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

Alexandra Elizabeth Darvel Hill

A thesis submitted to Victoria University of Wellington in partial
fulfilment of the requirements for the degree of Masters in
Development Studies

School of Geography, Environment and Earth Sciences,
Victoria University of Wellington
2019

Figure 0.1 Shopfront in South
Tarawa depicting an I-Kiribati
woman and man.

Abstract

Engaging men in sexual and reproductive health and rights (SRHR) has implications for gender equality and sustainable development. Promoting vasectomy can foster more equitable gender relations between partners, but research on this topic is extremely limited. My research shows that, in Kiribati, vasectomy uptake is both a cause and a consequence of gender equitable relationships, but connections are complex. Vasectomy uptake can also result from, and lead to, inequitable behaviours.

Links between vasectomy uptake and gender relations among couples in South Tarawa, Kiribati were explored using a qualitative case study informed by feminist theory and principles from indigenous methodologies. 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; and with six key informant interviews. Information generated was analysed thematically and further triangulated with international and Kiribati studies.

Among the participant-couples, vasectomy decision-making seemed equitable, consistent with other household decision-making. Notably, the wives were actively involved in their husbands' decision to be vasectomised. Husbands were often prompted by egalitarian concerns. However, vasectomised men are in the minority and challenge gender normative behaviour. Family planning was widely viewed as women's responsibility.

Most participants felt vasectomy created new opportunities that empowered women. Yet, some participants knew of men who used their vasectomies to control their wives' sexual and reproductive agency, and to enable extramarital relationships. Although vasectomy freed women from contraceptive responsibility, significant shifts in the gender division of labour did not follow, but exceptions existed.

This research shows that gender equity is likely to be a pre-condition of vasectomy, and that vasectomy can lead to equitable outcomes. Moreover, gender relations within and among couples were multifaceted and contradictions existed. My research makes a strong case for why heterosexual men should be central to gender and development.

Acknowledgements

My thesis, like raising a child, took the efforts of a 'village'. Kam rabwa, thank you.

To the incredible I-Kiribati women and men who contributed their time and knowledges to this research including, all the participants and others who made this research possible. Your openness and humour transcended cultures.

To all the Kiribati Family Health Association (KFHA) staff and youth volunteers for their outstanding support with my field research and for being so welcoming. Special thanks to Norma Yeeting, Amota Tebau, Tamoia Moannata, Abitara Tekeke, Taboneao Kaireiti, Tirika Bill, Tebamere Teitewae, Tiero Areieta, Mearite Aomoro, Rote Tong, Temeua Reia, Iakobwa Tebau, Tenanoia Mwea, and Abraham Tata.

To former KFHA staff Toani Narao, Teima Komeri and Teborataake Uein.

To David Kakiakia for being such a professional Research Assistant.

To the friends I made in Kiribati, I-Kiribati and from all corners of the world.

To Eliza Raymond, formerly of Family Planning New Zealand for her incredible support, including introducing me to KFHA. To Family Planning New Zealand for making this research possible.

To the Ministry of Foreign Affairs and Trade (MFAT) staff in New Zealand and Kiribati for their support and for granting me a New Zealand Aid Programme Field Research Scholarship.

To my inspiring supervisor Sara Kindon for sparking my passion in this area of research, her professionalism and friendship, and for pushing me out of my comfort zone; also, to John Overton for his academic support over the years and whom I admire for his wisdom and humility; to Teresia Teaiwa for believing in my topic and to all the academics and professional staff across the university who have offered me support and friendship.

To my special friends from Development Studies and other programmes, especially to Sokunthea Koy, Nguyen Nguyen, Holly Frieda O'Connor, Hang Trinh, Singkam Lueyeevang, Katia Guiloff, Adinda Muchtar, Endah Setyaningsih, Lorena de la Torre and Faka'iloatonga Taumoefolau for inspiring me.

To my dear friends Maren Bouttell, Catherine Guo and Bren MacPherson for their caring support.

To the incredible women and men who came before me particularly my grandmother Sylvia Hill, and above all, to my loving father, George Hill who championed women all his life and who I was so saddened to lose partway through this thesis journey.

To my dear family for their love, bottomless support and for keeping me grounded; to Adrian Kearns, I could not ask for a better partner; my amazing sons Thomas and Oliver Kearns-Hill, for always pushing my thinking over dinner and their humour; my incredible Mother-in-Law, Jenny Kearns; my dear Aunty Kerry Richards and Australian family; and my Mother, Roberta Hill for being a sounding-board, sharing her wealth of research knowledge and commitment to our whānau.

Te Mauri, Te Raoi ao Te Tabomoa.

Table of Contents

Abstract.....	2
Acknowledgements.....	3
Table of Contents.....	5
List of Abbreviations	9
Glossary of Kiribati Terms	10
List of Figures	11
List of Tables	11
Chapter 1 – Introduction.....	12
1.1 Research context.....	12
1.2 Background to Kiribati	13
1.3 Kiribati’s development challenges	15
1.4 Vasectomy trends in the Global South	17
1.5 Vasectomy in Kiribati	18
1.6 Rationale and research questions.....	19
1.6.1 Main research question	19
1.6.2 Sub-questions.....	19
1.7 Epistemology.....	20
1.8 Methodology.....	22
1.8.1 Where is religion in this thesis?	23
1.9 Positionality.....	23
1.10 Thesis structure.....	24
Chapter 2 – Intersections: gender equality, phases of development and vasectomy	26
2.1 Introduction	26
2.2 Understanding concepts of gender.....	26
2.3 Agency, power and empowerment	28
2.4 From WID to GAD – women’s place in development but where are the men?	30
2.5 Why is family planning women’s business?.....	34
2.6 The influence of gender norms on family planning practices.....	35
2.7 Vasectomy and gender equality	36
2.8 Conclusion.....	37
Chapter 3 – I-Kiribati women and men: multi-faceted identities.....	40
3.1 Introduction	40
3.2 The Kiribati context – WID or GAD?.....	40
3.3 Women in Kiribati society	42
3.4 Gatekeepers of the gender order	45
3.5 Beyond the vulnerability narrative – women’s agency	47

3.6	I-Kiribati men – hegemonic masculinities and beyond	49
3.7	Conclusion.....	52
Chapter 4 – Methodology and fieldwork reflections.....		54
4.1	Introduction	54
4.2	Methodology.....	54
4.2.1	Case study approach	55
4.3	Developing my research design	57
4.4	Collaborating with KFHA in the field	58
4.5	Cultural guide/ research assistant	59
4.6	Participants	60
4.6.1	Ethical considerations	61
4.7	Informal semi-structured in-depth interviews	62
4.7.1	Participants and participant recruitment	62
4.7.2	In-depth interviews.....	62
4.7.3	Ethical considerations	65
4.8	Focus group discussions.....	66
4.8.1	Participants and participant recruitment	66
4.8.2	Focus group discussions.....	67
4.8.3	Ethical considerations	75
4.9	Key informants.....	75
4.9.1	Participants and participant recruitment	75
4.9.2	Key informant interviews.....	75
4.10	Data generation	76
4.11	Data analysis methods	77
4.12	Final reflections.....	79
4.12.1	Reciprocity	79
4.13	Conclusion.....	79
Chapter 5 – The Kiribati gender order: through the participants’ eyes.....		80
5.1	Introduction	80
5.2	Introducing the participants	80
5.3	Women’s gender roles – family	83
5.4	Women’s gender roles – community.....	85
5.5	Men’s gender roles – family.....	86
5.6	Men’s gender roles – community	88
5.7	Decision-making.....	88
5.8	Blurring of gender roles	91
5.9	Societal changes impacting I-Kiribati families.....	93

