From women's business to men's business: Exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati

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Abstract

In Kiribati, an island nation in Oceania, men tend to dominate sexual and reproductive health decision-making and women assume disproportionate responsibility for contraception. Yet there are couples who challenge this and, moreover, disrupt the way that I-Kiribati gender relations are typically framed. I-Kiribati are the indigenous peoples of Kiribati. This article draws from research which explored links between vasectomy uptake and gender-equitable relations among couples in South Tarawa from 2017 to 2018. The case study, conducted with the support of Kiribati Family Health Association (KFHA), reframes essentialist notions of gender roles and gender relations in Kiribati. Building on international literature, the relational aspect of gender and gender normative behaviours associated with sexual and reproductive health and rights (SRHR) are examined. Semi-structured informal interviews were held with five vasectomised I-Kiribati men and their wives, interviewed as a couple and individually. Comparative analysis was undertaken with two same-sex focus group discussions, one with non-vasectomised men and the other with their wives, as well as with six key informant interviews. Qualitative data were analysed thematically within feminist and indigenous frameworks, and further triangulated with international and Kiribati studies. Findings suggest that gender equity is likely to be a pre-condition of vasectomy, and vasectomy can lead to equitable outcomes for women. However, connections are complex. Vasectomy, in and of itself, is unlikely to change deeply embedded inequitable practices. Vasectomy uptake can also result from, and lead to, inequitable behaviours. Gender relations within and among couples were multifaceted and contradictions existed. This article argues that approaches to SRHR which privilege dominant perceptions of gender roles and gender relations fail to recognise those who challenge normative behaviours, cannot effectively tackle gender inequality, and, at their worst, perpetuate inequalities.

Key words

Gender relations, gender equity, vasectomy, sexual and reproductive health and rights (SRHR), Kiribati

Introduction

Engaging men in sexual and reproductive health initiatives and, more specifically, promoting contraception for men has implications for gender equality, sexual and reproductive health and rights (SRHR), as well as broader development outcomes globally. Kiribati, like many of the nations in Oceania, is largely a patriarchal society (Committee on the Elimination of Discrimination against Women, 2020). Men tend to dominate decision-making, including sexual and reproductive health decisions. While I-Kiribati women assume disproportionate responsibility for contraception, they generally lack autonomy over contraceptive choices and control of their own fertility (Kiribati National Statistics Office et al., 2010). Yet there are also couples who disrupt this typical framing of I-Kiribati gender relations by choosing vasectomy[1] as their contraceptive choice, and these couples are central to this article. Vasectomy uptake challenges gender norms associated with contraceptive use because it requires active male involvement in family planning and can prompt dialogue about contraception choices between partners (Jacobstein, 2015; L. MacDonald et al., 2013). What is traditionally viewed as

'women's business' effectively becomes 'men's business' too. Vasectomy uptake in Kiribati is therefore worthy of analysis to better understand how to engage men in SRHR and improve gender equality.

This article explores links between vasectomy uptake and gender-equitable relations among couples in South Tarawa, Kiribati, drawing from case study research undertaken in 2017 and 2018 (see the method section for details). Since equitable gender relations, shared decision-making and spousal communication regarding family planning are associated with better SRHR outcomes (Kiribati National Statistics Office et al., 2010; Pulerwitz & Barker, 2008; Shattuck et al., 2014), it is likely that men who accept vasectomy are already in more equitable relationships with their partners; however, this notion does not appear to have been examined in any detail in studies conducted in the Global South.[2] Moreover, SRHR research appears to focus more on women than men and 'the underlying concern lies with reducing their fertility rather than with their power and autonomy as significant outcomes' (Greene & Biddlecom, 2000, p. 89).

We start by examining the SRHR, vasectomy and gender context globally, then in Kiribati. We then briefly discuss the research design and compare our findings with other Kiribati studies and international research on gender relations and SRHR. Women's agency is central to our analysis. We examine whether the participant-couples, in which the husband has had a vasectomy, either challenge or comply with the prevailing I-Kiribati gender order, concluding that gender-equitable relationships can result in better SRHR outcomes for women. We argue that privileging dominant perceptions of gender roles and gender relations fails to recognise those who contest normative behaviours and misses the opportunity to effectively tackle gender inequality. Furthermore, we suggest that nuanced understandings of gender relations must extend beyond gender and development research and become embedded in development practice too.

SRHR, gender norms and vasectomy: The global context

SRHR are essential to achieving human rights, health and, above all, sustainable development (Temmerman et al., 2014). SRHR has significant implications for women's health, education and employment (United Nations Population Fund, n.d.) and therefore directly impacts gender equality. Fundamentally, a woman's ability to access family planning and make decisions over her own body without stigma, discrimination and coercion are a determinant of her agency and empowerment (Kabagenyi et al., 2014; Malhotra & Schuler, 2005; Starrs et al., 2018). To be empowered means having the capacity to exercise choice over resources and to make strategic life-decisions (Kabeer, 1999).

Despite international agreements and country-level investment in SRHR, progress towards realising universal SRHR has been slow and uneven across and within countries (Starrs et al., 2018). For example, annually, more than 200 million women from the Global South want to avoid becoming pregnant but are not using modern contraception (Starrs et al., 2018). Gender inequality and entrenched discrimination of women and girls are fundamental barriers to women realising their sexual and reproductive health. Behaviours such as gender-based violence (GBV) can cause and perpetuate gender inequality and lead to poor SRHR outcomes (White et al., 2003). According to Starrs et al. (2018), nearly one in every three women in the Global South experience intimate partner violence or non-intimate partner sexual violence at some point in their lives. Gender inequality hinders all forms of sustainable development, and, of most concern, it breaches human rights.

Historically, sexual and reproductive health (SRH) programmes focused primarily on women, but it became increasingly clear that women-only programmes were not effectively

addressing gender inequality (Chant & Gutmann, 2002), nor achieving intended outcomes (Frye Helzner, 1996; Momsen, 2010) given the relational aspect of gender. This prompted calls to engage men in SRHR initiatives. For example, the 1994 International Conference on Population and Development Programme of Action (ICPD PoA) recommended encouraging men to take joint responsibility for SRHR in order to achieve gender equality (UNFPA United Nations Population Fund, 1994).

