Published in final edited form as:

Hum Reprod. 2005 November ; 20(11): 3078–3084.

EXPLORING OLDER ADOLESCENTS' AND YOUNG ADULTS' ATTITUDES REGARDING MALE HORMONAL CONTRACEPTION: APPLICATIONS FOR CLINICAL PRACTICE

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Abstract

BACKGROUND: Male hormonal contraceptive methods (HCM) are in Phase I clinical trials in the U.S. International studies report adults have positive attitudes regarding male HCM, but little is known about U.S. minority young peoples' attitudes – a population that experiences high unintended pregnancy rates.

METHODS: Thirty urban African American young persons (50% males; mean age=18.8 [SD=2.5]) participated in semi-structured interviews to explore attitudes regarding male HCM. Data was independently analyzed by two researchers according to qualitative research methodology, including transcript coding for content, categorization of codes, performance of content analysis for theme development, and corroboration of findings by a third researcher.

RESULTS: The data revealed five major themes that can facilitate and/or hinder male HCM adoption: 1) impact of reversing roles in HCM use; 2) men's lack of involvement in health care; 3) men's reliability to use HCM effectively; 4) perceived responsibility of men who use HCM; and 5) men's apprehension to use new medicines. Overall, participants had positive impressions about male HCM (67% M; 67% F) and female partner trust of males' use was high (85%), as were males' intentions (60%).

CONCLUSIONS: Findings provide a foundation for clinical interventions including: 1) increasing males' involvement in reproductive health, 2) helping males to overcome apprehensions about male HCM safety, and 3) standardizing male HCM education in the clinical setting. Future research efforts should examine whether study findings hold for other populations.

Keywords

Male reproductive health; contraceptive behaviors; African American; qualitative

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Funding Support This study was supported in part by Faculty Development Awards from the University of Maryland School of Medicine and the Department of Pediatrics (Dr. Marcell).

Introduction

Despite decreases in U.S. birth rates among adolescent and young adult females and declines in fatherhood rates among the same age groups over the past fifteen years (Martin et al., 2003), rates of unintended pregnancy remain high (Henshaw, 1998) and are even higher among ethnic minorities, including Hispanic and Black populations (Martin et al., 2003). For males in particular, pregnancy prevention methods are limited to abstinence and the use of condom or withdrawal methods, with *typical* use efficacies being 85% and 73%, respectively (Hatcher RA ed., 1998).

Hormonal contraceptive methods (HCM) for males are undergoing Phase I clinical trials. The availability of HCM for males will give the sexually active male more pregnancy prevention options. International studies have found that, on average, adult males have positive attitudes regarding male HCM (Heinemann, Saad, Wiesemes, White, & Heinemann, 2005; Martin et al., 2000; Weston, Schlipalius, Bhuinneain, & Vollenhoven, 2002) and that the use of these methods is acceptable to them in theory (Heinemann et al., 2005; Martin et al., 2000) and in practice (Sjogren & Gottlieb, 2001). Adult females also report they would trust their partners enough to use male HCM (Glasier et al., 2000). However, U.S. studies that have explored how potential users (and their partners) feel about male HCM are more than twenty years old (Balswick, 1972; Gough, 1979; Jaccard, Hand, Ku, Richardson, & Abella, 1981; Marsiglio, 1985; Weinstein & Goebel, 1979). This will be the first study to explore contemporary attitudes about male HCM among an U.S. sample of minority young persons.

Tested male HCM preparations include products that combine testosterone and progesterone in either oral or injection forms (Anderson et al., 2002; Handelsman, Conway, Howe, Turner, & Mackey, 1996; Kamischke, Venherm, Ploger, von Eckardstein, & Nieschlag, 2001; Meriggiola, Costantino, & Cerpolini, 2002). These products act mainly by inhibiting spermatogenesis (Handelsman, Conway, & Boylan, 1992; World Health Organization, 1996). Although not ready for clinical use (Grimes, Gallo, Grigorieva, Nanda, & Schulz, 2004), male HCM has been found to be safe, reversible, and as effective as female HCM (McLachlan et al., 2002; World Health Organization, 1996).