5.10	'The triple role of women'	94
5.11	Gender norms	96
5.11.1	Expectations of I-Kiribati girls and women	99
5.11.2	Expectations of I-Kiribati men	101
5.12	Conclusion	103
Chapter 6 – The complex nature of gender relations		104
6.1	The gendered nature of family planning	104
6.2	Challenges to men's masculinity	107
6.3	Spousal communication and family planning decision-making	109
6.4	Sexual coercion and women's lack of agency	113
6.5	Women's agency and vasectomy decision-making	115
6.6	Motivations to have a vasectomy	120
6.7	Perceived benefits for women	123
6.8	Vasectomy – a 'measure' of less equitable relationships?	127
6.9	Conclusion	130
Chapter 7 – Conclusion		132
7.1	Summary of thesis	132
7.2	Discussion	135
7.3	Limitations	139
7.4	Research strengths and academic contribution	139
7.5	Recommendations	140
7.6	Suggested areas for further study	141
7.7	Final reflections	141
Appendix A – Information sheets		143
In-depth interview participants in English and Kiribati		143
Focus group discussion participants in English and Kiribati		147
Key informants interviews – community leaders		151
Key informant interviews - service providers		153
Appendix B – Consent forms		155
In-depth interview participants in English and Kiribati		155
Focus group participants in English and Kiribati		157
Key informants		159
Appendix C – Confidentiality agreements		160
Cultural guide/Research assistant		160
Focus group participants		161
Focus group facilitator		162
Appendix D - Questions guides		163

In-depth Participants	163
Focus Groups.....	169
Key Informants.....	173
References	178

List of Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
GAD	Gender and Development
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICPD PoA	International Conference on Population and Development Programme of Action
IPPF	International Planned Parenthood Federation
KDHS	Kiribati Demographic and Health Survey
KFHA	Kiribati Family Health Association
KYIA	Kiribati Youth Initiative Association
MWYSA	Ministry for Women, Youth and Social Affairs
MoHMS	Ministry of Health and Medical Services
NGO	Non-Government Organisation
SRHR	Sexual and Reproductive Health and Rights
SRH	Sexual and Reproductive Health
STI	Sexually Transmissible Infection
UNFPA	United Nations Population Fund
WID	Women in Development
WAD	Women and Development
WDD	Women's Development Division

Glossary of Kiribati Terms

<i>babai</i>	large root vegetable, similar to taro used during special occasions
<i>bootaki</i>	to come together as a group, for example, for a meeting or a party
<i>I-Kiribati</i>	a person or group of people indigenous to Kiribati
<i>I-Matang</i>	a person or group of people of foreign origin, typically of European descent
<i>kainga</i>	extended family, whose members share common descent; also refers to the land that the group has ownership rights to
<i>koko</i>	sexual jealousy experienced between couples
<i>maneaba</i>	community or village meeting house(s)
<i>Te Mauri, Te Raoi ao Te Tabomoa</i>	Health, Peace and Prosperity – this saying appears on the Kiribati coat of arms and is also used to conclude formal speeches
<i>tiibuta</i>	smocked shirt made and worn by women
<i>unimane</i>	elder men or men that hold a position of status in the community; also council of elders

(Van Trease, 1993, pp. xvii – xviii).

List of Figures

Figure 0.1 Shopfront in South Tarawa depicting an I-Kiribati woman and man.	1
Figure 1.1 Map of Kiribati. Reprinted from https://sites.google.com/site/kiribatiembassyintaiwanroc/general-information	13
Figure 1.2 Map of South Tarawa by Dyer, A. 1993. Reprinted from Atoll Politics: The Republic of Kiribati. (p. 126), Christchurch, New Zealand; Fiji. Copyright (1993) by Macmillan Brown Centre for Pacific Studies and Institute of Pacific Studies. Reprinted with Permission.	15
Figure 1.3 Using the imagery of the maneaba to reflect my feminist framework. The foundation, the floor and posts, represent social constructivism. The beams of the roof depict feminist and indigenous methodologies, and the pandanas roof provides the 'ethic of care'.	21
Figure 1.4: With Thomas in Lae, Papua New Guinea in 1968.	24
Figure 4.1 Focus group programme.	69
Figure 4.2 Focus group participants' rights translated into Kiribati.	70
Figure 4.3: The ground rules determined by the women's focus group discussion participants.	72
Figure 4.4: The ground rules determined by the men's focus group discussion participants.	73
Figure 4.5: Data analysis, mind-mapping to uncover key themes and interconnected ideas.	78

List of Tables

Table 5-1: Women's demographic details - in-depth interview participants (IDIP).	81
Table 5-2: Men's demographic details - in-depth interview participants (IDIP).	81
Table 5-3: Women's demographic details - focus group (FG).	82
Table 5-4: Men's demographic details - focus group (FG).	82
Table 5-5: Key informants (KI).	83

Chapter 1 – Introduction

1.1 Research context

This thesis explores connections between vasectomy¹ acceptance and equitable gender relations among couples in South Tarawa, the capital of Kiribati, an island nation in the Pacific.

Women assume disproportionate responsibility for contraception in Kiribati (Kiribati National Statistics Office, Secretariat of the Pacific Community & Macro International Inc., 2010). However, a woman's contraceptive duty ends if her husband or partner has a vasectomy. Vasectomy uptake changes the gendered nature of contraception from "women's business" to "men's business" and arguably challenges gender norms that are associated with contraceptive use. Vasectomy, by its nature, requires active male involvement in family planning, and its acceptance can generate dialogue between partners (Jacobstein, 2015; L. MacDonald et al., 2013). Moreover, vasectomy is a safe, fast, effective permanent contraceptive method, and is among the most cost-effective family planning methods available (Perry et al., 2016). In Kiribati the procedure can even be performed in men's homes.

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 in Kiribati.

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 arguable 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 South². It also raises the question, 'Is vasectomy a cause or a consequence of gender equitable relationships, or both?'

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.

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 USA (Willis, 2005). Whilst these terms are also problematic, they do not position one country relative to another country.

1.2 Background to Kiribati

The Republic of Kiribati comprises 33 low-lying coral atolls spanning 3.5 million square kilometres of ocean (COP23 Fiji, 2017) (Figure 1.1). The people of Kiribati, I-Kiribati, are Micronesian (Tabokai, 1993). Cultural homogeneity extends across the 16 inhabited atolls in the Gilbert atoll chain (Brewis, 2001). I-Kiribati treasure their kinship ties and genealogies. Land and social obligations are highly valued, as are local skills and knowledge (Itaia, 1984).

Figure 1.1 Map of Kiribati. Reprinted from <https://sites.google.com/site/kiribatiembassyintaiwanroc/general-information>

The Kiribati way of life centres around the *maneaba*, or community meeting house. Principles of collectivism are supported through the *maneaba* system and communities are expected to contribute both individually and communally to their functioning (Tabokai, 1993). The *maneaba* is used for meetings, weddings and parties, and it is where important community decisions are made (Tabokai, 1993). Over time, the church and the *maneaba* system have become inter-linked (Tabokai, 1993), since religion also plays an important role in the lives of I-Kiribati. The majority of the population identify as Christian. Over half are

Catholic, while a third belong to the Kiribati Protestant Church, with the remainder belonging to the Mormon and Baha'i faiths (Government of Kiribati, 2005).