According to Ruxton and Oxfam (2004, p. 4), '[t]he emphasis of GAD [gender and development] on gender relations inevitably encourages a more active approach to men and masculinity issues than in the past'. A gender and development (GAD) approach explores how power operates in gender relations (Cornwall, 1997), and, by implication, it is concerned with *both* women and men (Chant & Gutmann, 2002). Yet heteronormative masculinities continue to largely inform development thinking (Cornwall, 2006; Jolly, 2011), and according to Jolly, are typically applied to SRH matters. Sharma (2009, p. 53) defines heteronormativity as 'Norms related to gender and sexuality … [which] keep in place patriarchy and compulsory heterosexuality as well as other systems and ideologies related to power'. In development discourse, men are often framed as both heterosexual and a problem – 'Oppressors … disinterested or violent' (Barker et al., 2010, p. 540) – whilst women are generally seen as victims (Barker et al., 2010; Cornwall, 2006). Such dualistic framing reinforces stereotypes about women and men, perpetuates perceptions of masculinities and femininities, and oversimplifies gendered power relations (Barker et al., 2010; Cornwall, 2006; Ratele, 2015). This binary lens fails to acknowledge women's agency and, moreover, appears blind to the part that women play in perpetuating gender norms (Cornwall, 2006; De Keijzer, 2004). Most significantly for our analysis, however, is that this binary framing does not recognise or give voice to men who engage in SRHR or who challenge inequitable gender norms and treat women equitably (Cornwall, 1997), such as through vasectomy uptake.

Engaging men in development initiatives that seek to improve outcomes for women is admittedly complex and not without challenges. In many contexts, men remain the gatekeepers of the gender order (Flood, 2015). Involving men can increase inequitable access to already limited resources and can reduce women's independence and agency. Furthermore, there are examples of SRHR awareness campaigns targeted at men which openly reinforce patriarchy (De Keijzer, 2004). De Keijzer (2004, p. 42) notes that while these programmes were successful at reaching men, they did so by perpetuating stereotypical male behaviours, with slogans that encouraged men to be macho or 'in control'. These approaches lacked a gender perspective and therefore failed to sensitise men or empower women (De Keijzer, 2004).

Although increasing efforts are being made to involve men in SRHR, there is uneven uptake of vasectomy globally. In countries with greater gender equality and higher socio-economic development, vasectomy uptake is higher (Jacobstein, 2015). For example, Aotearoa/New Zealand's vasectomy prevalence rate of 19.5 percent in 1995 (United Nations, 2011) is one of the highest rates in the world (Terry & Braun, 2011a). In the Global South, vasectomy uptake is limited (Perry et al., 2016) and rates of female sterilisation supersede vasectomy uptake, despite the significant comparative advantages of vasectomy (Johns Hopkins Bloomberg School of Public Health, 2008).

Although issues around vasectomy uptake in the Global South are complex, gender norms at all levels of society are documented barriers to uptake (Perry et al., 2016). Resistance to vasectomy uptake is common, since the responsibility for contraception shifts from women to men. Further, concerns abound about the loss of masculinity associated with vasectomy's apparent permanence and irreversibility (Drysdale, 2015; Kabagenyi et al., 2014; Marván et al., 2017).

While a number of studies have been conducted on vasectomy uptake in the Global South, for example in Papua New Guinea (Drysdale, 2015), parts of Africa (Bunce et al., 2007; Shattuck et al., 2014), and Mexico (Marván et al., 2017), few studies explicitly seek to address whether men who have a vasectomy are in more gender-equitable relationships. Some studies do, however, explore vasectomy uptake as a way of promoting gender-equitable relationships (MacDonald et al., 2013). Moreover, not all studies that seek to understand barriers to vasectomy uptake apply a gender lens, meaning that discussions of gender inequality, and the role that gender norms play in preventing vasectomy acceptance, are often absent. Yet there is recognition in some studies that '[c]ultural and gender norms often lead to preference for female contraceptive options and low acceptance of vasectomy' (Perry et al., 2016, p. 14).

Gender norms, SRHR and vasectomy uptake in Kiribati

Gender inequality, which is reproduced by gender norms, rests on unequal gender relations of power (Underhill-Sem, 2011) which have been markedly shaped by colonisation and globalisation (Davis Lewis, 1998; Ratele, 2015; Tusitala Marsh, 2000). In much of Oceania, gender norms are governed by hierarchical principles which determine social organisation, meaning that women are generally subordinate to men. Yet hierarchy can also be based on age, rank and other attributes (Underhill-Sem, 2011). Such inequitable power imbalances result in women having a lower status, while granting 'men disproportionate power in decision-making and negotiating sexual relationships' (Vu et al., 2017, p. 516). Diverse cultural and religious practices across the region, while in flux, also do not tend to promote the realisation of SRHR for women (Chetty & Faleatua, 2015).

Within Kiribati, 79 percent of I-Kiribati women aged between 15 and 49 years old said that they have experienced some form of controlling behaviour by men, and 62 percent reported experiencing a form of intimate partner violence (physical, sexual or emotional) (Kiribati National Statistics Office, 2019). There is evidence that, if I-Kiribati women deviate from prescribed gender roles, some I-Kiribati men feel justified in using physical violence to punish this behaviour (Secretariat of the Pacific Community, 2010). Further, women in violent relationships often lack joint decision-making regarding family planning, and there is a correlation between intimate partner violence and higher birth rates (Secretariat of the Pacific Community, 2010).

Although the seriousness of gender inequality in Kiribati should not be downplayed, it is also important to note that dominant development discourse tends to render invisible other narratives about I-Kiribati women and men, such as those who challenge hegemonic gender norms and gender relationships. For example, in some households, violence is not condoned, decision-making is shared and women have agency. According to the 2009 Kiribati Demographic and Health Survey (KDHS), women who are actively involved in household decision-making are also more likely to be using modern contraception (Kiribati National Statistics Office et al., 2010). There is also evidence that some I-Kiribati men are willing to assume responsibility for contraception, including condoms and vasectomy, but uptake rates of contraceptive methods designed for men remain low.

Knowledge of vasectomy has increased substantially in Kiribati over the past five years. In the most recent KDHS, 83 percent of women and 67 percent of men aged between 15-45 years who are married or in a union reported knowing that vasectomy is a form of contraception (Kiribati National Statistics Office, 2019). Uptake, however, remains extremely low. According to the KDHS, Kiribati's vasectomy prevalence rate was less than 3 percent in 2009 (Kiribati National Statistics Office et al., 2010). Unfortunately, the more recent Kiribati Social

Development Indicator Survey 2018-2019 does not capture the same data (Kiribati National Statistics Office, 2019). Male contraception usage is not disaggregated but is only shown by percentage of women aged 15-49 years whose partners were reportedly using male methods, such as condoms and vasectomy. Moreover, the fact that men were not surveyed about their contraception usage illustrates the ways that gender norms are perpetuated institutionally, therefore failing to provide an accurate picture. What is clear, however, is the significantly low numbers of women who reported that their husband or partner had had a vasectomy – less than 0.02 percent.

