She becomes pregnant by a teacher at the school and has been told she can no longer attend school while she is pregnant.

Appendix F: Qualitative Interview Guide

Things to remember

- Went want men to tell us why they think in certain ways. When men talking about masculinities and femininities, be thinking:
    - **Why** do they think this?
    - **Where** did they learn this?
    - **How** has this changed over time?
    - **What** do their friends think?

- Listen well, ask them about the context.
- **Remember** – this project is looking at **abortion** and **emergency contraception**. Make sure to ask men:
    - **Who** are the women they are referring to?
    - **What** do they think about this?
    - **Why** do they think that?

REMEMBER. This is a GUIDE. As long as you're focusing on men's attitudes, emotions, and what they do and why they do it with regards to emergency contraception, abortion and masculinities, this guide is to help you think of questions.

Topic Guide

1. Tell me a bit about yourself

- How is life for you?
- Do you do any work? What kind of work?
    - If no, did you do any work at another time?
- How are you finding things currently?
- Have things changed much in your lifetime? How?

2. Relationships

Think about: are their attitudes different for different women / men.
Ask them why!

- Tell me about your relationships?
- Have you been in many relationships in the past? Tell me about these
- What do you think about your current relationship? Is that different from past ones?
- Are relationships important for men? Are they important for women? Why? Is that specific to James Town?

3. Sex

- What do you think about sex?
    - Tell me more about why you think that? Is sex important? Why / why not?

    - Have your thoughts about sex changed over time? What were they like before?
- What do you think about your current sex life? Is that different from the past?
- How is sex talked about in James Town?
    - Is that the same as in the past?
    - What things do people say about sex?
- What do men think about sex?
- What do women think about sex?
    - Are there differences? Are there similarities?
    - Is it more important for men or for women?
- Do you and your friends talk about sex? What do they say?
    - Have these things changed over time? If YES, how?
- Where did you learn about sex?

4. Pregnancy

- What do you think about pregnancy and children?
    - Prompt: why do they think that?
    - Has that changed over time?
- Are there good times and bad times for someone to be pregnant?
    - What are these? Why are some good and some bad?
- How do people in Ghana see pregnancy?
- What do your friends think about pregnancy?
    - Do you discuss pregnancy with your friends? What do they say?
- What do your family think about pregnancy?
- Do you have any children?
    - Did you want to have all these children?
    - Were you ready to have children?
    - What made you feel ready / not ready to have children?
- If you don't have any children, why not?
    - Do you want children? Why?
- What makes a man a good father? What makes a man a bad father? Why? How do you feel about that?

5. Emergency Contraception

Ask men why!
If men don't know much about it, ask them about their friends, their partners, etc.
Do they know about it?
Is it talked about much?
What do people say?
Why do they think they say it?

- What do people in Ghana think about emergency contraception? Do people talk about it? What do they say? Why?
- Before you took part in the survey, had you heard of emergency contraception? Where did you hear about this? How did you feel about emergency contraception when you first heard about it? Is that different to how you feel about it now? How?
- What did you know about it?
- Have you ever had a partner who used it? What were the reasons for using? What did you think? Did you have a role in this?

- Have you bought / used emergency contraception? Tell me about this
    - How did you feel?
    - Why did you buy it?
    - Who was it for?
    - Would you do it again? Why / why not?
- Do you know anyone who has used it?
- Do you know anyone who sells it?
- What reasons did they give for using it?
- What do you think of women who take emergency contraception? Why? Has your opinion changed over time?
    - Is this different depending on who the woman is? Why?
- What do you think of men who buy emergency contraception? Why? Has your opinion changed over time?
    - Is this different depending on who the man is? Why?

6. Abortion

Keep on asking men why – why they think this? What their friends think? What women think? Does it depend on the woman and why.

- What do people in Ghana think of abortion? Do people talk about it? What do they say? Why?
- What did you know about abortion before we first spoke to you?
    - Where did you learn this? How did you feel about abortions when you first learnt about them? How do you feel about them now?
- Do you know anyone who has had an abortion? Who? Why did they have one? What did you think?
- What do you think about abortion? Why do you think that? Has that changed over time?
- Would you support someone get an abortion? Which people? Why?
    - Are there any differences in who you would support? Why?
- Have you ever supported or been involved in abortion?
    - What did you do? Why?
    - How did you feel?
    - Who was it for/
    - Have you done this more than once? Tell me about these times?
- What would you think of men who supported abortions?
    - Is this different depending on who the man is? Why?
- What would you think of women who supported abortions?
    - Is this different depending on who the woman is? Why?

7. Masculinities

- What makes a man a good person? What makes a woman a good person? Why is that? Where do you think you first heard these things?
- What makes a man a bad person? What makes a woman a bad person? Why is that? Where do you think you first heard these things?
- Were expectations different for men in the past? How? Why do you think things have / haven't changed?
- Were expectations different for women in the past? How? Why do you think things have / haven't changed?

- What are the most important characteristics for a man? What about a woman? What do you think of men who don't have those characteristics?
    - What do you think people in James Town think of men without these characteristics?
    - What about in Ghana more broadly?
- What are the most important characteristics among your friends? Why?
    - How do your friends feel about being good men?
    - What about your family? What is important for them?
- What does it mean to be a man? How do you feel about that? For you, has that changed over time?
- What are the good and bad things about being a man? Why do you think that? Have these changes over time?
- What makes a man a powerful person? What makes a man a powerless person? Why is that? Where did you learn this?

Notes – write your notes underneath each section

Section 1: Overall Comments – what were your impressions / thoughts? Describe the respondent's personality?

Your notes:

Section 2: Notes on "Tell me about yourself"

Your notes:

Section 3: Notes on "Relationships"

Your notes:

Section 4: Notes on "Sex"

Your notes:

Section 5: Notes on "Pregnancy"

Your notes:

Section 6: Notes on "Emergency Contraception"

Your notes:

Section 7: Notes on "Abortion"

Your notes:

Section 8: Notes on "Masculinities"

Your notes:

Appendix G: Workshop Training Module

Training Programme for Research Assistants

Draft Training Programme

Day 1:

Morning (with one break)

- Introduction to the research project and the methods that will be used.
- Findings in similar research projects and problems that they have encountered
- Discussion around the project topic (masculinity, abortion and emergency contraception).
- Discussion of ethical issues
    - **Handout** outline of the research topic (abortion and emergency contraception) and the research project (aims, research questions and proposed methods).