Given that Kiribati is comprised entirely of atolls, it has limited natural resources (Caulson, 1993). I-Kiribati, are, however, known for their resilience and ability to support themselves from the land and sea even during periods of scarcity (Talu & Tekonnang, 1984).

Historically, I-Kiribati could live within the limits imposed by the environment; for example, it is believed that, prior to the arrival of Europeans, both abortion and infanticide were practised to maintain sustainable family sizes (B. Macdonald, 2001). Being able to live in such a challenging environment, however, has been increasingly difficult due to social, economic and environmental changes (Caulson, 1993).

Europeans arrived in the Gilbert and Ellice Islands, as Kiribati was formerly known, in the 19th Century, introducing new material culture, technology and ideologies (B. Macdonald, 2001). The missions and British colonial government added demands that were both psychological and economic, and, while some of the innovations eased pressures on resources, others increased them (B. Macdonald, 2001). As B. Macdonald (2001, p. 13), notes:

... indigenous societies had never been static but had been living organisms constantly adjusting to changing circumstances but in the 19th century the forces of change were of an unprecedented range and magnitude.

After Kiribati gained independence in 1979, urbanisation and globalisation increased, impacting the Kiribati way of life (Caulson, 1993), particularly in South Tarawa, the site of this research (Figure 1.2). Traditionally, I-Kiribati had subsistence livelihoods (Brewis, 2001). While this lifestyle continues on the outer islands, people in South Tarawa have less opportunity to rely on the natural environment for food. Land is scarcer, and pollution impacts water and fish-stocks (Siddle, 2014).

South Tarawa has a cash-economy and locals are reliant on cash for food and everyday items (Government of Kiribati, 2005). Although people work in the formal economy, predominantly in the public service, job opportunities are limited and the distribution of income is uneven (Government of Kiribati, 2005). Almost half the population of South Tarawa are not in formal employment (National Statistics Office, 2016). Other sources of cash come from fishing, producing local crafts, and local skills.

Figure 1.2 Map of South Tarawa by Dyer, A. 1993. Reprinted from *Atoll Politics: The Republic of Kiribati*. (p. 126), Christchurch, New Zealand; Fiji. Copyright (1993) by Macmillan Brown Centre for Pacific Studies and Institute of Pacific Studies. Reprinted with Permission.

Many I-Kiribati work abroad to support their families as merchant seamen and fishermen on foreign-owned ships (Government of Kiribati, 2005), and more recently in tourism and aged-care in Australia (Pacific Periscope, n.d.). Remittances make a significant contribution to the national economy, together with revenue from fishing licence fees, and foreign aid (Asian Development Bank, 2018).

1.3 Kiribati's development challenges

Kiribati faces a range of development challenges, in part due to its atoll environment (Clouston, 1993). Kiribati's population of 110,110 (National Statistics Office, 2016) is predicted to almost double by 2050 (Kiribati National Statistics Office et al., 2010). South Tarawa, home to over half the population, has a population density equivalent to Hong Kong in places (Siddle, 2014). Rapid population growth and Kiribati's susceptibility to climate change, limited soil fertility and fresh water coupled with geographic isolation, high

transportation costs and a highly dispersed population (COP23 Fiji, 2017), while significant, can overshadow other factors that are restricting sustainable development.

Although SRHR outcomes are improving gender equality, gender based violence (GBV) and access to SRHR remain a concern. Strategies to address these interconnected problems are part of Kiribati's Development Plan 2016 – 2019 (Government of Kiribati, 2016). Kiribati's unmet need for family planning³ was 28 per cent in 2009, and the modern contraceptive prevalence rate (CPR) was estimated at just 18 per cent for married women (Kiribati National Statistics Office et al., 2010). To put this figure in context, Kiribati's modern CPR in 2009 was less than that of Sub-Sahara Africa, which recorded 22 per cent that same year, and drastically lower than East Asia's 77 per cent (Sharan, Ahmed, May, & Soucat, 2011).

However, a 2016 study conducted in South Tarawa suggests contraception uptake has increased in Kiribati. Fifty per cent of married or partnered women who were surveyed reported using contraception, but this figure included natural methods, such as ovulation methods (Daube, Chamberman, & Raymond, 2016). Unsurprisingly, fertility rates are high. While causes of unwanted pregnancies and unmet contraceptive needs are complex, it is likely that inequitable gender relations are a contributing factor, since women often lack decision-making power, even in terms of their own health (L. MacDonald et al., 2013).

Sexual and reproductive health has significant implications for women's health, education and employment (United Nations Population Fund, n.d.). Fundamentally, access to family planning fosters increased gender equity and women's empowerment (Kabagenyi et al., 2014). Conversely, gender inequitable practices such as GBV, can cause and perpetuate gender inequality and lead to poor SRHR outcomes (White, Greene, & Murphy, 2003). Gender inequality, in turn, hinders all forms of sustainable development, and, of most concern, it breaches human rights.

GBV is a major issue in Kiribati. Sixty-eight per cent of I-Kiribati women, aged between 15 and 49 years old, have experienced intimate partner violence (Secretariat of the Pacific Community, 2010). 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

³ Unmet need for family planning is the percentage of married or partnered women of reproductive age who want to stop or postpone childbearing but who report that they are not using any method of contraception to prevent pregnancy (United Nations, 2015).

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). Given GBV is linked to decision-making that is inequitable, having a better understanding of decision-making with vasectomy uptake could potentially uncover additional strategies to reduce GBV.

There are women and men who challenge the dominant picture of development in Kiribati, however. For example, in some households, violence is not condoned, decision-making is shared and some 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 contraception⁴ (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 rates of uptake of contraceptive methods designed for men remain low.

1.4 Vasectomy trends in the Global South

Like in Kiribati, vasectomy uptake in much of the Global South is limited (Perry et al., 2016). Rates of female sterilisation far outweigh vasectomy uptake, and yet vasectomy is a more effective, safe, and cheaper form of contraception (Johns Hopkins Bloomberg School of Public Health, 2008). In contrast, countries with greater gender equity and higher socio-economic development, also have high rates of vasectomy uptake (Jacobstein, 2015). Unsurprisingly, therefore, New Zealand, with a vasectomy prevalence rate of 19.5 per cent in 1995 (United Nations, 2011), is said to have some of the highest rates of vasectomy uptake in the world (Terry & Braun, 2011a).

Although issues around vasectomy uptake in the Global South are complex, and lack of availability and trained staff are part of the wider problem, gender norms at all levels of society are documented barriers to uptake (Perry et al., 2016). Resistance to vasectomy uptake is predictable since the responsibility for contraception shifts from women to men. Further, vasectomy challenges widely held views regarding masculinity. For example, in a

⁴ “A product or medical procedure that interferes with reproduction from acts of sexual intercourse” (Hubache & Trussell, 2015).

study in rural Uganda, men expressed concern that the permanence and apparent irreversibility of vasectomy was ‘consistent with losing one’s masculinity’ (Kabagenyi et al., 2014, p. 4). Other studies show that both men and women express concern about it causing men to become weak, and to lose income (Jacobstein, 2015) - both markers of a man’s masculinity.

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, Ehrenzweig, & Hernández-Aguilera, 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 (L. MacDonald et al., 2013).