Despite this low figure, in 2018, the Kiribati Family Health Association (KFHA) anecdotally reported that demand for vasectomy had increased since 2011, with an average of six vasectomies being performed per year between 2011 and 2013, jumping to 14 procedures in 2016 (Tekonnang, Male Health Professional, personal communication, 10 January 2018). While men who have had a vasectomy in Kiribati remain a minority, both they and their wives provide important insights about gender relations in Kiribati. Our research findings can thus inform efforts to challenge gender-normative behaviour associated with contraception and SRHR, as well as with development more broadly.

Research design

This research was informed by feminist theory and principles from Indigenous methodologies, as well as previous research in Kiribati and the Pacific. The research used a qualitative case study design to explore links between vasectomy uptake and equitable gender relations among couples in South Tarawa, Kiribati. The study met all ethical standards of Victoria University of Wellington.[3] Alexandra Hill collaborated with KFHA and an I-Kiribati research assistant to carry out 15 informal semi-structured interviews with five vasectomised I-Kiribati men and their wives (see Tables 1 and 2). The research assistant also acted as an invaluable I-Kiribati cultural guide. Participants were identified by KFHA and invited to join the study using purposive sampling. The couples were interviewed together and separately in their homes in the Kiribati language, and I-Kiribati cultural practices were observed. For example, the interviews were generally conducted sitting on mats on the floor and Hill respected gender appropriate behaviour, especially given the sensitive nature of the research. A male nurse from KFHA always accompanied the primary researcher to interview the men, while a female nurse provided support for the interviews with their wives. Interviews were translated in situ.

Two same-sex focus group discussions (FGDs), one with non-vasectomised men and the other with their wives, were held at KHFA's clinic with participants of similar marital status, age and life stage (see Tables 3 and 4). While all the participants in the FGDs were meant to be non-vasectomised men and their wives, we subsequently learnt that one participant had in fact been vasectomised. Although they did not meet the criteria for the FGD participants, it was not appropriate to ask them to leave once the session was underway. Hill was not present during the men's discussion. FGDs opened with prayer, songs and customary introductions and were concluded with a meal. The participants defined their own ground rules. Both FGDs were conducted in the I-Kiribati language and the women's discussion was translated in situ to enable the researcher to follow. The recordings were transcribed by the cultural guide and research assistant. Additionally, six key informant interviews were conducted in English with service providers and community leaders in Kiribati (see Table 5). A comparative analysis of the FGDs provided insights into the ways that the participant-couples either challenged or complied with the prevailing Kiribati gender order. Other data were analysed thematically and

findings triangulated with secondary data, including the KDHS along with SRHR and gender studies conducted in Kiribati and internationally.

This approach was not without challenges. As Hall (2002) notes, discourse is not innocent, and nor does narration 'take place in a vacuum: we function in geopolitical institutions that circumscribe what and how we narrate' (Kapoor, 2004, p. 644). We therefore attempted to be reflective of how our subjectivities and experiences as both I-Matang – people 'of foreign origin usually of European descent' (Van Trease, 1993, p xvii) – and belonging to a western institution may have shaped our understandings (Jackson, 2006). We did this by paying close attention to ethics, power and the politics of representation and knowledge production (Hesse-Biber & Piatelli, 2007), aspects that feminist research practice shares with Indigenous methodologies (Smith, 2012; Vaioleti, 2006). For example, KFHA's executive director and the senior vasectomy nurse, along with the I-Kiribati research assistant, acted as sounding boards for Hill and allowed her to check whether her interpretations were consistent with theirs. Moreover, Hill endeavoured to uphold the principle of reciprocity by ensuring the scope of the research was sufficiently broad to allow her to make recommendations to KFHA about vasectomy uptake, which she presented to them in a report at their request.

Vasectomy and gender equity in Kiribati: Research findings

In the sections that follow, we have attempted to 'write with' rather than 'write about' participants in the study, and have carefully thought how to frame each of their different lived experiences. Throughout the data generation and analysis, we sought to treat everyone with respect and to recognise that women's and men's life experiences were not homogeneous (Griffin, 2017; Hesse-Biber, 2007). Pseudonyms have been used throughout to protect the identity of participants, unless they explicitly requested otherwise. Hill has also maintained what Cleary (2013) calls an 'ethic of care' beyond her fieldwork through practical support to KFHA, including report-writing, as noted earlier, and supporting the vasectomy nurse to attend a conference and receive training in Aotearoa/New Zealand in 2018.

The case study research found that, within the five in-depth interview participant-couples, both the wives and husbands supported more equitable gender norms and gender equity was likely a pre-condition of the men having a vasectomy. Vasectomy also led to equitable outcomes for their wives, consistent with Jacobstein's argument that, 'with gender equity comes vasectomy and vice versa' (Jacobstein, 2015, p. 1). It appeared that no participant-couple condoned violence towards women. Household decision-making was shared between both partners, and the wives played an active role in their husband's decision to have a vasectomy, both explicitly and implicitly. The wives were able to make important decisions affecting their lives, suggesting that their agency, and the freedom that resulted from their husband's vasectomy, was potentially empowering.

The two key informants who had had a vasectomy and the vasectomised man and his wife who participated in the FGDs shared similar views about how vasectomy can empower women. The non-vasectomised men and their wives also talked about possible benefits for women. Across all participant groups in this research, the following direct and indirect benefits were reported: reduced childcare and household duties (compared to women with more children); being able to actively participate in the local women's group and accept leadership roles; increased opportunity to generate an income, work in the formal economy and achieve career advancement; and increased enjoyment of sex. Several wives also reported receiving greater support with household duties from their husbands following vasectomy.

However, connections between equitable gender relationships and vasectomy are complex and, in some cases, husbands displayed both equitable and inequitable behaviours simultaneously. Some participants knew of instances where men sought a vasectomy to behave less equitably, such as having relationships with women outside of their marriage or using it as a form of power over their partners. There was also evidence to suggest that, while vasectomy freed women from reproduction in the biological sense, many continued to perform the bulk of 'reproductive' work in the home. We therefore conclude that vasectomy, in and of itself, is unlikely to change deeply embedded inequitable practices; however, it is worth exploring the complex inter-related themes that emerged from the research to help inform future research and practice.