- **Lunch**

Afternoon (with one break)

- Introduction to household survey
- Discussion of survey methodologies
- Dissemination of draft survey for research
- Practice in asking questions and recording responses
    - **Handout** outlining the role of the data collector in surveys
- **Summary** of Day 1

Day 2

Morning (with one break)

- **Recap** of Day 1
- Introduction to qualitative data collection
- Introduction to topic guides and how to use them
- Training on asking questions in interviews and discussions and a reflection on the role of the interviewer
- Interview skills – probing, sensitivity, group moderation

- **Lunch**

Afternoon (with one break)

- In-depth interview role play
- Reflections and observations on role plays
- Role play a focus group
- Reflections and observations on role plays
    - **Handout** on key skills for qualitative interviewing
    - **Assignment** analyse the role plays – what could be improved and how?
- **Summary** of Day 2

Day 3

Morning (with one break)

- **Recap** of Day 2
- Review of the assignments and critical reflections
- Further in-depth interview role play and focus group discussion role playing, with note taking
- Review of the exercises

- **Lunch**

Afternoon (with one break)

- Review of interviewer techniques
- Review of moderator roles for focus group discussions
- Actors for role playing
- **Summary** of Day 3

Day 4

Morning (with one break)

- Review of all the training so far
- Actors for Focus Group Role Play
- Critical reflections
- Actors for surveys
- Critical reflections

- **Lunch**

Afternoon (with one break)

- Review of the training process
- Critical reflections

Appendix H: Table of changes to survey instrument

Question considerations as a result of the pilot survey:

Consideration
Always include “don’t know” in any binary yes/no question
Allow individuals to answer multiple ethnicities. Allow individuals to respond how they identify (with the possibility of ticking multiple), in order to reflect that ethnicity is asked due to the touchstones it implies, which are related to someone’s belief and cultural systems
Allow men to define their own relationship status, including additional relationships (ask separately whether these are sexually active)

Question changes as a result of the pilot survey:

Old Question (piloted)	**New Question (post pilot)**
How old were you on your last birthday?	How old are you?
Do you know the year you were born?	What year were you born?
[No question asked]	Do you have a birth certificate?
[No question asked]	Do you know where it is?
What ethnicity do you consider yourself?	What ethnic group / tribe do you belong to?
In your house, what is the main material of the floor?	In your room, what is the main material of your floor?
We are not going to ask you questions about your personal life. How would you describe your current relationship status?	Are you currently in a relationship? Can you describe that relationship to me?
You mentioned you are in X relationship, is this a sexual relationship?	[Following on from above] Is it a sexually active relationship?
[No question asked]	Have you ever had sex?
[All the children related questions]	Do you have any children or are you caring for any children like a father?
Attitudes towards pregnancy section	In your opinion, who should decide when to have children? In your opinion, who should decide how many children to have? When having sex, how often do you use contraception / family planning? Why do you always / sometimes / never use contraception? When having sex, how often does the person you are having sex with use contraception / family planning?

	In your opinion, why do you always / sometimes / never use contraception? In your opinion, who should make the decision about whether someone uses contraception / family planning?
In general, not relating to your personal life, who should make the final decision regarding: Spending household money on food Spending money on household purchases Whether to have sex or not How to care for children What to name a child When a child / young person should marry Who should inherit household goods / assets What profession a child / young person should take	For you, who should make or did make the final decision regarding? When you should / did marry? What profession you should / did take? When to start having sex for the first time? Currently whether to have sex or not? The continuation of your education? What clothes you wear? Where you currently live now? In the household, who should make the final decision regarding? Spending money on food Spending money on bills + rental Spending money on electrical items Spending on furniture Spending on school fees How to care for children How to discipline children Who a child should live with What to name a child Who should inherit the household The division of household chores?
6.5. – the "is it important questions" – **additional questions that were added**	Show emotion? To what to have sex with men? To be the main cook for his family? To have multiple sexual relationships at the same period of time? To beat his partner? To beat his children? For a husband to share household duties with his wife? A man to report when a woman beats him to the police?
6.5. – the "is it important questions" – **questions in pilot that were deleted**	Have a job Have the final say at home Be tough Not have sex with other men Be having relationships with women at the same time Have sex at least once a month Look after his children financially Provide care for his children

	Control when a woman gets pregnant Be kind Care for others Have his own home Be financially independent Cook for his family Dress sharp Have gone to school
[No question asked]	Do you have difficulty performing sexual intercourse

Appendix I:

Men's Involvement in Women's Abortion Related Care: A protocol for a scoping review

Primary Author: Joe Strong, MSc

Abstract

Men have been recognized as integral in the process towards universal sexual and reproductive health and rights (SRHR). This includes their ability to exert control and shape the conditions under which women and pregnant people navigate their abortion-related care trajectories. In other aspects of SRHR, policy and programmes have increasingly sought to engage 'men as partners', though there remain gaps in evidence over the roles and involvement of men in abortion-related care.

This scoping review protocol outlines the planned stages of a full scoping study aimed at identifying the most relevant literature and evidence of men's involvement in abortion-related care. The results of this scoping review will be submitted for peer-review publication with the intention of informing future research on men and abortion.

Background

The potentially significant role of men in shaping the sexual and reproductive health and rights (SRHR) of women was a key outcome of the 1994 International Conference on Population and Development (Basu 1996). Such a focus manifested into the programme and policy interventions aimed at engaging 'men as partners', which have been particularly focused in low- and middle-income countries (Dodoo 1998, Starrs, Ezeh et al. 2018).

Evidence emphasises that men do have a significant role in women's SRHR (Hindin 2000, Varga 2003), including over contraceptive-decision making (Shattuck, Kerner et al. 2011, Kriel, Milford et al. 2019), access to SRHR services (Hook, Miller et al. 2018, Sitefane, Banerjee et al. 2020). This role is not always positive; men's involvement in contraceptive decision making can be coercive or exacerbate gendered power dynamics (Blanc 2001, DeRose, Dodoo and Patil 2002, DeRose and Ezeh 2005, John, Babalola and Chipeta 2015). Moreover, where men tend to have greater control of resources, they can act as gatekeepers to care (Story, Barrington et al. 2016). Evidence indicates that men view engagement in reproduction as positive (Sternberg and Hubley 2004). Whilst evidence among women also indicated positive attitudes towards men's involvement, this was not uniform across all aspects of reproduction (Biddlecom and Fapohunda 1998, Rahman, Perkins et al. 2020).