Moreover, not all studies that seek to understand barriers to vasectomy uptake apply a gender lens, meaning that issues 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). Notably, issues relating to how vasectomy is perceived to impact masculinity are more widely addressed, particularly in terms of this being a barrier to uptake (Drysdale, 2015; Kabagenyi et al., 2014; Marván et al., 2017).

1.5 Vasectomy in Kiribati

Although no current literature explicitly addresses vasectomy in Kiribati, the 2009 KDHS and a contraceptive usage and barriers study (Family Planning, 2016) provide insights into its prevalence and community knowledge of this method. Kiribati’s vasectomy prevalence rate was less than three per cent in 2009 (Kiribati National Statistics Office et al., 2010).

Community knowledge too appears particularly low – only 18 per cent of surveyed I-Kiribati men and 4 per cent of women could name vasectomy as a contraceptive method (Family Planning, 2016).

Demand in Kiribati, however, appears to have been steadily increasing since 2011. Kiribati Family Health Association (KFHA), the main vasectomy provider in Kiribati, performed about

six vasectomies per year between 2011 and 2013 (Male Health Professional, personal communication, January 10, 2018). This jumped to 14 procedures in 2016. Men who are willing to have a vasectomy in Kiribati challenge gendered normative behaviour associated with contraception, not just in Kiribati but in much of the Global South (Perry et al., 2016), and are arguably already in more equitable relationships with their partners.

1.6 Rationale and research questions

Accordingly, this research seeks to examine the gendered experiences and perceptions of some I-Kiribati women, men and couples regarding vasectomy uptake. The research aims to:

- Understand how couples negotiate gender norms that can act as barriers to vasectomy acceptance,
- Examine the role of spousal communication in their decision-making, and
- Investigate what implications vasectomy acceptance has for women when men assume the role of contraception.

1.6.1 Main research question

What are the connections between vasectomy acceptance and equitable gender relations among couples in Kiribati?

1.6.2 Sub-questions

1. What are I-Kiribati women's and men's roles and responsibilities within the household and community?
2. How do women and men make important decisions that affect their families, including ones relating to their sexual and reproductive health?
3. What are the impacts of vasectomy for women?

1.7 Epistemology

The research works within a social constructivist epistemology, since social constructivists are concerned with how humans generate meanings through their engagement with the world in which they live (Creswell, 2014). This worldview assumes that historical and social perspectives shape how humans both engage with and make sense of their world, and acknowledges that understandings are often predetermined by cultural background (Crotty, 1998); consequently social constructivists draw on participants' subjective meanings (Creswell, 2014). Such an epistemology is appropriate because of my focus on the views and lived experiences of I-Kiribati women, men and couples regarding vasectomy uptake in Kiribati. Further, it has allowed me to study multiple views and 'to look for the complexity of views' (Creswell, 2014, p. 8).

Methodologically, the research sits within a feminist research framework while also acknowledging indigenous approaches and critiques (Figure 1.4). The concept of 'gender' is central to feminist theory and feminist epistemologies value and legitimise experience-based knowledges (Jackson, 2006). These principles closely align with my research topic. Originally, feminist theory focused primarily on differences and inequalities in relation to women's position relative to men (Griffin, 2017), but feminists increasingly recognised that inequalities did not just operate along gender lines. Today feminists engage with issues of difference between and across genders, ethnicity, class, sexuality and other markers of difference (Griffin, 2017; Hesse-Biber, 2007) "in an attempt to explain the interrelationship of multiple forms of oppression" (McEwan, 2001, p. 98). Furthermore, binary notions of difference and universalisms are rejected. In other words, women's lived experiences are not homogeneous. Finally, feminist theory is the "only lens that specifically names and is reflexive about the politics and problematics of gender" (Pillow & Mayo, 2007, p. 156).

Figure 1.3 Using the imagery of the maneaba to reflect my feminist framework. The foundation, the floor and posts, represent social constructivism. The beams of the roof depict feminist and indigenous methodologies, and the pandanas roof provides the ‘ethic of care’.

However, a feminist approach is not only concerned with research outcomes – the process of conducting the research is equally important (Campbell & Wasco, 2000). Fundamentally, feminist research practice, that is feminist praxis, is attentive to issues of ethics, power and how knowledge is created (Hesse-Biber & Piatelli, 2007), principles shared with indigenous methodologies (Smith, 2012; Vaiolenti, 2006). Adopting a feminist research methodology necessitated that I value local knowledge, generate knowledge without misappropriation (England, 2008; Willis, 2005), recognise issues of power, strive to create egalitarian relationships with research participants, engage with participants in a culturally- and ethically-appropriate way (Howitt & Stevens, 2010), and attempt to bring about positive change through my research (McEwan, 2001).

As an *I-Matang*, “a person... of foreign origin usually of European descent” (Van Trease, 1993, p xvii) working with an indigenous community, I was also mindful about issues of representation. While I admit that ‘writing with’ rather than ‘writing about’ was not easy in practice, I gave considerable thought to how I have framed each of the participant’s different lived experiences. 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). Likewise, feminist epistemologies acknowledge that the researcher is not neutral. Therefore, I was reflective of my own subjectivities, as I knew my personal experiences would also shape my understandings and representations through this thesis (Jackson, 2006). As Falconer Al-Hindi and Kawabata (2002, p. 114) suggest, I have identified and located myself “not just in the research but also in the writing”. Perhaps most importantly, I have maintained what Cleary (2013) calls an ‘ethic of care’ that extended beyond my fieldwork.

A feminist approach demands such reflexive research practices. Consequently, I make personal biases, values and positionalities explicit; and acknowledge my findings may be impacted by my interpretations and representations of participants (Creswell, 2014; Sultana, 2007). Acting in this way helps to situate the research and knowledge production (Sultana, 2007). Therefore, I describe my positionality before concluding this chapter, since this informs my position in relation to others’ based on markers of difference (Chacko, 2004; G. Rose, 1997).

1.8 Methodology

I used a qualitative case study approach to conduct this research and held informal semi-structured interviews with five vasectomised I-Kiribati men and their wives, who were interviewed as a couple and individually. Comparative analysis was undertaken with two same-sex focus group discussions: one with men who had not had a vasectomy but shared characteristics with vasectomised men; and the second with the wives of these men. I also made observations, which I noted in a fieldwork diary. Further, six key informant interviews were conducted with service providers and community leaders. I analysed the data thematically and further triangulated my findings with secondary data, including the 2009 KDHS, other SRHR studies conducted in Kiribati and international research on vasectomy uptake.

I have made every effort to protect participants’ identities, particularly given the sensitive nature of this research. Unless participants requested otherwise, I have used pseudonyms and other descriptors, and where necessary have masked other identifying characteristics (Dowling, 2010).

1.8.1 Where is religion in this thesis?

Arguably, this thesis should address the topic of religion, given its significance in Kiribati and since some religions ban the use of modern contraceptives. However, I made a conscious decision to avoid this topic completely, to respect KFHA's wishes and prevent jeopardising their programmes. If it became known that some Catholic men had received a vasectomy, Catholic leaders, could use their positions of power to challenge KFHA's work.