Theme 1: The gendered nature of family planning

As with other roles within I-Kiribati families, the responsibility for family planning was significantly gendered and, 'like other forms of domestic labour, the time, attention, stress and physical burden associated with avoiding pregnancy lies primarily on the shoulders of women' (Bertotti, 2013, p. 13). In our study, across all the participant groups, family planning was generally associated with women's methods, such as contraceptive injections, implants and natural methods, and was seen as a role primarily undertaken by women, as reflected in this comment by Taouea, one of the key informants (KI):

> I get the impression that when it comes to family planning that it always tends to be the role of the women … I don't know why we have that sort of idea that when it comes to family planning, we tend to look upon our women folks. (Member of Parliament, male, KI)

Similarly, Teima, another key informant, said:

> They [men] really don't want to do that, to take the family planning, just happy to leave it to the women because it is her own problem. (Government Health Official, female, KI)

Among some of the in-depth interview participants (IDIP), similar thinking was also apparent, even though the men were all vasectomised. For example, there was little mention, by either the men or their wives, of the two modern contraceptive methods that exist for men. Only two male in-depth interview participants, Taomati (a shop owner and father of four) and Auati (who was retired and had four adult children), talked about the condom. Only Toriua (who primarily cared for his three children while his wife worked) talked about vasectomy. None of the women discussed either of these male-methods. Moreover, few participant-couples reported having used condoms prior to their vasectomy, apart from Taomati and Auati. This finding is in keeping with results from a previous survey (KDHS, 2009), which found that, while just over half of all surveyed men who were aged 15-49 years had used a male-orientated contraceptive method at some time, only 40 percent of married men were using a male method (Kiribati National Statistics Office et al., 2010).

Consistent with gender normative behaviour, only two men explicitly stated that husbands should share contraceptive responsibilities with their wives. Given that contraception was generally associated with women, it was perhaps unsurprising that most in-depth interview participants failed to identify their partner's or their own vasectomy as a form of contraception. Nonetheless, as Teuarei (who had six children) said:

> Men have to share with the wife. It is not only the wife to have family planning. (Local food producer, male IDIP)

Deeply embedded normative views regarding contraception in Kiribati are also closely linked to notions of masculinity and femininity and are, arguably, heteronormative. In other words,

these normative views about contraception and notions of masculinity and femininity privilege heterosexual constructs in terms of both women's and men's behaviour *and* identities. For example, I-Kiribati men appear to conform to dominant notions of manhood and are expected to be physically strong, breadwinners, decision makers, powerful, able to control women and to be (hetero)sexually capable (Jewkes & Morrell, 2010; Sweetman, 2013); this is consistent with international literature. Heterosexuality is both assumed and enforced as the norm (Connell, 1987; cited in Jewkes et al., 2015, p. 1582). Consequently, if men assume responsibility for contraception, this challenges gender norms that consider contraception a woman's responsibility. Thus, there is the potential to shift the balance of power. The findings in our research are therefore consistent with the KDHS, as well as international studies which also document that family planning is seen as 'women's business' (Bertotti, 2013; Drysdale, 2015; MacDonald et al., 2013; Perry et al., 2016).

While I-Kiribati women were generally expected to assume the role of family planning, they do not always have autonomy over contraceptive choices or even whether they could control their fertility, since men tended to dominate decision-making (Brewis, 2001; Kiribati National Statistics Office et al., 2010). This creates a tension because contraception is a woman's 'responsibility' yet she does not have full agency to exercise this responsibility. Women 'have always been taught to stay in the background and defer to men' (Ngaebi et al., 1993, p. 267), while 'a man is publicly considered to be the head of marriage and the family, and the active decision-maker and final authority' (Brewis, 2001, p. 396).

Theme 2: Spousal communication, conflict and family planning decision-making

While almost 70 percent of married women surveyed for the KDHS said that their husbands knew they were using contraception (Kiribati National Statistics Office et al., 2010), what is not clear from these results is how equitable or autonomous the decision-making process was. However, the in-depth interview participants, regardless of gender and whether interviewed as a couple or alone, believed that spouses should talk about family planning as a couple and that decisions about contraceptive choices should be made together. For example, Arotita (Auati's wife), said:

> The husband and wife has to decide whether the wife has to go to clinic to have family planning. Mostly the two, the husband and the wife. (Retired, female, IDIP)

Similarly, Teuarei's wife Marva reflected:

> I believe in having a good relationship and communicating well. There will be no issues later. (Produces local food, female, IDIP)

These participants' attitudes are echoed in other studies which found that inter-spousal communication regarding contraception usage was relatively common in Kiribati (Brewis, 2001; Kiribati National Statistics Office et al., 2010) and that both spouses should reach agreement regarding family planning (Brewis, 2001).

While such comments were encouraging when considering connections between SRHR and gender equity, responses from some of the male participants suggested that inter-spousal dialogue did not necessarily equate with equitable decision-making, despite this inference being made by the KDHS. Some conformed to hegemonic gender norms and believed it was the man's responsibility to decide if his wife could use family planning. For example, Taomati's comments were somewhat contradictory and suggested that the husband is fundamentally in control:

> It is important to sit together rather than just the wife go to the clinic, straight to the clinic and take the method. She should sit together with her husband and agree with her husband whether he says 'yes' or 'no', they should both agree before taking the method. (Shop owner, male, IDIP)

Some participants recounted that fights and other relationship issues were commonly associated with family planning decisions. Men generally attributed conflict to situations when women acted without their husbands' knowledge. This is reflected in the views expressed by Itaaka, a father of three and one of the in-depth interview participants:

> It is not good. When the wife hides it from the husband … something is going to happen [more laughter] like … they can fight and argue with each other. They can also separate. (Informal employment, male, IDIP)

Opinions amongst the men in the FGDs were mixed. The views expressed by Awi, a FDG participant who has five children, were consistent with those of some interview participant couples, discussed earlier:

> More decisions are made by women because they know what is good for them to use and men should support his wife's decision. (Bus driver, male, FGD)

Awi's beliefs contrast with the experiences of two women focus group participants who shared that they practised subversive contraceptive use. Uebou, who is the mother of five children, said:

> I already have an injection without my husband knowing it. I am hiding it from him because he refuses me to have family planning. (Not in formal employment, female, FGD)

Raimoa, who has eight children, meanwhile, confided:

> I only talk to my parents, Mum and Dad and they are agreeing for me to [use] family planning, even though the husband refuses me to use family planning. (Not in formal employment, female, FGD)

Kabeer (1999, p. 438) reasons that a woman's agency can take many forms, including 'deception and manipulation, subversion and resistance'. The deception of Uebou and Raimoa implies that they lacked equitable gender relations, particularly in terms of decisions affecting their own health. Yet by taking control of their own fertility, they also exercised their agency and practised resistance to their husbands' attempts to control their reproductive choices.
Previous research has also documented that men who are violent towards their intimate partners are more likely to refuse to use, or prevent their partner from using, family planning as well as practising controlling behaviour that affects their partner's SRHR (Secretariat of the Pacific Community, 2010, 2015). Although Uebou and Raimoa did not divulge whether they had experienced violence, it is likely that if their husbands knew of their subversive contraception use, there could have been serious repercussions for them.