Several issues may impact the use of male HCM in particular populations worldwide. One issue is cultural acceptance of male HCM (Heinemann et al., 2005; Martin et al., 2000; Potts, 1996). Another issue is the probable restriction of product use in males who have not yet completed pubertal development, since testosterone administration could halt its completion (the median age of males' entry into Tanner Stage 5 for pubic hair and genital development in the U.S. ranges from 15.3 to 15.8 and 15.0 to 16.0 years old, respectively, depending on ones ethnic background (Sun et al., 2002)). Despite peri-pubertal males' limitations around HCM use, adolescent females' partners may be eligible since males, particularly in urban areas, are on average 2 to 4 years older (Hardy, Duggan, Masnyk, & Pearson, 1989; Lindberg, Sonenstein, Ku, & Martinez, 1997). Thus, the purpose of this study was to explore attitudes regarding male HCM among an urban U.S. sample of minority young persons. Findings will help to inform future clinical practice and educational interventions regarding male HCM.

Methods

Design

This study used qualitative research methods. Semi-structured key informant interviews served as the instrument for data collection (Lincoln & Guba, 1985).

Participants

Older adolescents and young adults were recruited from the Adolescent and Young Adult Center at the University of Maryland, Baltimore from September 2003 to February 2004 using posted flyers, distributed handouts, and clinic outreach. Criteria for inclusion were: age 16 to 24 years old, sexually active, engaging in heterosexual sex, and able to understand and speak English. The rationale for including sexually active participants was to have a sample that had previous experiences with birth control methods. The rationale for limiting males who were 16 years or older was that male HCM will likely be restricted to post-pubertal males (Sun et al., 2002). Males and females (15 each group) were recruited to explore gender differences in attitudes towards male HCM. The recruitment sample for each group was chosen to limit informational redundancy (the point at which no additional data can be gathered from an interview) (Lincoln & Guba, 1985).

Thirty-eight persons were screened for participation (21 males); 97.4% (20 males; 17 females) fulfilled study criteria; and 81.1% followed through with interviews (5 males and 2 females did not return for the scheduled interview or were unavailable). Participants' mean age was 18.8 years [$SD=2.5$] and 93.3% were Black, 3.3% White, and 3.3% "other" ($N=30$; 50% males, Table 1). Informed consent was obtained from all participants as outlined by the University of Maryland, Baltimore's Office of Research Subjects. Participants were provided a stipend of \$15 for transportation and meals.

Procedures

Data were gathered by in-depth, semi-structured, face-to-face interviews. The interviewer (AVM; SB) conducted sessions with each participant that consisted of two parts: a brief educational overview of male HCM followed by the semi-structured interview. Established instruments (Glasier et al., 2000; Martin et al., 2000) and behavioral theory (Becker, 1976; Fishbein, 1980; Rosenstock, Strecher, & Becker, 1988) informed the brief educational overview of male HCM and the semi-structured interview guide.

The brief educational overview lasted approximately 5–10 minutes and was analogous to a typical provider-patient interaction for female hormonal contraception, taking into account the average time spent with differing physician specialties with adolescent or adult patients (Woodwell & Cherry, 2004). The overview topics included the types of male HCM in development (oral and injection), composition, mechanism of action, and side effects.