1.9 Positionality

In Kiribati culture most extended family groups identify with their "'home islands'...(tracing back through both parents, and sometimes even grandparents origin)" (Borovnik, 2005, p. 134). So in keeping with I-Kiribati practices, my home island is Australia. I was born in Perth and my *kainga* ("extended family, whose members are bound by common descent" (Van Trease, 1993, p xvii)) still live there. My mother's home island is also Australia. My maternal grandparents, too, hailed from Australia and were European Australians. My father's home island was England, like my paternal grandparents'. If you take me at face value, I am an *I-Matang*, a middle-class feminist from the Global North, but this description oversimplifies me as a person. I spent the first two years of my life living in Lae, Papua New Guinea, on an agricultural research station (Figure 1.4) and have lived, socialised and worked cross-culturally for most of my life.

In my working life, I was drawn to international education and have been privileged to support and work with indigenous students from Australia and from countries as diverse as Sierra Leone, Haiti, Laos, Vanuatu, Papua New Guinea, Timor Leste and even Kiribati.

I am advantaged socio-economically, both in New Zealand and when compared with people in Kiribati, and have been fortunate to pursue education up to post-graduate level. While many of my positionalities are at odds with those of the I-Kiribati women and men I interviewed and often rendered me very much an outsider, I am also a mother, a daughter and a wife. I, too, have a vasectomised partner. My positionalities with the participants were therefore complex, and not always outsider/insider.

Figure 1.4: With Thomas in Lae, Papua New Guinea in 1968.

1.10 Thesis structure

Chapter 2 introduces key definitions which underpin this thesis. I review Pacific and international literature, highlighting some gaps that this thesis addresses. I specifically look at women's and men's 'place' in development theory and practice, and in relation to issues of gender equality, gender norms and family planning praxis. I conclude by examining links between vasectomy and gender equity.

Chapter 3 analyses the literature that exists on I-Kiribati women and men, to give context for an exploration of gender relations in my subsequent findings and discussion chapters. I critique how I-Kiribati women and men are typically framed by development discourse, which I support with feminist arguments. I conclude by examining widely understood notions of masculinity and how these relate to I-Kiribati men.

My methodology is described in more detail in Chapter 4. I explain why I undertook a case study approach, and how this method aligns with my feminist framework. I discuss how I partnered with KFHA to develop the research design, and recruit participants. Much of this chapter focuses on my methods and rationale for using them. I interweave reflections and ethical considerations. I then describe my data generation and analysis process, and conclude with ethical concerns which had not been previously addressed.

Chapter 5 introduces participants' 'voices', and is attentive to the literature I review in Chapter 3. This chapter melds my findings with a discussion that focuses on gender roles for women and men within the family and at the community level. I also examine blurring in gender roles, and highlight how gender roles are more complex than dominant narratives might suggest. I offer some suggestions of factors which may precipitate gender roles being challenged.

In addition, I explore I-Kiribati women's triple roles – reproductive, productive and community work – linking to concepts introduced in Chapter 3. I address gender norms related to child-preference and land-rights. In conclusion I examine gendered expectations for I-Kiribati women and men in terms of their behaviour and attitudes to highlight where there was consensus but also some divergent views among participants.

Chapter 6 combines my findings with a discussion. It explores participants' perceptions on contraceptive and reproductive responsibilities, spousal communication and family planning decision-making. I examine the gendered nature of family planning and how gender norms define I-Kiribati women's reproductive role. I explore links between resistance to vasectomy and its perceived threats to masculinity. I pay particular attention to the concept of 'agency' and look at connections between women's agency and equitable gender relations, and how this applies in relationships in which the husband had had a vasectomy. I also address links between vasectomy and less equitable gender relations, highlighting the way that connections between vasectomy and gender equity are complex. Throughout this chapter, I compare my findings with other Kiribati and international studies.

In Chapter 7, my thesis conclusion, I summarise my findings with a discussion. I address the strengths and academic contributions of my research and suggest implications for future development policy and practice. Additionally, I offer some ideas for future studies. This thesis demonstrates that vasectomy uptake is both a cause and consequence of gender equitable relationships in South Tarawa, Kiribati; however, connections are complex and men sometimes opt for vasectomy to facilitate inequitable practices in their relationships.

Chapter 2 – Intersections: gender equality, phases of development and vasectomy

2.1 Introduction

This chapter starts by defining the key concepts I work with in this thesis. I then explore connections between these concepts as part of a wider literature review, including literature from the Pacific. Particular attention is paid to women's and men's 'place' in development theory and practice, specifically in relation to issues of gender equality, gender norms and family planning praxis. To conclude, I examine links between vasectomy and gender equity.

2.2 Understanding concepts of gender

Concepts of gender are interrelated and share similar socially constructed underpinnings. Consistent across gender and gender relations is their relational nature. Moreover, gender is embedded in social relations that are shaped by other markers of difference, such as age, race, ethnicity, sexual orientation, class and disability (Nawyn, 2010; Ruxton & Oxfam, 2004). In turn, gender norms are reproduced by individuals through these social relations (Jewkes, Flood, & Lang, 2015), and power is inherent in them (Kabeer, 2003).

Gender can be described as socially-determined notions of masculinity and femininity that define how men and women are identified (Momsen, 2010). However, gender is not simply about being a man or a woman. Feminist theories argue that gender is both dynamic and fluid, and binary notions of gender have been rejected (Mahler & Pessar, 2001; Momsen, 2010). Whilst in theory 'gender' is perceived as fluid, people's lived realities perhaps suggest otherwise. According to Kabeer, for example, relationships within families are 'gender-ascriptive' (2003, p. 50). "In other words, to be a husband, wife, brother or daughter is to be a male or a female" (Kabeer, 2003, p. 50).

Gender roles, similarly, are roles, behaviours, activities and attributes that are widely considered appropriate for men and women within a specific culture; and include household tasks and forms of employment (Momsen, 2004; UN Women Training Centre, n.d.).

Although gender roles might appear fixed, they can evolve over time (UN Women Training Centre, n.d.), particularly in response to economic development (Momsen, 2004).

Gender relations are concerned with how power between women and men is constructed and maintained (Agarwal, 1997; Mosedale, 2005). According to Agarwal, gender relations, as with all social relations, embody the material and ideological, which is what renders them complex. Agarwal (1997, p. 1) posits that gender relations:

... are revealed not only in the division of labor and resources between women and men, but also in ideas and representations – the ascribing to women and men of different abilities, attitudes, desires, personality traits, behavior patterns, and so on.

The gendered division of labour and different sociocultural norms and expectations are defined by the gender order – in other words the overall system of gender relations in a society (UN Women Training Centre, n.d.). The gender order or gender regime determines what is acceptable and encouraged for women and men in a given context. Gender norms markedly impact the gender order, since they regulate how men and women should behave, their roles in society and how they are valued. Gender norms are unwritten rules largely determined by cultural beliefs and practices (Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010; Jewkes et al., 2015). Gender norms also vary according to the context since they are “constructed and learned differently in different settings” (Barker et al., 2010, p. 541), and people are impacted differently by them.

Gender norms are one of the reasons that gender inequality is so hard to change. According to Underhill-Sem (2011, p. 17) “the [gender] norms that reproduce this inequality rest on gender relations of power”. I address these interrelations in more detail in Chapter 3.

Gender inequality generally involves unequal power relationships and distribution of resources between women and men. As previously noted, gender is crosscut with other markers of difference (Momsen, 2004), and this is described by the concept of intersectionality. This concept recognises that inequalities do not just operate along gender lines. Intersectionality is also concerned with how notions of difference mesh with norms, cultural ideologies and institutional systems and the impact that these interactions have on power relationships (Davis, 2008). Underhill-Sem (2011, p. 12) argues that applying “the concept of intersections allows for more complex analysis that deepens understandings of the nature of the relationships between different groups of people”. At the same time, she

acknowledges that some intersecting points are more fixed and uses the example of 'rank', which is applicable in much of the Pacific (Underhill-Sem, 2011).