Theme 3: Sexual coercion and women's lack of agency

This study did not set out to examine sexual coercion, but the topic was raised by some of the male focus group participants during a discussion about abstinence. Abstinence is practised by couples who do not use modern contraception for religious reasons. Sexual coercion involves men asserting what Rowlands (1998) describes as 'power over' their spouse using coercion, violence or threat (also Kabeer, 1999; Willis, 2005). Sexual coercion therefore compromises women's agency and undermines gender equality. Consequently, demographic health surveys use a woman's ability to refuse sexual intercourse with her husband or partner as a proxy indicator of women's empowerment (Kiribati National Statistics Office et al., 2010).

For some I-Kiribati men in the FGDs, sexual coercion appeared acceptable, and the topic was met by laughter from the group. According to Mwemwe, a father of four:

> Men usually take woman for sex by force. (Business owner, male, FGD).

Similarly, Karoua, who had three children, commented:

> In a couple life, the man is the one who decides and really force a woman to sex, I can say that because when the woman refuses to sex at night, that could bring another fight the following morning. (Not in formal employment, male, FGD)

In previous studies (Brewis, 1992; KDHS, 2009), I-Kiribati women and men held different attitudes towards a woman's right to refuse sex. Fewer I-Kiribati women than men thought that women were justified in refusing to have sex with their husbands or partners, which highlights how women also adopt socially and culturally accepted inequitable gender norms (Cornwall, 2006). It also illustrates the ways in which gender norms are reproduced through relationships (Jewkes et al., 2015). Gender norms are both produced and reproduced in relationships through the social interaction that occurs between individuals, as they 'engage in practices that signify, align or contest various notions of masculinity or maleness and femininity or femaleness'(West & Zimmerman, 1987; cited in Cislaghi & Heise, 2020, p.411).

Such entrenched gender norms, shaped by cultural beliefs and practices (Barker et al., 2010; Jewkes et al., 2015), can reinforce hegemonic masculine behaviours, including men being less likely to challenge violence against women (Sonke Gender Justice Network, 2013). For example, De Keizer argued that men's 'violent responses, [are] often seen as [a] legitimate "correction" of female behaviour' (2004, p. 29). They are socially and culturally validated, and are likely to occur particularly when women do not comply with their prescribed gender roles (Secretariat of the Pacific Community, 2010). The fact that Mwemwe and Karoua openly discussed forcing their wives to have sex implies this behaviour and the ideologies which support it are also socially acceptable in Kiribati.

Moreover, Mwemwe's and Karoua's views demonstrate a sense of entitlement, which as De Keizer (2004) suggests, involves them exercising their privilege as men. Brewis (1992) found that men generally asserted control over their wives by dictating both the timing and frequency of sex, while women were expected to acquiesce and provide this service. For Brewis' participants and as well as Mwemwe and Karoua, sex was seen as a man's right, and when a man's rights are 'denied or questioned, violence in various forms may be the consequence' (De Keijzer, 2004, p. 30).

During the FGDs, not all the men spoke up when the topic of sexual coercion was raised, perhaps suggesting that they felt some ambivalence about it or possibly wanted to conceal their own attitudes and behaviours, so their views on sexual coercion were unclear. However, Awi did not appear to favour sexual coercion and advocated that husbands and wives should discuss family planning together:

> Woman know their fertile period, so in that way they can ask their husband when they should and shouldn't have sex. (Bus driver, male, FGD).

Yet Awi's remarks also suggest that Taake, his wife, may have lacked agency in terms of initiating sex.

The extent to which both male and female in-depth interview participants' views varied from those expressed by Mwemwe and Karoua during the FGDs was not made evident. This topic had not been explored during the in-depth interviews since it was not part of the original scope of the research, as noted earlier. Responses by both the female and male in-depth interview participants generally suggested that they did not condone the use of violence

in relationships, citing violence against women as undesirable behaviour; but it was not clear if sexual coercion in a relationship was perceived as a form of violence. For example, Karoua's comments revealed that his wife, Mawaruru, was not always treated equitably, and yet, in other respects, she had agency and was an equitable partner in her husband's decision to have a vasectomy, as discussed in the following section.

Theme 4: Women's agency and vasectomy decision-making

In this case study research, vasectomy decision-making was seemingly an equitable process and reflected the ways in which the in-depth interview participants made other decisions that directly affected their families, including decisions about their finances, children and land. In Kiribati, however, shared decision-making between couples is not the norm. According to the KDHS, only 47 percent of women reported that household decisions were made jointly, and 25 percent reported having no say in any decisions related to 'household purchases, visits to their family or their own healthcare' (Kiribati National Statistics Office et al., 2010, p. 249). These statistics are important in relation to contraceptive uptake, because 'women who participate in more household decisions are more likely to use a method of contraception or a modern method of contraception compared with other women' (Kiribati National Statistics Office et al., 2010, p. 259). Moreover, when men support more equitable gender norms, their wives' contraceptive usage is higher (Pulerwitz and Barker 2008).

Although the KDHS did not report a correlation between women's level of decision-making and men's contraception usage, our research suggests that it is highly likely one exists, particularly in terms of vasectomy. Furthermore, the fact that the male in-depth interview participants collaborated with their wives about significant household decisions would suggest their acceptance of more equitable gender norms. Surprisingly, the husbands of the participant-couples did not fit the general profile of I-Kiribati men surveyed in 2009 for the KDHS. Of the survey participants, support for more equitable decision-making was reportedly greatest amongst educated I-Kiribati men who were employed, lived in an urban area and were from wealthier households (Kiribati National Statistics Office et al., 2010). Equitable decision-making was measured in the KDHS using five key indicators: making major household purchases; making purchases for daily household needs; visits to the wife's family or relatives; what to do with money that the wife earns; and how many children to have. In contrast to the survey participants, the male in-depth interview participants in this study had limited formal education and most were not in formal employment. The only shared characteristic was that the male in-depth interview participants were based in urban locations.

A woman's ability to influence her husband to have a vasectomy is arguably a measure of her agency. Her influence can be explicit through a direct request to her husband to have a vasectomy, and in this sense she may be an agent of change. Alternatively, her influence may be more implicit – that is, her husband opts for a vasectomy out of concern for her wellbeing. Irrespective of which role they assumed, the wives interviewed for this research played a key role in the vasectomy decision-making process. Each of the couples discussed the procedure and the implications for their families collaboratively. In-depth interview participants shared consistent responses within and across the couples when asked about their decision-making, and these responses were supported by two of the key informants (Taouea, a male Member of Parliament, and Petero, a male Local Government Executive) and by Karoua, one of the focus group participants. A common response of these participants was illustrated by Taomati who reflected:

> We started off with the male condom, you know the condom and we also used the withdrawal but we realised that it is not effective so we sit again, we decide and I choose that my wife should undergo TL, tubal ligation.