This scoping review uses the theoretical framework developed by Coast, Norris et al. (2018), which conceptualises the factors that shape the decision-making, timing, and sources of abortion-related care. Abortion-related care trajectories are shaped by myriad factors that traverse abortion-specific experiences, an individual's context, and the (inter)national / sub-national contexts. These factors shape the conditions under which a pregnant person seeks their care, and their autonomy within this decision-making.

This scoping review intends to map the existing evidence on the involvement of men in abortion-related care. It seeks to answer the following questions:

- What is known about the involvement of men in women's abortion-related care?
- What are the methods and sampling that have been used to address this?
- How does the evidence map onto the existing abortion trajectories framework developed by Coast, Norris et al. (2018)?

Methods

Objective

The objective of this scoping review is to understand what evidence exists on the role of men in abortion-related care.

There are a number of scoping reviews and systematic reviews that exist in an area similar to this, though only one is focused on men (Altshuler, Nguyen et al. 2016). This focused on non-coercive men's involvement with studies collected between 1985 to 2012. Other systematic reviews have focused on the economic components of abortions (Coast, Lattof et al. 2021, Moore, Poss et al. 2021) and of post-abortion care (Shearer, Walker and Vlassoff 2010), post-abortion family planning counselling and services (Tripney, Kwan and Bird

2013, Rogers and Dantas 2017), and self-management (Moseson, Herold et al. 2020), including telemedicine (Endler, Lavelanet et al. 2019).

Inclusion and exclusion criteria

The scoping review will use the following inclusion criteria:

- Published between 01.01.2010-20.12.2019
- Research on humans
- Full text in English language
- Peer-reviewed
- The studies must also be focused on abortion and either reference men in the title or abstract or include men in the sampling frame.

The shifting landscape of abortion trajectories, impacted by new technologies such as medical abortion and legal changes as in the case of Argentina or Poland, made a shorter publication date range suitable (Berer 2017, Broussard 2020). Moreover, the only prior systematic review on male partner involvement included publications between 1985 and 2012 (Altshuler, Nguyen et al. 2016). This evidence mapping aims to further map the evidence of men's involvement, building on previous contributions to the field, but ensuring the studies included are relevant to the current abortion landscape.

Studies will also be labelled whether they are in a low, middle, or high-income country, as per the World Bank classifications.[14]

Study selection

Database search: Electronic databases will be searched, with the search syntax amended to ensure that it can be understood in each of the following databases:

- EMBASE
- PsychINFO
- MEDLINE (Ovid)
- CAB Direct
- CINAHL

The studies included will be limited to English to reflect the language limitations of the author and Research Assistant. Included studies will be downloaded and screened on EndNote using the following process:

- Citations from databases will be combined
- Duplicates will be identified and removed
- Titles and abstracts will be screened and studies excluded based on the criteria
- Included studies will be full-text screened and included or excluded with reason

Search terms

The following search terms were developed with an LSE librarian for each journal (searches conducted May 2020):

[14] https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

EMBASE	(induced abortion and male).sh. or ((Abortion* or termination* or (menstru* and regulat*) or antenatal) and (man or men or male or masculin* or adolescen* or boy or boys) and (pathw* or passage* or rout* or course* or traject* or direction* or influen* or involv* or support* or participat*)).ab. or ((Abortion* or termination* or (menstru* and regulat*) or antenatal) and (man or men or male or masculin* or adolescen* or boy or boys) and (pathw* or passage* or rout* or course* or traject* or direction* or influen* or involv* or support* or participat*)).ti.
PsychINFO	(induced abortion and human males).sh. or ((Abortion* or termination* or (menstru* and regulat*) or antenatal) and (man or men or male or masculin* or adolescen* or boy or boys) and (pathw* or passage* or rout* or course* or traject* or direction* or influen* or involv* or support* or participat*)).ab. or ((Abortion* or termination* or (menstru* and regulat*) or antenatal) and (man or men or male or masculin* or adolescen* or boy or boys) and (pathw* or passage* or rout* or course* or traject* or direction* or influen* or involv* or support* or participat*)).ti.
MEDLINE (Ovid)	(abortion, induced and men).sh. or ((Abortion* or termination* or (menstru* and regulat*) or antenatal) and (man or men or male or masculin* or adolescen* or boy or boys) and (pathw* or passage* or rout* or course* or traject* or direction* or influen* or involv* or support* or participat*)).ti. or ((Abortion* or termination* or (menstru* and regulat*) or antenatal) and (man or men or male or masculin* or adolescen* or boy or boys) and (pathw* or passage* or rout* or course* or traject* or direction* or influen* or involv* or support* or participat*)).ab.
CAB DIRECT	((subject:(abortion) OR ab:(((Abortion* OR termination* OR (menstru* AND regulat*) OR antenatal) AND (man or men OR male OR masculin* OR adolescen* OR boy OR boys) AND (pathw* OR passage* OR rout* OR course* OR traject* OR direction* OR influen* OR involv* OR support* OR participat*))) OR title:(((Abortion* OR termination* OR (menstru* AND regulat*) OR antenatal) AND (man or men OR male OR masculin* OR adolescen* OR boy OR boys) AND (pathw* OR passage* OR rout* OR course* OR traject* OR direction* OR influen* OR involv* OR support* OR participat*))) AND yr:[2010 TO 2019])
CINAHL	MW (abortion, induced AND men) OR TI (((Abortion* OR termination* OR (menstru* AND regulat*) OR antenatal) AND (man or men OR male OR masculin* OR adolescen* OR boy OR boys) AND (pathw* OR passage* OR rout* OR course* OR traject* OR direction* OR influen* OR involv* OR support* OR participat*))) OR AB (((Abortion* OR termination* OR (menstru* AND regulat*) OR antenatal) AND (man or men OR male OR masculin* OR adolescen* OR boy OR boys) AND (pathw* OR passage* OR rout* OR course* OR traject* OR direction* OR influen* OR involv* OR support* OR participat*)))

Extraction method

During the screening process, a Research Assistant will conduct a screening of 5% of the total sample with duplicates removed. The author and the RA will then compare these studies to look for any systematic (frequently occurring >1% of the time) or non-systematic (<1% discrepancies) in the exclusion and inclusion terms. In the event of a systematic discrepancy, another 5% sample of studies will be randomly selected after discussions to ensure that both the author and RA understand the criteria. In the event of non-systematic discrepancies, the RA and author will discuss their reasoning and come to a joint conclusion how best to proceed with the article.