In keeping with the Theory of Reasoned Action (Fishbein, 1980) and the Health Belief Model (Becker, 1976; Rosenstock et al., 1988), probes were developed for the semi-structured interview guide that focused on the participants' advantages, disadvantages, concerns, normative influences, and intentions to use (or partner intentions to use) male HCM. Example probe questions included:

- ? *What are the advantages (or disadvantages) of a male using hormonal birth control (in general; the pill; the shot) to prevent getting a girl pregnant?*
- ? *What do you think about hormonal birth control for males?*
- ? *Are there any persons or groups who would approve (or disapprove) of a male using a hormonal birth control method to prevent getting a girl pregnant?*
- ? *What were your first impressions about these male birth control methods after I described them?*
- ? *Would you (or your partner) be interested in using these methods? Why (or why not)?*

Using the interview guide, the interviewer asked open-ended questions, followed up participants' responses, and sought clarification or elaborations as necessary. The semi-structured interview lasted approximately 30 to 40 minutes and the entire session lasted approximately 45–50 minutes. All sessions were tape-recorded. Written notes were made during and after each interview.

Data Analysis

Audiotapes and notes from the sessions were transcribed. Two researchers (AVM; SB) independently coded interview transcripts for content and proposed categories for codes as outlined by Miles and Huberman (Miles & Huberman, 1994). Transcripts were coded separately for each gender to account for the differential experience of birth control use. The two researchers compared the codes and proposed categories. The majority of the time (greater than 95%) there was agreement. When categories were not agreed upon, there was a discussion and a mutually agreed upon category was used. Transcripts were then recoded using this final common list of categories.

After all data were transcribed and coded, data were analyzed for patterns and meanings in context. That is, data were scrutinized to discover saturation of ideas and recurrent patterns of similar and different meanings, expressions, and practices. The behavioral theory that guided the semi-structured interviews, specifically The Theory of Reasoned Action and the Health Belief Model, also assisted in the organization of theme development, e.g. the identification of advantages and disadvantages to using male hormonal contraception methods. At all times, findings were traced back to raw data to ensure credibility of the data, recurrent patterning of themes, and confirmability of data and analysis. We did this by generating frequency tables for each category that allowed for further content analysis of the data using frequency tabulations for theme development (Miles & Huberman, 1994). This also guided the research process in further collection of data and checking among participants on the credibility of the findings. The researchers pre-determined that a minimum of one-third of participants for each gender was required to make a theme salient for presentation. Themes were then identified separately for each gender and compared. Quotes that were selected for presentation are good illustrations of the identified themes.

Steps were taken to corroborate study findings, a concept in qualitative research similar to reliability and validity in quantitative research (Miles & Huberman, 1994). These included: 1) use of independent investigators (AVM and SB) to code transcripts, 2) systematic checking of themes against supporting quotations by a second analyst (SB), and 3) independent review of transcripts, categories, frequency tables, and themes by a third investigator (KP).

Results

Participants had either a high school diploma or were currently enrolled in school (Table I). The majority of participants were not working (46.7% males; 80% females), lived in Baltimore City, and lived in households with an average median household income of approximately \$36,400 based on census tract data derived from participants' zip codes (U.S. Census Bureau, 2003). The majority of participants were single (67.7% males; 60% females) and 73.3% of all males and 53.3% of all females were not parents.

Birth Control Experience.

All participants had experience with various birth control methods; males were most experienced using condoms and the withdrawal method and females were most experienced with the pill, shot, patch and condom. Discussions about birth control methods focused on the benefits and side effects of the methods they primarily used (Table II).

Themes

Participants' discussions about male HCM attitudes revealed five major themes (Table III) that represent factors that may facilitate and/or hinder male HCM adoption: 1) the impact of reversing roles in HCM use; 2) men's current lack of involvement in health care and reproductive health; 3) men's reliability to use HCM effectively; 4) perceived responsibility of men who use HCM; and 5) men's apprehension to use new medicines.

Theme 1: The impact of reversing roles in HCM use—*Interest of participants to reverse roles in the use of hormonal contraception.* More than half of female participants (60%) expressed excitement about the potential to change roles with males in the use of hormonal contraception ("females will not have to go to the doctor [as much];" "[there will be less of a] burden on females"). A few females expressed strong opinions that males need to "experience" what females go through taking hormonal contraception, including the side effects.

Two male participants also expressed the desire to reverse roles. Reasons included "[females will be] more comfortable with a man who is on HCM" and "males [who are on it] will relate better to females" because of this shared experience.