> But she is scared as she is not fit and healthy so we decide again and then we both agree to take on the vasectomy. (Shop owner, male, IDIP)

Of the participants from the FGDs who had not had a vasectomy, or whose husbands had not had the procedure, views were more mixed. Not all participants felt that the decision to have a vasectomy should be a shared decision between the husband and wife. Some participants felt that the husband should be the one who decided, given that it affected him directly and because it could impact his status as the 'boss' and head of the household. For example, when asked during the men's FGD who should be involved in the decision to have a vasectomy, Peter a father of four, who was not in formal employment, responded:

> Peter: The husband, as he's the one to have a vasectomy.
>
> Facilitator: Can you explain, in what way?
>
> Peter: He has to think carefully before he's having a vasectomy and also because he's the boss.

There are examples from other cultures in which men share similar thoughts to Peter's. A study conducted in India determined that men were more likely to decide to have a vasectomy independently; some men felt it was their decision alone and they could not be influenced (Scott, Alam, & Raman, 2011). These men's views, and that of Peter who had not himself had a vasectomy, are not in keeping with the responses from the in-depth interview participants, nor the other men in our study who had had a vasectomy.

Among our in-depth interview participants, there was some variation in who proposed the idea of having a vasectomy. Wives appeared more likely to initiate the idea with their husbands if they had received medical guidance to discuss permanent contraception options. For example, Taomati's wife Oreti, one of the in-depth interview participants, was discouraged from having a tubal ligation because she had Hepatitis B. It is possible that the couple-counselling provided by KFHA, irrespective of which spouse initiates the idea, fosters more equitable decision-making because the sessions are facilitated in a way that encourages partners to reach a joint decision about the husband's vasectomy. This demonstrates how institutions can reinforce equitable gender norms. However, couple counselling is not always offered as part of vasectomy provision.

Regardless of whether a woman receives medical advice or not, it is also possible that, as in Tanzania (Bunce et al., 2007), I-Kiribati men may resist the procedure if their wife is the one to raise the idea because of the position men hold as the primary decision-maker in the family. However, further research is needed to capture the views of men who may have considered a vasectomy but opted not to have one.

Nevertheless, comments made by three key informants – Selefina and Tekonnang, both health professionals, and Tangariki, a community leader – suggest that I-Kiribati men would be likely to show some resistance to a request from their wife to have a vasectomy. These key informants said that women are often required to find ways to get their husbands to accept ideas that may be sensitive, such as using contraception, or that challenge the man's control in their relationship. For instance, Tangariki made the following observation:

> I realise that educating the women how to negotiate and communicate well with their partners because even the educated ones can't communicate on this issue with the partner because the males will say, 'oh you are being sexy, or dirty-minded' and then the frustration goes to the women. (Women's Community Leader, female, KI)

Contrary to these views, all the participant couples who had undergone a vasectomy said that they had no issue discussing it with each other, even though the husband may have made the final decision to go ahead with the procedure. It appears that the in-depth interview participants

did not act in ways that were always reflective of wider normative gender relations in Kiribati.

Irrespective of how the final decision was made, wives played an active role in the decision-making process, including in some instances persuading their husbands to have the procedure. Given the dominant position that men hold in Kiribati society, the fact that these women were able to have this influence was not an inconsequential finding. This finding is consistent with a study on vasectomy uptake in Papua New Guinea, which determined men's wives were largely influential in the decision-making process and, in some cases, obtaining their wife's approval was key (Drysdale, 2015). Similarly, Bunce et al. (2007) found that the wives of men who had had a vasectomy in Tanzania were actively engaged in the decision-making process and that spousal influence was significant.

Theme 5: Motivations to have a vasectomy

Men are often motivated to have a vasectomy out of concern for their wife, as previous studies from countries as diverse as Papua New Guinea (Drysdale, 2015), Tanzania (Bunce et al., 2007), Rwanda (Shattuck et al., 2014) and New Zealand (Terry & Braun, 2011a) have demonstrated. In this situation, women may not initiate the idea, but the men's actions demonstrate that they both value and care for their wife's wellbeing, which would suggest that she has agency in the relationship. Key motivations expressed by the men in this study included economic reasons, a desire to have a smaller family, and a concern for their wife's health, which we focus on here.

Most of the husbands from the in-depth interviews expressed an explicit concern for their wife's health, citing the following reasons: it was unsafe for their wife to have any more pregnancies/children; the use of modern contraceptives caused their wives to have undesirable side effects; a tubal ligation would have a greater impact on a woman than a vasectomy has on a man. These were similar reasons to those given by men in previous studies in Papua New Guinea (Drysdale, 2015) and Tanzania (Bunce et al., 2007).

Notably, several of the men opted for a vasectomy over their wives having a tubal ligation even when the medical professionals presented them with both options. Itaaka's wife Teraitabo's comments illustrate this:

> I got the information from the hospital when I was giving birth, and those in the hospital they talk about vasectomy and tubal ligation and so they told us to decide. Because the husband said it was a big operation for me so he preferred that he would take the vasectomy. One reason is that my last baby it was a very difficult delivery, and so my husband decides to have a vasectomy, rather than me having to have an operation. (Mother and garland maker, female, IDIP)

Auati similarly believed a vasectomy was simpler and less invasive for a man than tubal ligation is for a woman, but was also concerned about the effects of modern contraception on his wife Arotia's health. He said:

> When the men heard about it they were encouraged to have a vasectomy to keep the wife safe from the other modern methods because some women were sick from using those other modern methods. So the men … it is like they were trying to help the wife to get healthy. (Retired, male, IDIP)

While Marva mentioned that her husband Teuarei was prompted to have a vasectomy out of a concern for her health, she shared some additional insights into his motivations:

> He has the passion for me, for my health and looking at me while dealing with many children to look after and the work at home – that is what influenced him to have his vasectomy. (Local food producer, female, IDIP).

Men like these, who accept a vasectomy out of concern for their wives' health, challenge hegemonic masculine constructs and development discourse relating to SRHR, which invariably frame men as 'oppressors … disinterested or violent' (Barker et al., 2010, p. 540).

Although there is overwhelming evidence to substantiate this description of some men, failure to acknowledge the complexity of gender relations renders alternative masculinities largely invisible. The messaging about men as described above by Barker et al. (2010) can also serve to perpetuate gender norms in practice if they lead SRHR providers to avoid engaging with men, thus reinforcing the notion that family planning is women's responsibility.