Data will be extracted from the included full texts by the author alone, due to budgetary constraints. The country, sample size, method, and relevant findings will be recorded for all relevant studies in Excel, ready for analysis.

Quality assessment

As a scoping review, it is not necessary to interrogate and analysis the quality of the evidence, as would be appropriate with a systematic review (Peters 2020). This scoping review seeks to map existing evidence in order to provide indications of where future research could explore and interrogate the involvement of men in abortion trajectories.

Presentation of results

The results of the methodology will be presented in a flow chart that reflects the extraction methods and provides the number of studies included or excluded and the reasons for exclusion.

The results will be presented in a journal paper that draws on the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for scoping reviews (PRISMA-ScR) checklist (Tricco, Lillie et al. 2018). The number of included studies and the reasons for studies excluded at full text will be presented.

Conclusion

This document outlines the scoping protocol to be used to map the evidence of men's involvement in abortion-related care. The output of this scoping review will be relevant for identifying evidence gaps and shaping the direction of future research in the field.

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Competing interests

None

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Appendix J: Scoping Review Extraction Codebook

	Author
	Title
	Year
	Country
	Region
Methods	**Aim / Objective**
	Qual / Quant
	Sample
	Tools
	Notes
	Results
	Conclusions
	Limitations
	Recommendations for further research?

Appendix K: Scoping Review Summary of Included Studies (n=37)

Lead Author / Year	Country / Region	Aims / objectives	Study sample	Study site	Method
Alex-Hart[62] 2015	Nigeria Sub-Saharan Africa	To evaluate the sexual behaviours of secondary school students in Port Harcourt	1,047 students (537 women, 510 men)	Six public secondary schools	Quantitative
Summary of results	<u>Abortion-specific experiences</u> Of the 11% of men who reported a partner ever being pregnant, 26.8% of male respondents assisted their girlfriends in obtaining an abortion. <u>Individual context</u> 48.2% of men were reported to have denied paternity.				
Appiah-Agyekum[69] 2015	Ghana Sub-Saharan Africa	To explore the factors that influence abortion decisions	142 students (53 men, 89 women)	University of Ghana students	Qualitative
Summary of results	<u>Individual context</u> Key determinants of decision making among students were education, religious beliefs, health reasons, financial/economic factors, and family. Less influential were partner's views, societal pressure/stigma, work /career, and peer influence.				
Aziato[64] 2016	Ghana Sub-Saharan Africa	Gain an understanding of reactions to unplanned adolescent pregnancies in Ghana	15 focus groups with 92 adolescents aged 10-19 who had a recent termination	Public health facilities in Accra, Kumasi, Tamale	Qualitative
Summary of results	<u>Abortion-specific experiences</u> In response to pregnancy, girls reported that the character in the vignette would feel sad, alarmed, uncomfortable, not happy and that she might want to terminate the pregnancy. They mentioned that pregnancy and school were not seen as compatible.				

	Respondents suggested that parents might facilitate an abortion. This was focused on disclosure to mothers, but also discussions included fear/concern over the reaction of both parents (e.g. calling the boy to deal with it). Some suggest parents would provide contraceptives to avoid it happening again. Respondents who had partners who obtained medication worried about the safety. <u>Individual context</u> With regards to partner reaction, adolescents suggested it would be shock, surprise, confusion, denial of pregnancy. If the partner was a student or unemployed, they might suggest termination. Male respondents reported that they could deny the pregnancy.				
Bain[70] 2019	Ghana Sub-Saharan Africa	To understand the adolescent decision-making process and outcome towards pregnancy and abortion	Adolescents aged 13-19 who had at least one pregnancy (n=15), one abortion (n=15) and 23 stakeholders	Jamestown, Accra, Ghana	Qualitative
	<u>Individual context</u> Partners, friends, and family members were the main groups involved in adolescent abortion decision-making. Fathers influenced in a "top-down" manner, having greater decision-making power including threatening to disown the adolescent unless the pregnancy was terminated.				
Challa[42] 2018	Ghana Sub-Saharan Africa	To explore the social ecological context of adolescent SRH in Ghana	63 women aged 15-24	School and clinic-based sites in Accra and Kumasi	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Many women reported keeping pregnancy or abortion a secret from parents to avoid being disowned, abused verbally or physically), or ejected from the home by family.				
Chatchawet[57] 2010	Thailand East Asia and the Pacific	To gain a greater understanding of the type and amount of support men can offer women obtaining abortions	23 people (12 women and 11 men) who had experienced complications of unwanted pregnancy termination	Three hospital in-patient departments	Qualitative

Summary of results	<u>Abortion-specific experiences</u> Men demonstrated accepting some responsibility for the pregnancy termination. Support was demonstrated by searching for information about pregnancy termination; accompanying women to appointments; staying with them during termination. Most men said desire to assist was about ensuring their partners had an efficient and safe termination. Support could also take the form of providing financial assistance needed. Men in the sample reported that they showed support by not leaving their partner during the abortion. This included: being physically close to their partners; waiting nearby, e.g. in front of the room, during the termination of the pregnancies; and, telephoning their partners. Male partners providing support was seen as lessening any emotionally negative experience of abortion by women.				
Che[60] 2017	China East Asia and the Pacific	To explore perceptions and decision making around contraceptive use, experiences of abortion services, and post-abortion contraceptive decision-making	40 in-depth interiews with women who had experienced abortions and select partners Seven focus groups with men and women	Facilities in urban and rural settings	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Men reported being able to accompany their partners and were invited to join in post-abortion family planning discussions. Men considered being involved in these discussions important.				
Coast[71] 2016	Zambia Sub-Saharan Africa	Analysing care-seeking pathways of women who had either a safe abortion or sought care following an unsafe abortion	112 women who sought care for abortions or post-abortion care	A hospital in Lusaka, Zambia	Qualitative
Summary of results	<u>Abortion-specific experiences</u> In accounts of decision-making, women reflected on weighing up the risks, such as the risk of physical harm versus desperation to remove the pregnancy. Financial costs played a role in the timing and complexity of trajectories of abortion; women without independent means faced dilemmas.				