Belief that hormonal contraception is 'just for females.' Initial reaction by about half of male participants and a few female participants was that hormonal contraception is made "just for females." For some, hormonal contraception was viewed as **only** a female method ("it is too much like what a female does") and participants could not see how this would change:

Male #13: "...Birth control [is]...made for women, so I don't think [males]...would take them."

Others had more positive views about the expansion of hormonal contraception to males, especially as the interviews progressed and participants' questions were answered.

Male #9: "I never thought they would come out with a birth control for guys... I always that it was for...females only. So when I heard [about] it, I thought it was cool that they finally started thinking about males more often when it came to things like that."

Female #9: "[A male]...would be like 'a guy does not take birth control. ...that's what females do.' [It's the] same thing...when being a househusband first started. Guys would be like 'You are in the house watching the kids? That is a women's job.' So [males taking hormonal contraception] would be like that."

Theme 2: Men's current lack of involvement in health care and reproductive health—Many female participants believed males do not currently engage in the types of health behaviors that are expected of females ("going to the doctor," "taking medicine") and felt these behaviors "[are just] not part of [males'] routines." Females also recognized that males lack the same reproductive health requirements that guide females to go to a health care provider. Females believed a critical step for males will be to learn "how to take care of themselves" including learn "how to go to the doctor:"

Female #1: "Look at it like this, we go to the clinic a lot and males don't go to the clinic as often...He is not going to remember to take the pill as much as I would remember to take it...Then...some men...don't like to take medicine or pills period."

Theme 3: Men's reliability to use HCM effectively—While many participants had positive impressions regarding male HCM, some female participants were concerned whether males are responsible to use male HCM effectively. These concerns were based on participants' experiences regarding how males act in relationships: from "males are promiscuous" to "males

don't use condoms". A few females were concerned that male use of HCM will encourage them to be promiscuous:

Female #7: "...[Males] will want to have sex with every girl now because [he will] feel that [he] can't get a girl pregnant."

Female #9: "[Male HCM] might make [a male] think [he] could just sleep around because [he] do[es]n't have to worry about mak[ing] any babies. That could be a disadvantage."

This was less of a concern for other females who felt that if their partners were on HCM they would not be able to make another woman pregnant.

Female #13: "We wouldn't have to worry about...him getting some[one] else pregnant if he is with someone else and does not use a condom..."

Theme 4: Perceived responsibility of men who use HCM—Participants discussed males need to be "in more control" and "take more responsibility in family planning" beyond the use of just condoms. The majority of participants discussed one advantage to males' use of HCM is that it may teach males how to be responsible in pregnancy prevention and in their relationships:

Male #8: "...[S]ome guys don't like using condoms but when [a girl becomes] pregnant [some guys] are quick to say it is not theirs. ...I think [male hormonal contraception will]...do a lot of guys a favor. ...It is going to be good for guys."

Male #9: "...I wouldn't have to rely on the female taking...birth control and I wouldn't have to worry about getting a girl pregnant."

Female #10: "Instead of [males] always putting [birth control] on [the female]... [males] can play a part...now and take responsibility."

Female #9: "It [will] show...responsibility because it takes a lot to pop a pill everyday or...to make your appointment to go and get your shot..."

Each gender viewed the male's present pregnancy prevention role in a relationship differently. Female participants had a broad view of the male's role, ranging from his need to be responsible (e.g., "he should go to the doctor to care for himself," "he should use condoms") to the need to support his partner in birth control decision-making (e.g., "he should remind [his partner] to use birth control," "he should go with [his partner] during her check-ups"). On the other hand, male participants held a more narrow view – namely to "use a condom."

Theme 5: Men's Apprehension to use new medicines—The final theme, apprehension to use new medicines, emerged among only male participants. Males discussed that future use of male HCM would be dependent on the need to see others using it first.