That said, research participants frequently cited examples of men being motivated to have a vasectomy for less equitable reasons. The link between vasectomy, infidelity and feelings of jealousy in relationships was a recurring theme throughout the interviews and even in informal conversations. However, these comments were generally anecdotal and referred to men outside this study. Teima, one of the key informants, reflected:

> I haven't heard from women in regard to vasectomy but I have in mind that they might fear [their husbands] of having multiple partners because they cannot have children. (Government Health Official, female, KI)

Several participants knew of men who chose vasectomy to assert their power over their wives' sexual and reproductive agency. The examples the participants recounted were not personal experiences, however. Teraitabo, Itaaka's wife, said that jealous men are motivated by a desire to catch their wives out:

> because if their wife goes with other men then they will know because she will get pregnant and they will know. (Mother and garland maker, female, IDIP)

While it is possible that some men want to be involved in sexual and reproductive health decision-making as a means to control their wives, this research suggests that others are motivated by a genuine sense of care for their wives. This has implications for development policy makers and service providers who need to find ways to effectively engage men in SRHR provision. As with our research, MacDonald et al.'s (2013, p. 41) study of men in India and Vietnam found that, '[d]espite cultural norms about men's sexual behaviour, many men are in fact willing and able to participate more fully in women's sexual and reproductive health if given a "comfort zone" and an opportunity to do so'.

Further, there is a need to continually acknowledge the complexity of gender relations. Taomati and Itaaka were motivated to have a vasectomy out of care for their wives' health, and yet their wives, Oreti and Teraitabo, commented on the inequitable distribution of labour in their households, which had prompted them to want their husbands to seek a vasectomy. This shows that men's and women's motivations around vasectomy do not always align, and need to be better understood if more effective approaches are to take place in the future.

Theme 6: Gender-equitable outcomes of vasectomy?

Across all groups, participants perceived that women benefitted from their spouses' vasectomy through reduced workload, since having fewer children to manage reduced women's duties and responsibilities in the home. However, some participants also saw increased 'free time' as an opportunity for women to do more in the home, spend more time with the children and earn more money, meaning that their reproductive, productive and community work (Moser, 1989) after their husband's vasectomy actually increased. As Taomati, Oreti's husband said:

> She has time to be involved in the women's group and also she has time to sell-out things and assist in the home. (Shop owner, male, IDIP)

Vasectomy was also seen by one participant as enabling women to advance professionally, free from the fear and consequence of further pregnancies and children. Anatia, Toriua's wife, said that her husband's vasectomy had improved her employment opportunities. She reflected:

> I can work and get more money, than being pregnant – I had to stay at home. (Shopkeeper, female, IDIP)

One of the key informants, Petero, also commented:

> You know rather than having more babies now – the worry, the stress that is also gone. And for me that was really bad and worry about the next one, so bad, and I think that is also for the women, the same kind of feeling. No need to study my body because now it is complete. It was good even actually to take off professionally for women. My wife was also working as a clerk in the Council so she had more time. (Local Government Executive, male, KI).

Further, for some women, vasectomy shifted the gender division of labour in the home. For example, Marva felt that since her husband Teuarei's vasectomy, he contributed more in the home:

> He has been changed. He is more smart now, smarter, stronger and can help with washing the clothes and taking care of the children. Not like before vasectomy. (Local food producer, female, IDIP)

Arotita, too, responded similarly to Marva. She said that a man's vasectomy meant that couples 'can share the load at home'.

It is possible, however, that the behavioural changes that Marva witnessed were in part a reflection of the length of time they had been together as a couple, and not just a consequence of the vasectomy. Terry and Braun (2011b, p. 479) posit that 'the social location of the long-term relationship is a valuable resource for egalitarian shifts in men's language (and potentially behaviour)', which aligns with other research results. For example, Fleming et al.'s study across eight countries (as cited in Flood, 2015) determined that men with higher levels of education and married men had more equitable gender attitudes than unmarried men. According to Flood, these findings 'suggest that men's attitudes towards gender also are shaped by their intimate relations, with men who live and negotiate with female intimate partners perhaps (but not inevitably) becoming more gender-equitable in their attitudes' (2015, p.16). The changes may not necessarily mean that male privilege is eliminated or undermined (Terry and Braun, 2011b). Whilst men's attitudes may evolve, this does not necessarily translate into a more equitable division of housework or child care, for example.

Increased sexual pleasure following a husband's vasectomy was another perceived benefit raised in focus group discussions. Marva also shared this thinking and described how she felt following Teuarei's vasectomy:

> Before I enjoy having sex but the difficult part is [getting pregnant]. Now with my husband having the vasectomy I now only have the enjoyment and look forward every night! (Local food producer, female, IDIP).

Expressing an enjoyment of sex implies a woman has a certain degree of agency. '[C]ontrol over sexual relations' is a measure of women's empowerment (Malhotra & Schuler, 2005), and yet, as Cornwall et al. (2008) argue, development discourse invariably fails to recognise women's agency and desires relating to sex. As our study highlights, when women can enjoy sex without fear of pregnancy, it is empowering for them. This is a basic human right. Whilst this is a sensitive topic, further research is needed to explore the connection between development, sex and women's agency.

Discussion and Conclusion

This research used a gender lens to examine the connection between equitable gender relations and vasectomy uptake among five couples in South Tarawa, Kiribati. Through the discussion of various themes, we have shown that vasectomy acceptance was both a consequence and cause of more equitable gender relations amongst the in-depth interview participants, reinforcing

Jacobstein's point that, 'with gender equity comes vasectomy and vice versa' (2015, p.1). Most of the I-Kiribati men in this study wanted to be actively involved in family planning decision-making and were willing to accept responsibility for contraception through vasectomy, in contrast with gender-normative behaviours. Moreover, their wives' ability to make important decisions that affected their lives was indicative of their agency and empowerment (Malhotra & Schuler, 2005), which contrasted with dominant discourses about I-Kiribati women.

This research has also revealed that gender norms in South Tarawa, Kiribati, are not fixed. Each of the five participant-couples revealed aspects of gender-equitable household decision-making, which included decisions about family planning, family size, their land and their finances. Significantly, wives were instrumental in the vasectomy decision-making process, and the decision also appeared to be negotiated equitably, reflecting the way that the participants made other family-related decisions. For the Kiribati participant-couples, the vasectomy resulted in outcomes which, in some cases, fostered both women's and men's agency to adopt different roles through a redivision of household tasks. In some cases, it also gave wives more opportunities beyond the home and increased their enjoyment of sex. Vasectomy uptake therefore has wider implications for gender equality.