	<u>Individual context</u> Different sources of advice were sought based on different age groups - e.g. adolescents went to peer groups from fear of parental disapproval. Among married women who feared their partner's reaction, it was harder to seek informed advice.				
Dahlbäck[68] 2010	Zambia Sub-Saharan Africa	To explore young women's experiences of pregnancy loss	87 young women who had induced abortions (n=34) and spontaneous abortions (n=53)	A hospital in Lusaka, Zambia	Mixed methods
Summary of results	<u>Abortion-specific experiences and Individual context</u> Partner factors played a "decisive role" in the final decision-making process to have an abortion. Five partners abandoned their girlfriends and 11 denied paternity. They refused financial and emotional responsibility.				
Freeman[41] 2017	Zambia Sub-Saharan Africa	To examine men's involvement in women's abortion seeking	71 women who obtained abortions and 41 who obtained post-abortion care	A hospital in Lusaka, Zambia	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Some women deliberately excluded men due to fear of men's interference with abortion decisions or fear of their reaction to the pregnancy. Men's active involvement - most influential when acting as shared decision makers, sounding boards, facilitators to obtaining care by paying, arranging, or accompanying a woman. Husbands and boyfriends were most frequently featured in respondents' narratives of men's participation in abortion decision making. Respondents who decided with their partner to abort the pregnancy typically reported that their partner continued to be involved when they obtained services. These men provided emotional support, facilitated abortion by seeking and providing information about where services could be obtained, and accompanied respondents to access care. Most frequently, men supplied the money for transportation and treatment. <u>Individual context</u> Men rejected paternity or the relationship - this was a common reason that women gave for men being absent. Where men were absent, women were more likely to be attending for post-abortion care, while where men knew of their partner's abortion, the majority of abortions were safe. Younger women were more likely to report partner violence or rejection than older women, although age did not appear to have an impact on involvement.				

Hirz[40] 2017	Philippines East Asia and the Pacific	To understand men's belief and perception of their roles surrounding unintended pregnancy and induced abortion	15 men for interviews and 43 for focus group discussions	An urban area in the Philippines	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Men stated they would feel morally and financially responsible in the event a pregnancy occurred. Men were more nuanced in the responses in in-depth interviews. They recognised that women are fearful of disclosure, that there are physical and social consequences facing women and that a man's decisions would heavily influence abortion outcomes. <u>(Inter)national and sub-national contexts</u> Occurrence of unintended pregnancies was attributed to God's will. Participants in FDGs endorsed belief that induced abortions were a sin. Men expressed frustration at a perceived lack of control over situations regarding pregnancy and induced abortion, and fear that they did not want to commit or be complicit in a sin.				
Izugbara[48] 2014	Kenya Sub-Saharan Africa	Explore the drivers of women's choices when pregnant	80 women aged 16-49	Nairobi, Kenya	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Fear of partner responses led to women keeping their pregnancies a secret. One respondent reported her partner being violent when she disclosed her pregnancy. Men exerted "considerable" influence over the pregnancy trajectory, both to seek an abortion or continue a pregnancy. Some men paid the women to terminate the pregnancy. <u>Individual context</u> Women with unacceptable pregnancies reported abandonment and rejection by male partners and parents. The type of man was important for women as to whether the pregnancy was acceptable (e.g., age, wealth).				

Kalyanwala[56] 2010	India South Asia	To examine the abortion-related experiences of unmarried women aged 15-24 who obtained abortions	549 women aged 15-24	16 clinics in Janani	Quantitative
Summary of results	Abortion-specific experiences 92% of respondents whose partners knew of the pregnancy reported receiving support: 86% reported emotional support, 51% financial support. Other pregnant individuals reported their father's providing financial support. Women who did not receive support from their partner had higher odds of second trimester abortion than those with full partner support. Those who had first trimester abortions compared to second were more likely to receive partner support (95% vs 82%) and have a partner accompany them (78% vs 48%).				
Kalyanwala[55] 2012	India South Asia	To interrogate the experiences of unmarried young abortion-seekers	549 women aged 15-24, 26 for interview	16 clinics in Janani	Mixed methods
Summary of results	Abortion-specific experiences Lack of partner support was reported by only a few women and most had disclosed their pregnancy / abortion. Partners are more likely than any other to provide support. This support can be: deciding on abortion together, emotional support, accompanying to facility, arranging covering costs More women reported not disclosing to their family out of fear of reaction.				
Kumi-Kyereme[49] 2014	Ghana Sub-Saharan Africa	To examine the key influences in abortion decision-making in Ghana	401 women with records in abortion logbooks	Three abortion service providers	Mixed methods
Summary of results	Abortion-specific experiences Overall, 32.67% (n = 131) of the respondents did not seek approval from anyone before receiving an abortion; 54.36% (n = 218) required their partner's approval; 8.23% (n = 33) consulted with their mother for the decision; and the remaining 4.74% (n = 19) made the abortion decision with role-players categorized as "Others", which includes friends, siblings, aunts/uncles, employers and mothers-in-law. Men operationalised their role as 'breadwinners' during decision-making around pregnancies and abortions.				