2.3 Agency, power and empowerment

Concepts of agency, power and empowerment are closely related to gender and are central to this thesis. Agency refers to a person's ability to make, voice and control decisions (Willis, 2005); however, it is not simply about decision-making. For Kabeer (1999, p. 438), agency goes beyond observable action, "it encompasses the meaning, motivation and purpose which individuals bring to their activity, their *sense* of agency, or 'the power within'". Agency can be exercised in multiple ways. For example, "bargaining and negotiation, deception and manipulation, subversion and resistance" are forms of agency (Kabeer, 1999, p. 438).

In reference to power, agency can have both positive and negative meanings (Kabeer, 1999). Power, as with concepts of gender is also relational, and is embedded in everyday life in social, economic and political systems (Nelson & Wright, 1995). For Foucault, power is not some finite entity that can be located – instead, it exists in social relations (as cited in Rowlands, 1998, p. 14). In a positive sense, agency can be conceptualised as 'power to', which is when a person is able to make and act on their own life choices, even when faced with opposition from others (Kabeer, 2005, p. 14). 'Power over' on the other hand, is a type of controlling power (Rowlands, 1998), and refers to the ability of some actors to dominate and override the agency of others, and in doing so depriving others of power (Kabeer, 2005). It can be exercised through the use of violence and other forms of coercion, for example; however people can also respond with resistance (Rowlands, 1998). The notion of 'power over' is based on an assumption that power is finite, "...if some people have more, others have less" (Rowlands, 1998, p. 13).

Concepts of 'power to' and 'power over' are linked to understandings of empowerment. Within the gender and development context, 'empowerment' addresses women's ability to exercise 'power over' and access other forms of power, such as 'power to' and 'power within' (Rowlands, 1998). However, empowerment is a much contested term in development theory and practice (Zakaria, 2017) and empowerment means different things

to different people (Cornwall, 2016; Mosedale, 2005). Of most relevance to this research are feminist conceptualisations of empowerment from the 1980s and 1990s, since these address issues of power and the relational aspect of empowerment (Cornwall, 2016).

According to Sen (1997) “[e]mpowerment is, first and foremost, about power; changing power relations in favour of those who previously exercised little power over their own lives” (as cited in Cornwall, 2016, p. 344). If power is equated with control as discussed earlier, then empowerment can be thought of as the process of gaining control (Cornwall, 2016; Kabeer 1999).

Empowerment as a process occurs when people are able to make strategic life choices when they were previously not able to do so. Kabeer (1999) proposes that having the capacity to exercise choice comprises three inter-related aspects: resources, agency and achievements. Broadly speaking these aspects are concerned with people’s ability to access all types of resources including social resources, now and in the future; to make decisions but also to be able to apply less tangible forms of agency, such as negotiation; and outcomes that positively affect their well-being (Kabeer, 1999). For example, equitable household decision-making, access to and control over family resources, the ability to make child-bearing decisions, control sexual relations and use contraceptives are all determinants of women’s empowerment (Malhotra & Schuler, 2005).

Despite divergent understandings of empowerment, there is some consensus in the literature (Mosedale, 2005). To be empowered suggests that one was previously disempowered and “it is relevant to speak of empowering women, ... because, as a group, they are disempowered relative to men” (Mosedale, 2005, p. 244). Empowerment comes from within and it is not something another party can do to or for women (Cornwall, 2016; Mosedale, 2005). In other words, development initiatives can facilitate women empowering themselves but not actually empower them directly. Moreover, as Kabeer’s definition illustrates, empowerment involves people being able to decide and act on things that are important in their lives. Finally, empowerment is ongoing.

Cornwall (2016, p. 345) posits that, for empowerment to be transformative, entrenched structural inequalities need to be addressed, which in turn is dependent on what she refers to as “two vital levers”. Processes that generate shifts in consciousness are the first ‘lever’. These include tackling limiting normative beliefs and expectations which can keep women in

positions of subordination and dependency, and “challenging restrictive cultural and social norms and contesting the institutions of everyday life that sustain inequality” (Cornwall, 2016, p. 345). The second lever involves engaging “with culturally embedded normative beliefs, understandings and ideas about gender, power and change” (Cornwall, 2016, p. 345). Empowerment as transformation goes beyond the level of the individual to challenge taken-for-granted, everyday assumptions which underpin gendered inequalities in any given cultural context. Cornwall (2016, p. 345) says that there are a range of ways that this can be achieved. It is about “[c]hanging notions of what a woman or a man should be or do”, and questioning understandings of gender relations and identities. I address empowerment in Chapter 6, specifically in relation to vasectomy uptake. Having defined key concepts that underpin this thesis, I will now show how they fit within the broader topic of gender and development.

2.4 From WID to GAD – women’s place in development but where are the men?

Development policy and practice started differentiating between men and women in the early 1960s; however, women’s ‘place’ in development has evolved since then (Saunders, 2002). Approaches to working with women (and men) reflect different waves of feminist thinking. Initially women were defined by their reproductive role, which saw the advent of mother-child programmes (Momsen, 2010; Saunders, 2002). It was also at this time that the connection between family planning and population control was first made.

The welfare approach, as it was known, received considerable backlash from feminists in the 1970s, and was critiqued for being a paternalistic form of development that reinforced existing gender roles, since it framed women solely as wives and mothers and failed to recognise women’s productive labour (Momsen, 2010; Saunders, 2002). Women in Development (WID) replaced welfarism. Ester Boserup, a liberal feminist, precipitated a major shift in thinking regarding women’s place in development and this flowed through into programme initiatives that started to address women’s roles as economic actors (Saunders, 2002). WID was in turn replaced by Women and Development (WAD).

Consistent across welfarism, WID, and WAD, however, is the exclusive focus on women. It was not until the advent of Gender and Development (GAD) that men started to be part of

the conversation. GAD is concerned with gender relations and therefore by implication women and men (Chant & Gutmann, 2002). It also addresses concepts of power, since gender relations are fundamentally about issues of power (Cornwall, 1997). Proponents of GAD sought to analyse how development reshapes power relations between the genders (Momsen, 2010).

Although GAD was first conceptualised by academics in the mid-1970s (Momsen, 2010), engaging men was not universally recognised as important until the mid-1990s when it became increasingly clear that women-only programmes were not achieving intended outcomes (Frye Helzner, 1996; Momsen, 2010), nor were they effectively addressing gender inequality (Chant & Gutmann, 2002). A gendered approach was required (Momsen, 2010). It prompted calls by the development sector to engage men in areas that historically targeted women only, such as sexual and reproductive health (SRH) (Frye Helzner, 1996).

There are a range of reasons why focusing on women's situations in isolation was not working and why women-only programmes have not been effective at tackling gender inequality. Such programmes even have the potential to intensify gender inequalities (Sweetman, 2013). At a fundamental level, men's and women's lives are inextricably interconnected and "the success of 'women-only' projects is constrained as men are a central part of gender relations" (Wanner & Wadham, 2015, p. 17). For example, globally men tend to hold decision-making power at various scales from the household through to government. Husbands, fathers, brothers, partners, male community leaders often act as gatekeepers (Kaufman, 2004; Onyango, Owoko, & Oguttu, 2010). Therefore, excluding men can increase hostilities between women and men, resulting in increased resistance from men (Chant & Gutmann, 2002; Onyango et al., 2010; Wanner & Wadham, 2015) and at worst, punitive action towards women (Sweetman, 2013).