Male #12: "...I['ve] got to...wait and see someone that I know [who] is taking it and...wait for [male HCM] to be on the market...to see how it works. ...I don't know the risk so... With any kind of new medication...you don't want to just jump on it. You want to wait and see what the studies show, see what the experts say about it."

Male #15: "If I knew some people that used it and nothing happened to them then yeah [I'd use it]."

For some males, the brief overview helped them become more receptive to male HCM and altered initial negative impressions. The majority of males felt persons closest to them, including family, friends, and partners, would support their use of these products, but they expressed the decision to use it would be of their own choice.

Impressions and Intentions to Use Male HCM

Initial impressions about male HCM were positive among the majority of participants (67% males; 67% females). Most females preferred males use HCM in the form of a shot because they did not feel “males would remember to take a pill daily.” Male participants were split about their preferred route of HCM use mainly due to a “fear of needles” or a “dislike of taking pills.” Despite concerns raised, the majority of females (85%) reported they would trust their male partner to take HCM and 40% of females perceived their partners would. Sixty percent of male participants reported positive intentions to use HCM. Table IV lists salient advantages and disadvantages regarding males’ use of HCM.

Additional Issues

Participants had many comments and questions. A few participants made the initial assumption that male HCM’s composition and side effects was exactly the same as that of female methods. Consistent with previous hormonal contraception experience, females’ questions focused more on the mechanics of product administration and use (e.g. “what happens when a pill is missed,” “where do you get the shot”). Males’ questions focused more on how male HCM works (“where does the sperm go?,” “what happens with the sperm count?,” “what is its long-term impact on fertility?”).

DISCUSSION

This is the first study to explore an U.S. minority sample of young persons’ attitudes regarding male hormonal contraception. The themes that emerged in this study represent factors that may facilitate and/or hinder the adoption of HCM for males once it is made available. Facilitating factors included female participants’ expressed interest in reversing roles with males in the use of hormonal contraception and participants’ beliefs that men who use HCM will be perceived to be responsible. Hindering factors to successful adoption of male HCM include the fact that many participants believed that hormonal contraception is only for women, that men are not actively involved in health care, especially reproductive health, that men may not be reliable to use HCM effectively, and that men are apprehensive to use new medicines. These study findings provide a foundation to inform clinical interventions as male HCM is prepared for use in the U.S.

Consistent with findings from a previous study (Sjogren & Gottlieb, 2001), many participants expressed the desire for males to control their reproductive capacity beyond condom use and the withdrawal method. Prior to the availability of modern hormonal contraception for females, males played a larger role in contraceptive responsibility. Today, gender differences are not observed in intended or actual condom acquisition practices (Klein et al., 2001), and studies show consistent use of condoms decline as young males get older and within the context of relationships (Ku, Sonenstein, & Pleck, 1994). With the availability of HCM for males, contraceptive decision-making by both genders may be altered. Current guidelines promote the use of dual contraception (e.g., the use of hormones by females and condoms by males) to prevent against pregnancy and the transmission of STDs and HIV. Participants were interested to reverse roles in hormonal contraception use, but few participants discussed the need for men to continue to use condoms while on HCM to protect against STDs/HIV (dual male contraception) or the need for dual hormonal contraception (use of hormones by both partners) and how this would effect the adoption of HCM by males. *Triple* contraception was also not discussed as an option (dual hormonal contraception and male condom use). Once male HCM is made available, clinical guidelines will need to be developed to better inform pregnancy prevention efforts and the importance of safe sex in unstable relationships since male HCM will not be able to prevent the transmission of STDs or HIV.

Initial impressions about male HCM were very positive among study participants. Males' intentions and females' trust of one's partner to use male HCM were also high. Education efforts regarding male HCM should not be limited to only older married males (Schnare & Wang, 2004) and should also include females, since females represent significant sources of information for males (Ackard & Neumark-Sztainer, 2001; DiIorio, Kelley, & Hockenberry-Eaton, 1999; Fuhrer & Stansfeld, 2002). Although a few female participants perceived a strong connection to hormonal contraception as a "female's rite," the majority of females believed that males' use of HCM might serve as a catalyst to more responsible male behaviors. Future studies will be necessary to examine whether such beliefs translate into actual behavior change.