	Individual context Knowledge of the law, occupational status, number of children living and level of formal education increased odds of seeking consent of male partners over "others".				
Leone[46] 2016	Zambia Sub-Saharan Africa	To compare the costs of post-abortion care following unsafe abortion with the costs of safe abortion care	112 women who sought care for abortions or post-abortion care	A hospital in Lusaka, Zambia	Qualitative
Summary of results	Abortion-specific experiences 705 of women reported receiving some help, including from husbands or partners, with 50.4% of that help being financial (e.g., money for transport).				
Macleod[74] 2013	South Africa Sub-Saharan Africa	To study men's constructions of abortions in South Africa	37 articles on abortion and 20 men	University and East London, South Africa	Mixed methods
Summary of results	(Inter)national and sub-national contexts Men reported shock at the notion that a woman would terminate a pregnancy without their consent. The 'New Man' discourse of being supportive and attentive was used in discourses by some focus-group discussants to explain how to persuade a woman out of an abortion.				
Marlow[63] 2019	Ghana Sub-Saharan Africa	To understand what men, know about abortion, why they support their partners, and develop an intervention to improve safe abortion access	11 focus groups of men aged 15-54 (8-12 men in each focus group)	Upper East and Upper West provinces, Ghana	Qualitative

Summary of results	Abortion-specific experiences Men reported learning about abortion services from the hospital, friends, and the radio. Some reported arriving to the hospital having previously tried methods. Men reported seeking the services of herbalists and drugs from pharmacists to keep abortions secret from the community. Out of the 11 focus groups, 7 reported supporting women to abort to finishing schooling, 6 if the women had a young child, 5 for mothers' life, 4 for incest, 3 to care for current family, 2 if pregnancy unplanned and 1 to avoid shame. Whilst men understood that abortions were more safely provided in hospitals, they reported seeking other providers. (Inter)national and sub-national contexts In seven focus groups, men utilised the language of "sin" and that an abortion was "killing" to draw on community norms against abortions.				
Moore[50] 2011	Uganda Sub-Saharan Africa	To examine men's and women's perspectives on men's involvement in abortion decision-making and seeking post-abortion care	61 women aged 18-60 and 21 men aged 20-50	Kampala and Mbarara, Uganda	Qualitative
Summary of results	Abortion-specific experience There were conditions under which some men expressed support, e.g., being involved in the decision making, helping women make doctors' appointments, providing financial support / facilitating transport. Due to secrecy, men talked about not knowing if their partners had abortion complications. Men stated that if a man finds out that the woman terminated a pregnancy without his knowledge, he cannot support her no matter what health problems she experienced. (Inter)national and sub-national contexts Men's responses largely reflect the prevailing socio-cultural norms and values. When questioned generally, male respondents' status that men are not supportive of women having abortions. Reasons including not agreeing with the practice, belief that the child is a member of society, that the women could die, fear of being arrested, the woman is hiding an affair. Less frequent were costs of abortion and PAC.				
Mwilike[67] 2018	Tanzania Sub-Saharan Africa	To determine the feasibility of an education programme	15 pregnant adolescents aged 15-19	A health facility in rural Tanzania	Mixed methods

Summary of results	Individual context Rejecting and denying paternity had a significant role on women's decisions about whether to abort, particularly for unmarried, pregnant adolescents.				
Nonnenmacher[45] 2014	Brazil Latin America and the Caribbean	To explore the perception of women in relation to the reactions and behaviour of their partner in abortions	285 women who had miscarriages and 31 women who had abortions	Hospitals in two Brazilian cities	Quantitative
Summary of results	Abortion specific experiences Women reported that their male partners were more supportive of spontaneous than induced abortions and they would try to hide the latter from these partners.				
Obiyan[75] 2014	Nigeria Sub-Saharan Africa	To explore parental involvement in adolescents' sexual and reproductive health education	460 female adolescents for questionnaires, 31 female adolescents and 33 parents for focus group discussions	Yoruba communities in Osun State	Mixed methods
Summary of results	(Inter)national and sub-national contexts Male participants believed that single women were more likely to consider abortion than non-single. Men had mixed feelings about whether unintended pregnancies were their responsibility or not. Fathers argued that mothers were closer to their daughters when it came to discussing abortion intentions and that there were gaps in communication between fathers and adolescents.				
Olsson[72] 2010	Sri Lanka South Asia	To understand experiences of unmarried pregnancy termination seekers to influence future programme development	19 women who had abortions	A health centre, Colombo	Qualitative

Summary of results	<u>Individual context</u> Women had various factors that they considered in the decision to seek pregnancy termination: family pressure; partner's qualities and attitude towards pregnancy; economic aspects; own feelings, values and future fertility. Pregnancies and termination occurred in relatively long-lasting relationships - preceding planned marriage - as out of wedlock pregnancy was reported as unacceptable.				
Omidey[51] 2011	Nigeria Sub-Saharan Africa	To explore whether abortion options were chosen and how they were perceived	17 (10 women, 7 men) interviews, 4 focus group discussions (2 with men, 2 with women)	Local universities and surrounding areas	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Women reported being given money by partners and told to seek an abortion, if unmarried. Partners' reactions were significant, as were parent's reactions for women who were single. Fear of repercussions led some women to decide to abort. Male partners played a significant role in determining pregnancy outcomes, including providing financial, material, and emotional support. <u>Individual context</u> Women reported that their concerns over their partner denying their pregnancy led them to seek abortions, including to avoid a known pregnancy not being associated to a “responsible” man.				
Palomino[52] 2011	Peru Latin America and the Caribbean	To explore participants' individual experiences with reproduction and reproductive decision-making	Interviews with 12 women aged 21-35, 7 men aged 18-37, 2 focus groups with men and 2 with women (33 participants overall)	Metropolitan Lima	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Partners were not always the main sources of finances and resources, and an adolescent boy reported that his financial dependence reduced his role in pregnancy decision-making, which was also reported by adolescent women in the study. <u>Individual context</u> Pregnancy-related decisions were not made by the woman alone. Their partner was generally involved, as well as family members. Men and women differed on who had control, with evidence suggesting it ranged between equal decision-making to male controlled decisions.				

	Some respondents reported being coerced to have an abortion by partners or family members, while multiple men argued that they made the decisions on pregnancy outcomes, including abortions. Other men had more equitable views, including that the pregnant woman should decide. For women, age had an impact on their decision-making, with respondents linking being younger or less informed with allowing partners to take control.				
Petitet[61] 2015	Cambodia East Asia and the Pacific	To examine the implementation and the effects of the distribution of Medabon on women's reproductive choices and practices	10 women, 6 men, 8 health care providers, 4 pill sellers	One site in Takmao and 7 in Phnom Penh	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Men knew about different abortion services and learnt about them through newspapers and radios. Four men had accompanied their partners for medical abortion and expressed a desire to help their partners were possible. Three accompanied their partners for PAC.				
Rehnström Loi[66] 2018	Kenya Sub-Saharan Africa	To explore decision-making preceding induced abortion	9 women aged 19-32	Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) or Kisumu East District Hospital (KDH) in Kisumu, Kenya	Qualitative
Summary of results	<u>Abortion-specific experiences</u> Disclosure of pregnancies to partners was often done to seek financial support. Almost all women expressed that they had a disagreement with their partner and that their fear of possible consequences (including anger, violence, or divorce) was a factor in the decision to seek care without telling a partner. Women reporting feeling forced or misled into abortions, with one respondent reporting that her partner involved an abortion provider to help him terminate the pregnancy without her consent. <u>Individual context</u> Women reported that their partners' unwillingness to financially support a child was a key reason for seeking abortions. In addition, unstable relationships with partners were cited. The context of the relationship of the woman and the man responsible for the pregnancy also influenced disclosure - women who were single				