Many health, education, family planning, and development programmes targeting women in various parts of the world find that men are an important obstacle – and often the main one – to women's participation and to a project's success (De Keijzer, 2004, p. 28).

Programmes targeted exclusively to women also have the potential to increase women's workloads and responsibilities (Ruxton & Oxfam, 2004; Wanner & Wadham, 2015). In addition, women-only programmes can reinforce gender norms, for example women as

‘carers’ and men as ‘breadwinners’ (Ruxton & Oxfam, 2004, p. 5). This is particularly evident in family planning programmes, which generally target women only (Greene et al., 2006).

While GAD champions the involvement of men, there is also recognition that GAD does not represent a complete rejection of projects and strategies that focus on women (Ruxton & Oxfam, 2004); however, even in these focused interventions it is argued that gender relations must be central. “The emphasis of GAD on gender relations inevitably encourages a more active approach to men and masculinity issues than in the past” (Ruxton & Oxfam, 2004, p. 4). The 1994 International Conference on Population and Development Programme of Action (ICPD PoA) explicitly addressed these concerns, and working with men was part of its recommendations (UNFPA United Nations Population Fund, 1994).

Given this focus, GAD was meant to herald a move away from focusing exclusively on girls and women. Arguably, this has not occurred in practice (Jolly, 2000; Sweetman, 2013). Whilst women continue to be disproportionately disadvantaged by gender inequalities it is understandable that many development programmes continue to exclusively target women. Sweetman (2013, p. 3) argues:

The justification is the fact that the big picture is still a world order which requires radical action to advance gender justice, challenge the conservative forces which threaten to roll back progress on women’s rights, and empower women in the global South.

What is more, involving men can increase inequitable access to already limited resources and can reduce women’s independence and agency. Engaging men is therefore complex and not without its challenges. However, the exclusion of boys and men is not simply about redressing inequality. It could be argued that institutional gender norms, and dominant notions of masculinity frame men’s ‘gendered place’ in development as either invisible, ‘a problem’, or not gendered (Chant & Gutmann, 2002; Ratele, 2015). These dominant masculine constructs, known as heteronormative masculinities, largely inform development thinking (Cornwall, 2006; Jolly, 2011), and according to Jolly are typically applied to SRH matters (Terry & Braun, 2011a).

In this context Sharma’s (2009, p. 53) definition of heteronormativity is most relevant “...norms related to gender and sexuality ... keep in place patriarchy and compulsory heterosexuality as well as other systems and ideologies related to power”. Men are 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). This dualistic framing reinforces stereotypes about women and men and overlooks the multiplicity of masculinities and femininities that exist. It also oversimplifies gendered power relations (Barker et al., 2010; Cornwall, 2006; Ratele, 2015). Perhaps most importantly, this framing fails to acknowledge women’s agency or recognise or give voice to men who challenge inequitable gender norms and treat women equitably (Cornwall, 1997). Finally, this binary lens appears blind to the part that women play in perpetuating gender norms (Cornwall, 2006; De Keijzer, 2004).

In contrast, Mehta et al. (2004, p. 98) suggested adopting “[a]pproaches that view men in a positive way – as partners or allies” which they argue is “especially useful in redefining men’s involvement in the promotion of gender equity”. However, SRHR awareness campaigns that target men need to be cautious to avoid openly reinforcing patriarchy. De Keijzer (2004, p. 42) noted that there have been cases in other countries in which SRHR programmes effectively reached men, but at the same time reinforced 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).

The notion that gender is a relational construct also appears to be missing from the research context. Surprisingly, there are few gender studies that focus on both women and men, and while there are advantages in studying their experiences in isolation, there are “severe drawbacks when one is examining a subject such as reproduction” Gutmann (2009, p. 26). Reproduction and contraception research appears to favour women and “the underlying concern lies with reducing their fertility rather than with their power and autonomy as significant outcomes” (Greene & Biddlecom, 2000, p. 89).

Moreover, a lack of research about heterosexual men and their reproductive and contraceptive practices and experiences and their inter-relationship with women again reinforces assumptions about men and feeds into the oversimplified understandings of gender relations and masculinities (Gutmann, 2009; Terry & Braun, 2011a).

2.5 Why is family planning women's business?

Studies from diverse locations in the Global South suggest that men primarily make family planning decisions - including whether contraception is used, the type, and family size (L. MacDonald et al., 2013; Kabagenyi et al., 2014; Walcott et al., 2014). Men are, however, less likely to assume any responsibility for contraceptive use, as *both* men and women typically believe that reproductive health, and more specifically contraception, is 'women's business' (Drysdale, 2015; L. MacDonald et al., 2013; Onyango et al., 2010). Women are expected, therefore, to carry the burden of contraception usage, but for the most part lack the autonomy to make family planning decisions (L. MacDonald et al., 2013).

Gender norms and gender relations are reinforced by deeply embedded cultural (Onyango et al., 2010; Ratele, 2015) and religious practices. Colonisation and globalisation, too have shaped contemporary gender relations in many parts of the world and influenced concepts of manhood and womanhood in different contexts (Davis Lewis, 1998; Ratele, 2015; Tusitala Marsh, 2000). Davis Lewis (1998, p. 647) suggests that colonisation, Christianity and modernisation have had a profound and arguably negative impact on the lives of women in the Pacific, and in reference to present-day gender relations, states that "the politics of tradition and gender are intertwined and colored by colonial and missionary definitions of female and domesticity".

In much of the Pacific, gender norms are governed by hierarchical principles which determine social organisation, meaning that women are generally subordinate to men, but hierarchy can also be based on age, rank and other attributes (Underhill-Sem, 2011, p. 13). Inequitable gender norms can also foster power imbalances that invariably 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). Unsurprisingly therefore, gender norms have a profound impact on people's sexual and reproductive health.

Chetty and Faleatua (2015) acknowledge that, while diverse cultural and religious practices exist across the Pacific region and are constantly evolving, it is safe to say that generally these practices do not promote the realisation of SRHR for women. "Pacific Island patriarchal cultures, which sit comfortably embedded within contemporary religious practice, most commonly conservative Christianity, shape and constrain the opportunities

for realising rights” (Chetty & Faleatua, 2015, p. 12). That being said, societies are not fixed and cultures also evolve (Underhill-Sem, 2011), as was noted in Chapter 1 about early Kiribati society.

Gender norms at an institutional level also perpetuate the notion that family planning is the role of women (Jacobstein, 2015). For example, women-only family planning programmes discourage male involvement and responsibility (L. MacDonald et al., 2013), as a male participant in a West Kenyan study illustrates: “When family planning came, they started talking to the women and left the men out, so the men knew it was a woman’s affair” (Onyango et al., 2010, p. 39 & 40). This example highlights the way in which institutional gender norms can both cause and perpetuate gender inequality.

2.6 The influence of gender norms on family planning practices

Studies from diverse locations including Western Jamaica and Brazil have shown that men’s family planning practices are directly influenced by inequitable gender norms and masculine behaviours (Pulerwitz & Barker, 2008; Walcott et al., 2014). Men who favoured inequitable gender norms were less likely to actively avoid unplanned pregnancies (Walcott et al., 2014); in contrast support for more equitable norms was associated with higher contraceptive usage (Pulerwitz & Barker, 2008).