The perceptions that males lack involvement in health care, especially reproductive health care, are consistent with previous study findings (Marcell, Klein, Fischer, Allan, & Kokotailo, 2002; Porter & Ku, 2000; Sandman, Simantov, & An, 2001) and can be a potential stumbling block for the adoption of this method. Concerns about men's reliability to use HCM effectively stemmed from participants' experiences regarding how males act in relationships. These findings are consistent with studies performed approximately 20 years ago among older and predominantly white populations (Marsiglio, 1985; Scanzoni & Szinovacz, 1980; Weinstein & Goebel, 1979). The lack of help seeking and involvement in risk-taking behaviors are characteristics of traditional male gender roles promoted in the U.S. (e.g., males are supposed to be strong and competitive, not express emotions, and avoid help seeking) (Pleck, 1995). Previous studies have found that males who hold more traditional masculine beliefs are less likely to seek care (Addis & Mahalik, 2003; Good, Dell, & Mintz, 1989) and are more likely to be involved in risk behaviors (Pleck, 1995; Pleck, Sonenstein, & Ku, 1993, 1994). Identifying ways to change social constructs that promote more traditional male role attitudes and behaviors will be critical in the overall acceptability and use of male HCM. It is interesting to note that although most females would trust their own partner to use HCM, female participants still tended to stereotype males' behaviors in general as being "irresponsible." On the other hand, males held a different view of their pregnancy prevention from females, and did not include health care seeking or partner communication as part of it. It may be that females are assessing men as being irresponsible based on behaviors that are not on men's radar.

To help men engage in health care, we can apply lessons learned from recent strategies to engage men in reproductive services (Center for Reproductive Health Research and Policy Institute for Health Policy Studies, 2002; Sonenstein, 2000; The Male Advocacy Network, 2002). Components of successful strategies to engage males include: 1) increasing the awareness of male reproductive health; 2) partnering, collaborating, and mobilizing organizations; 3) providing appropriate and comprehensive reproductive health education; 4) working to institutionalize programs; and 5) providing guidance and referral. Holding reproductive health clinical sessions with couples (Becker & Robinson, 1998) is an example of a method that can engage men in the clinical setting.

Finally, health care providers will need to explain concretely to patients how HCM for men differs in composition and side effects from HCM for females. Applying lessons learned from social marketing of other products or procedures designed specifically for men (e.g., medications for erectile dysfunction (Shabsigh, Perelman, Laumann, & Lockhart, 2004) and vasectomy (Markman & Frankel, 1982; Mumford, 1983; Smucker, Mayhew, Nordlund, Hahn, & Palmer, 1991)) may help relay males' concerns about product safety and acceptability. Although participants in our study did not raise questions about the effect of male HCM on male libido, this may be relevant especially if approved products are found to impact sexual performance. Lessons learned from decades of providing female HCM should also be reviewed (Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit, 2004; Office of Population Affairs & Office of Family Planning, 2001), although anticipatory guidance and education strategies for males may need to look different.

This study has several strengths and limitations. Qualitative methods allowed for the generation of themes to reveal in-depth information about participants' attitudes regarding male hormonal contraception. However, because the sample was drawn from one urban clinical setting, findings may not generalize to other clinical settings, to other young adults, to non clinical-based samples, or to older populations. Future studies may be warranted to determine whether study findings hold for these groups.

This study's findings highlight a number of clinical practice issues that will need to be addressed as male hormonal contraception is prepared for use. We need to find ways to 1) increase males' involvement in health care and reproductive health, 2) standardize male HCM education for males and females in the clinical setting once it becomes available, and 3) help males to overcome apprehensions about male HCM safety. Future research efforts should examine whether these patterns also hold for other populations.