	were more likely not to tell their partner of the pregnancy or abortion.				
Rominski[43] 2017	Ghana Sub-Saharan Africa	To understand the perspective of women who decide to terminate	18 women seeking care for complications from abortions and 11 for abortion-care (aged 13-35)	Three hospitals in Ghana	Qualitative
Summary of results	Abortion-specific experiences Women reported that they self-managed their abortion over fear of disclosure. Women learnt abortion methods through social networks. They expressed taking drugs provided by friends or boyfriends, despite not necessarily knowing what they were.				
Schwandt[44] 2013	Ghana Sub-Saharan Africa	To understand the decision-making process associated with induced abortion in Ghana	58 interviews (19 with men, 20 with women, 11 with family planning nurses, 8 obstetricians / gynaecologists) and 9 focus groups (4 with women, 2 with men, 1 with family planning nurses, 2 with obstetricians / gynaecologists)	two teaching hospitals, Ghana	Qualitative
Summary of results	Abortion-specific experiences Women discussed fears disclosing and some did not disclose prior to abortion over fear of reaction. Individual context Men were the first decision makers post pregnancy discovery. Their acceptance or rejection was critical - acceptance was of paternity. Men's ability to deny responsibility was a major fear of respondents. This has an indirect impact on the abortion trajectory of a woman				
Shekhar[39] 2010	Kyrgyzstan Europe and Central Asia	To estimate the abortion rates by different background characteristics	3848 women aged 15-49 (Demographic and Health Survey)	National	Quantitative

Summary of results	Individual context Women's attitude towards becoming pregnant and their husband's attitude towards abortion were significantly associated with the likelihood of an induced abortion.				
Sowmini[54] 2013	India South Asia	To identify the reasons that cause delay for adolescents and young women seeking safe abortion services	34 unmarried young women seeking abortion	Tertiary hospital abortion clinic, Trivandrum	Qualitative
	Abortion-specific experiences Most adolescents were accompanied by their mothers to obtain an abortion, with few involving their sexual partners and only two reported that their partner accompanied them or provided financial support.				
Srivastava[65] 2019	India South Asia		20 medical abortion users and 20 partners	Three districts, Uttar Pradesh, India	Qualitative
Summary of results	Abortion-specific experiences Men were frequently the ones bringing MA kits for their female partners. Male respondents indicated that the chemist was often a male friend of theirs. Lack of knowledge meant the chemist was often trusted to provide the right information and dosage, as well as potential side effects. Such information could be lost in transit when male partners obtained the abortion method on behalf of their partner, leading to a lack of knowledge of side effects amongst women.				
Steven[73] 2019	Democratic Republic of the Congo Sub-Saharan Africa	To explore leaders' perceptions of their role in addressing unintended pregnancies in the community	12 male community leaders	Six rural health zones, North and South Kivu	Qualitative
Summary of results	(Inter)national and sub-national contexts Community leaders were all male. Their attitudes towards abortion were very negative, including perceiving abortion as unchristian, immoral, or in violation of community norms. Women who had abortions were seen as criminals, and community leaders reported involving the police in instances of abortions or isolating / forcing a woman out of the community.				

	In spite of this, community leaders indicated that women who had an abusive, alcoholic or unemployed partner, or who faced financial difficulties, could seek an abortion. Community leaders considered themselves responsible for the provision of PAC.				
Tatum[47] 2012	Mexico Latin America and the Caribbean	To examine the factors influencing how young women make reproductive decisions	12 interviews and 4 focus groups with women aged 13 to 17	Mexico City	Qualitative
Summary of results	Abortion-specific experiences Partners could offer emotional support, though often support was in accordance with the partner's wishes and not necessarily the respondent's. Of the six interview respondents who had an abortion, four reported that their partner was willing to assume responsibility of fatherhood, including involving the adolescent's father for approval. Two respondents described being forced to have an abortion by their fathers without their consent. Individual context Absence of a viable co-parent influenced some women to abort. In all cases where partner was not involved, women decided to abort. For the two focus group discussion participants who did not have an abortion, their partners assumed responsibility and were working.				
Tong[58] 2014	Malaysia East Asia and the Pacific	To explore the experiences of women and their needs regarding abortion	31 women aged 21-43 who had obtained abortions	An urban family planning clinic in Penang	Qualitative
Summary of results	Abortion-specific experiences Some respondents indicated that an abortion decision should be between a woman and her partner. Others reported that they felt forced to abort as their partner claimed not to be ready for marriage or to financially support the child, thus making the pregnancy unacceptable. Partners could play a supportive role, including seeking information, paying for services and accompanying women.				

Ushie[53] 2019	Kenya Sub-Saharan Africa	To understand community perception of abortion is critical in informing the design and delivery of interventions to increase access to safe abortion	36 women and 12 men for interview, 9 health care workers. 9 focus groups with women and 9 with men	Kisumu and Nairobi counties	Qualitative
Summary of results	Abortion-specific experiences The study reported that the majority of girls relied on boyfriends, as well as friends, relatives, and mothers, to raise money for their care. This includes one (male) respondent referencing that this could result in unwanted disclosure of a pregnancy. (Inter)national and sub-national contexts In communities where men, and their families, conduct informal "background checks" on women, knowledge of abortions is considered undesirable and means a woman is perceived as a bad potential wife. Men report thinking that these women might continue to have abortions, which limits their ability to achieve social success through parenting. However, men and women also reported that abortions were increasingly normalised in their communities.				
Zuo[59] 2015	China East Asia and the Pacific	To examine why unmarried women delay obtaining an abortion and identify correlates of the delayed decision	1,271 unmarried women aged 15-24 who had sought abortions	Shangai, Chengdu, and Taiyun	Quantitative
Summary of results	Abortion-specific experiences 73-85% of male partners had positive reactions to pregnancy disclosures and provided comfort / solutions. 12-28% of women reported that partners were pleased about the pregnancy, either due to it cementing their relationship or to confirming fertility. 6-12% of partners responded with fear.				