Yet, connections between gender equity and vasectomy are complex. Some participants reported knowing of men outside this study who used their vasectomies to behave less equitably, such as having relationships with women outside of their marriage, and as a form of power over their partners. A man's role as the primary decision-maker and 'boss', including on decisions about sex, meant that equitable or safe outcomes for women were not always assured. There was also evidence to suggest that while vasectomy frees women from reproduction in the biological sense, 'there is an on-going "reproductive burden" for women, in that they still maintain the larger proportion of the (largely silent and unnoticed) domestic share, through childcare etc.' (Terry & Braun, 2011b, p. 491). This appeared to be the lived experience of many of the I-Kiribati women in this study. If anything, the additional 'free time' generated by having fewer pregnancies and children to support actually resulted in women assuming more duties – reproductive, productive and community work. However, some of the new responsibilities enhanced women's agency and were empowering, contributing positively to the women's lives, rather than negatively.

Vasectomy, in and of itself, is unlikely to change deeply embedded inequitable practices; changing gendered behaviours is particularly challenging and inequitable gender norms operate across all levels of society. Tackling gender inequality with men has been shown to be more effective in health programmes that apply an 'ecological approach' (Barker et al., 2010). These programmes explicitly address gender equality and work at multiple levels of society and across multiple themes. Therefore, gender-equitable practices that result from a single-focus vasectomy programme are likely to have eventuated because of other factors at play, as this research has demonstrated. For example, the in-depth participant couples already shared decision-making about major things impacting their lives, and were therefore predisposed towards equitable practices. Moreover, our results would suggest that the couples behaved in ways that were consistent with the five indicators of women's empowerment used in the 2009 KDHS, as noted earlier.

SRHR providers in Kiribati should be encouraged to continue actively engaging men in SRHR initiatives – both in their own right as contraception users (condoms and vasectomy) and in their roles as partners, fathers and community leaders – to support women using contraception, as other studies have also identified (Daube et al, 2016; Macdonald et al., 2013).

Above all, this research shows that gender relations are complex, and that more effective SRHR outcomes are achieved for women (and men) when both parties are involved. Attention

needs to be paid to how power operates within relationships, acknowledging that people are multifaceted and that power is dynamic and operates in a relational way between women and men. Failure to recognise this complexity can reinforce essentialist framings of gender, gender roles, gender relations, sexualities, masculinities and femininities. It can result in simplistic development solutions which reinforce inequalities by overlooking gender relations of power or how cultural and gender norms evolve and change.

Although most I-Kiribati men appeared to maintain a position of control in their families and acted as gatekeepers, at least publicly, this research has demonstrated that there are I-Kiribati women who have agency and are empowered in their relationships. Significantly, there are also women and men who support equitable gender norms. This has implications for SRHR providers and development more broadly. Learning from their experiences opens up space for alternative paths to sustainable development and greater gender equity.

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Notes

1. Vasectomy is a minor surgical procedure that ultimately makes a man sterile. The procedure is done under local anaesthesia and takes about 20 minutes. In Kiribati, it is often performed in the man's home.
2. I use the term Global South to describe countries that are located in the Pacific, Africa, Asia, Latin America and the Caribbean, and Global North for New Zealand, Australia, Japan, Europe and the United States (Willis, 2005). Whilst these terms are also problematic, they do not position one country relative to another country.
3. This research was approved by the Victoria University of Wellington Human Ethics Committee, ethics approval number 23625.

Table 1: Women's demographic details - in-depth interview participants (IDIP)

Couple	Pseudonym	Gender	Age	Number of children	Level of education*	Household and livelihood activities
IDIP 1	Oreti	F	37	4	Form 4	Mother and helps with business
IDIP 2	Arotita	F	51	4	Form 3	Retired
IDIP 3	Anatia	F	33	3	Form 6	Shopkeeper
IDIP 4	Teraitabo	F	32	3	Form 3	Mother and garland maker
IDIP 5	Marva	F	38	6	Primary (Class 7)	Not in formal employment but makes and sells local food

Table 2: Men's demographic details - in-depth interview participants (IDIP)

Couple	Pseudonym	Gender	Age	Number of children	Level of education*	Household and livelihood activities
IDIP 1	Taomati	M	33	4	Form 3	Runs a business, local shop
IDIP 2	Auati	M	55	4	Form 3	Retired
IDIP 3	Toriua	M	36	3	Primary	Looks after their children and is a carpenter by trade. Not currently in formal employment
IDIP 4	Itaaka	M	46	3	Form 3	Not in formal employment but sells coconuts and works informally at a kava bar
IDIP 5	Teuarei	M	49	6	Form 3	Not in formal employment but makes and sells local food

Table 3: Women's demographic details - focus group (FG)

Couples	Pseudonym	Gender	Age	Number of children	Level of education*	Household and livelihood activities
FG 6	Mwatiera	F	45	4	Primary (Class 9)	Cleaner
FG 7	Mawaruru	F	50	3	Primary	Not in formal employment
FG 8	Uebou	F	32	5	Primary (Class 6)	Not in formal employment
FG 9	Raimoa	F	30	8	Primary	Not in formal employment
FG 10	Taake	F	48	5	Primary (Class 9)	Not in formal employment
FG 11	Teuebong	F	36	4	Form 5	Runs a business
n/a	Akeke	F	34	2	Primary (Class 9)	Not in formal employment
n/a	Ruru	F	48	6	Primary	Not in formal employment
n/a	Teete	F	36	4	Form 2	Security guard
n/a	Momo	F	37	3	Primary (Class 7)	Self-employed
n/a	Maria	F	36	4	Form 3	Not in formal employment

Table 4: Men's demographic details - focus group (FG)

Couples	Pseudonym	Gender	Age	Number of children	Level of education*	Household and livelihood activities
FG 6	Peter	M	46	4	Form 4	Not in formal employment
FG 7	Karoua	M	51	3	No schooling	Not in formal employment
FG 8	Waitongo	M	25	2	Primary (Class 5)	Not in formal employment
FG 9	Tutu	M	45	6	Primary	Not in formal employment
FG 10	Awi	M	54	5	Primary (Class 9)	Bus driver
FG 11	Mwemwe	M	45	4	Form 5	Business

***** As reported by participants; the stage was not always divulged. Primary School, Classes 1-6, from 6-12 years old. Junior Secondary School, Forms 1-3, from 13-15 years old. Senior Secondary School, Forms 4-7, from 16-19 years old.

Table 5: Key informants (KI)

Pseudonym	Key informants	Gender
Taouea	Member of Parliament	M
Petero	Local government executive	M
Tangariki	Women's community leader	F
Teima	Government health official	F
Selefina	Executive health professional	F
Tekonnang	Health professional	M

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