Acknowledgements

We thank Maureen Black, Ph.D. for her review and comments of a previous version of the manuscript, as well as all of the participants who helped make this study possible.

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Table I

Participant Demographics

	Males (N=15)	Females (N=15)
	% or Mean (SD)	
Gender	50%	50%
Age	18.9 (2.4)	18.6 (2.6)
Race/ethnicity		
African American/Black	86.7%	100%
White	6.7%	-
Other	6.7%	-
Education Status		
Enrolled in high school	33.3%	46.7%
High school diploma	60.0%	46.7%
Some college	6.7%	6.7%
Employment Status		
Working	53.3%	20.0%
Unemployed	46.7%	80.0%
Relationship Status		
Single	66.7%	60.0%
Single, but in committed relationship	33.3%	40.0%
Parental Status		
No children	73.3%	53.3%
1–2 children	13.3%	40.0%
Baby on the way	13.3%	6.7%

Table II
Current Birth Control Experience, Side Effects, and Benefits

		Males (N=15)		Females (N=15)	
Recall for self or partner		%(n)		%(n)	
Birth control experience					
Female methods:	Pill	53%	(8)	87%	(13)
	Shot	67%	(10)	47%	(7)
	Patch	20%	(3)	40%	(6)
	Ring	6%	(1)	6%	(1)
	Female condom	20%	(3)	-	-
	Diaphragm	6%	(1)	-	-
Male methods:	Condom	100%	(15)	73%	(11)
	Withdrawal	47%	(7)	-	-
Birth control side effects					
Pill:	Forgot dose	13%	(2)	47%	(7)
	Makes female sick	6%	(1)	27%	(4)
Shot:	Weight gain	40%	(6)	27%	(4)
	Condom:	Can't feel anything	40%	(6)	40%
Break		40%	(6)	13%	(2)
Don't fit		40%	(6)	-	-
Withdrawal:	Doesn't always work	20%	(3)	-	-
Birth control benefits					
Pill:	Prevents pregnancy	-	-	33%	(5)
Shot:	Prevents pregnancy	20%	(3)	27%	(4)
	No missed doses	-	-	20%	(3)
Patch:	Change once weekly	-	-	33%	(5)
Condom:	Prevents pregnancy	47%	(7)	20%	(3)
	Can't get STD	53%	(8)	27%	(4)

Table III

Study Themes by Gender

Themes	Males (N=15)		Females (N=15)	
	% (n)		% (n)	
1. The reversal of roles in HCM use	13%	(2)	60%	(9)
Positive interest to reverse roles in HCM use	47%	(7)	27%	(4)
Hormonal contraception is “just for females”	-	-	40%	(6)
2. Men’s current lack of involvement in health care & reproductive health	60%	(9)	87%	(13)
3. Men’s engagement in traditional gender roles	47%	(7)	47%	(7)
4. The impact of male HCM on being responsible	30%	(5)	-	-
5. Men’s apprehension to use new medicines				

Table IV
Advantages & Disadvantages to Males' Use of Hormonal Contraception Methods

	Males (N=15)		Females (N=15)	
	%(n)		%(n)	
Advantages				
Pregnancy prevention (PP)	73%	(11)	80%	(12)
Shot easier to take than pill	47%	(7)	80%	(12)
Gives males more responsibility for PP	27%	(4)	33%	(5)
Takes burden of PP off female	20%	(3)	47%	(7)
Back-up to condoms or female HCM	20%	(3)	20%	(3)
For males who don't like condoms	13%	(2)	20%	(3)
Males will not forget to take shot	-	-	73%	(11)
Provides males more choices	-	-	27%	(4)
Disadvantages				
Forget to take pill	60%	(9)	100%	(15)
Side effects	60%	(9)	73%	(11)
Males don't like needles	47%	(7)	47%	(7)
Go to doctor to get it	33%	(5)	33%	(5)
No STD protection	20%	(3)	47%	(7)
Males will not like it	-	-	47%	(7)