Appendix L: Policy Briefs

Men, masculinities, and sexual and reproductive health attitudes and behaviours in Ghana

Economic and Social Research Council

The study surveyed 306 men based in James Town, Accra, and interviewed a sub-sample of 37 men. The research tools focused on **emergency contraception** and **abortion**, exploring men's knowledge, attitudes, and involvement.

MEN AND ABORTION

98% of men had heard of abortions, and 53% of men knew that abortions were permitted in Ghana

35% of men first heard about abortions in school;
31% of men first heard about abortions from their community, including campaigns and programmes;
23% of men first heard from male or female friends

17% of men reported ever having supported someone obtain an abortion, including supporting other men who's partners were pregnant

Men reported that their involvement was most often in the form of sharing information, sourcing a provider, and financial contributions

60% of men said they would never support someone obtain an abortion, the remainder would either support anyone or would support specific relations of women, particularly girlfriends and daughters

Unmarried men and working men were more likely to be supportive of abortions than married or men out of work

"I am the one who force her to do it [have an abortion] because I had made up my mind that…. She got pregnant and I wasn't ready to have a child."
42-year-old

MASCULINITY MATTERS

- Men emphasised the need to be financially stable and accrue resources, particularly to provide food, shelter, and clothing for children. Where men felt they were yet unable to fulfil these masculine ideals, they were more likely to discuss both supporting an abortion as well as pressuring a woman into an abortion.

- Men were especially concerned about how a pregnancy would make them look to their friends and community. Men expressed desires for pregnancies that would make them look masculine, such as with a formal partner after they had accrued enough resources for their own room. Pregnancies that occurred unexpectedly or before they felt financially ready were seen as threatening to their masculinities, and men often feared mockery and isolation by their community.

- Men's attitudes towards abortion was not static – they were not consistently 'pro' or 'anti' choice. Rather, their opinion shifted depending on their relationship to a woman. This included different attitudes for a girlfriend, wife, sister, daughter, or friend. Different relationship types were seen as having a different impact on a man's masculinity and the image of his manliness.

Read more: Strong J, Lamptey NLS, Quartey NK, et al. "If I Am Ready": Exploring the relationships between masculinities, pregnancy, and abortion among men in James Town, Ghana. Social Science & Medicine

www.sciencedirect.com/science/article/pii/S0277953622007602

MEN AND EMERGENCY CONTRACEPTION

36% of men had heard of the phrase 'emergency contraception'. 43% of men knew about emergency contraception but did not know the term.

Men were more likely to know brand names – Lydia and Postinor 2 – than the phrase 'emergency contraception'.

- 27% of men first heard of EC from friends;
- 21% of men first heard of EC from TV, radio, or other media;
- Only 8% of men first heard of EC at school.

- 21% of men reported ever having bought EC, primarily for a sexual partner;
- 43% of all men said it would be unacceptable for their partner to buy EC and 37% said they would never buy it.

Buying EC can be embarrassing for both men and women, reducing their desire to go to a pharmacy

"They [men] also think it is good but you know most of them feel shy to go to the pharmacy to say I want to buy this drug you know, that is the major problem most of my friends complain of that they can't go to the pharmacy to buy this kind of medicine so I think they are cool with it but how to get it is their problem."
28-year-old, never bought EC

Men had mixed knowledge about the safety of emergency contraception

"I am scared because they say when you take it too much it destroys the woman's womb"
18-year-old, previously bought EC

Men had mixed perceptions towards EC, seeing it as good for family planning but a sign of women's irresponsibility

"The ladies that use it say it is good for them, it allows them to do a lot of things and even if you ejaculate in them it doesn't allow them get pregnant"
42-year-old, never bought EC

"[If] she starts using that thing [EC] without telling you... you don't know but some other time you might see it in her bag... that means she goes to have sex elsewhere."
39-year-old, never bought EC

Men saw EC as a way to control their partner's reproductive health

"She told me she is fed up with EC, so I persuaded her by buying it for her to use because I told her I'm not ready for a pregnancy now"
26-year-old, previously bought EC

"If she wants a baby but you are not ready, she may not take the medicine or all two of you have to agree on. And you must be there to make sure she takes it"
31-year-old, previously bought EC

POLICY RECOMMENDATIONS

Men are involved in sexual and reproductive health decisions and policy needs to reflect this

1. The evidence shows that men are involved in both abortions and the procurement and decisions around using emergency contraception. This involvement is sometimes consensual but can also be non-consensual and include men putting pressure on women.

2. Policies need to explicitly acknowledge the role of men as sources of information and financial support. Policies designed to improve women's autonomy should increase information dissemination and financial support packages, or make SRHR care free, in order to mitigate reliance on men.

Incorporate masculinities in policies and programmes

1. Men's attitudes and behaviours are frequently driven by norms around how a man is expected to behave. Policies to improve access to SRHR must include interpersonal, community, and structural level aims and objectives.

2. Effective policies should take a gender transformative approach, which aims to reshape masculinities towards equality, equity, and sexual and reproductive rights. This includes centring the bodily and decision-making autonomy of women and girls in programmes designed for men.

Increase comprehensive sex and sexuality education, including provider training, on SRHR

1. Policies and programmes that increase knowledge dissemination through schools and the media are critical, as these were the places men most often heard about SRHR for the first time. This includes accurate information that abortions and emergency contraception are safe and legal.

2. Programmes and interventions should adopt language that reflects the everyday language men use, including alternative language to 'emergency contraception', e.g., brand names.

3. Pharmacists should be trained to provide EC services without stigma. Sensitivity training should be available in order to mitigate men's feelings of shyness at purchasing EC.

More research needs to be conducted on the mechanisms that drive men's involvement in abortion and EC use

1. Research on sexual and reproductive health should include men and boys, to better understand their involvement and the impact this has on the SRHR of women and girls

2. This includes sampling beyond just the partners of women. Men can have an influence on SRHR as fathers, brothers, friends, and non-primary partners. Failure to acknowledge this can decentre the lived realities of women and girls

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