Conversely, Nanda et al. (2013), found that Tanzanian men’s attitudes to gender norms and their wives’ contraceptive usage were not related, and yet there was a correlation between women’s gender attitudes and contraceptive usage. Whilst there are some inconsistencies across these studies in terms of men’s gender equitable/inequitable attitudes and their partners’ contraceptive usage, there is consensus that when women have more equitable attitudes about gender, contraceptive usage is higher, highlighting the way that both women and men reproduce gender norms (Nanda et al., 2013).

Gender roles and norms affect spousal communication, ultimately shaping family planning decision-making (Hartmann, Gilles, Shattuck, Kerner, & Guest, 2012). A number of other studies have also identified connections between male involvement in family planning, spousal communication, and contraceptive usage (Feyisetan, 2000; Lasee & Becker, 1997), but the findings were not always consistent (Hartmann et al., 2012). Further, little is known

about the dynamics of communication that influences couples' family planning decision-making (Hartmann et al., 2012). However, results from a more recent study that examined the types of couples that opted to have a vasectomy in Rwanda demonstrated that greater inter-spousal communication can be correlated to higher family planning usage (Shattuck et al., 2014, p. 564).

It could be argued that, as with development programming and policy in practice, family planning research has also applied a women-only narrative, and that, not only is the relational aspect of gender invariably missing, so too are the men. Consequently, few studies appear to have explored spousal communication relating to family planning decision-making and male-centred methods of contraception, and how these are connected with more equitable gender relations, if at all.

2.7 Vasectomy and gender equality

As Chapter 1 noted, it is likely that gender equity is a precursor to vasectomy uptake. Notably, countries with high gender equity, such as New Zealand, Canada, Denmark and the United Kingdom, also have high rates of vasectomy uptake. Although research exploring connections between gender equitable relationships and vasectomy uptake appears almost non-existent, the Rwandan study, described earlier, did find that couples opting for this procedure had relatively equitable relationships (Shattuck et al., 2014). Further, men in a New Zealand study consistently stated that they had opted to have a vasectomy as it was their turn to accept contraceptive responsibility in their relationships (Terry & Braun, 2011a, 2011b), implying that these were equitable relationships.

Terry and Braun (2011a, p. 276) caution, however, that vasectomy uptake provides but “one measure of men’s involvement in reproductive and contraceptive actions” and that men’s willingness to have one actually involves “the negotiation of a complex set of social and psychological meanings related to masculinity, sexuality and contraceptive involvement”.

The authors suggest that by and large the discourse of the men in their study positioned their partners as “recipients of ...[their] efforts to be responsible, rather than co-actors in the process” (Terry & Braun, 2011a, p. 288). Whilst men mentioned their partners, at times

the men “downplayed the ‘couple work’ that may exist in the decision-making process” (Terry & Braun, 2011a, p. 288).

Whilst there is limited evidence to suggest vasectomy uptake is more likely in equitable relationships, the question remains, *does vasectomy acceptance promote more equitable behaviour?* Barker et al. (2010) contend that there has been a move away from single-focus programme interventions to tackle gender inequality, such as providing vasectomy. Other authors, however, posit that vasectomy promotes gender equality since it necessitates active male involvement in family planning, and it releases women from the responsibility for contraception (Jacobstein, 2015; L. MacDonald et al., 2013). In addition, studies have found that, even if men make the final decision (Bunce et al., 2007), couples will generally discuss vasectomy uptake jointly, which fosters inter-spousal communication. However, it is also possible that these couples would have talked about family planning anyway.

Vasectomy, in and of itself, is unlikely to change deeply embedded inequitable practices, since changing the gender order is particularly challenging and inequitable gender norms operate across all levels of society (Barker et al., 2010). As Barker et al. found, health programmes that adopt an ‘ecological model’ are more successful at effecting equitable behavioural changes in men. Such programmes seek to transform gender relations, promote gender equitable relationships and work at multiple levels of society, across multiple themes. This finding suggests that gender equitable practices that result as a consequence of a single-focus vasectomy programme are borne out because other factors are also at play, as my thesis seeks to explore.

2.8 Conclusion

This chapter introduced socially-constructed concepts of gender which underpin my thesis. I explained that these interrelated concepts determine what it means to be a woman or a man in a given cultural context, but that these concepts are not always fixed. Furthermore, concepts of gender ascribe socially acceptable behaviours, attributes and roles in society for women and men. I highlighted the way that gender, gender relations and power are embedded in social relations. I defined gender norms, and showed how gender norms are reproduced through these social relations. I stated that gender relations are explicitly

concerned with how power operates between women and men and that the overall system of gender relations in a society is known as the gender order. I introduced the concept of intersectionality, explaining that inequalities are not isolated to gender alone.

Next, I described agency, power and empowerment and looked at how these concepts interconnect. I demonstrated that there are many variations of power and agency, and that agency should not only be equated with decision-making. I explained that earlier notions of empowerment are most relevant to this thesis since these concerned issues of power and the relational aspect of empowerment.

I then examined different phases of development from the 1960s, specifically in relation to women's and men's place in development theory and practice. I explained why despite efforts to include men, development programmes continue to target women, particularly family planning initiatives. I established why this is unsurprising given that women continue to be disproportionately affected by gender inequalities; and yet it is also problematic, as doing so can reinforce inequalities. However, I also acknowledged that working with men is not without challenges.

I illustrated how institutional gender norms too, can cause gender stereotypes to be perpetuated, often with programmatic consequences, which I cover in more detail in Chapter 3. I argued that dualistic categories have been applied to women and men in development, and that these oversimplify gendered power relationships and fail to acknowledge multiple masculinities and femininities. I also suggested that the notion that gender is a relational construct appears to be missing from the GAD research context too, and that heterosexual men appear largely absent.

I explored why family planning is associated with women, and why this does not mean they necessarily have autonomy around family planning decision-making. I looked at how colonisation, culture and religion have influenced gender norms and gender relations, and how some practices are restrictive for women, and supported this with examples from the Pacific. Finally, I looked at current evidence that links vasectomy to gender equality and determined there is research suggesting that vasectomy is a consequence and cause of gender equitable relationships.

I will examine the literature on I-Kiribati women and men in Chapter 3, drawing on my analysis from this chapter. This analysis also forms the foundation for my findings and discussion chapters (5 and 6) that relate to the participants in this research.

Chapter 3 – I-Kiribati women and men: multi-faceted identities

3.1 Introduction

Chapter 3 builds on, and links to, the concepts and GAD theory and practice addressed in the preceding chapter. I start by questioning which model of development applies in the Kiribati context. Next, I engage with what is written about I-Kiribati women to better understand their lives in relation to men's lives. I then examine the role that men play in maintaining the current gender order. Subsequently, I scrutinise the way I-Kiribati women are framed by development discourse and present a range of arguments that contest this way of thinking. I conclude Chapter 3 by looking at hegemonic masculinities, relating this to I-Kiribati men; and provide an analysis of the ways I-Kiribati men are typically framed by development discourse.

3.2 The Kiribati context – WID or GAD?

Although there is limited literature that applies a gender analysis to development in the Kiribati context, it is likely that Kiribati follows Pacific trends. A study about gender mainstreaming in Kiribati, conducted by the Secretariat of the Pacific Community (2015, p. 3) states the following:

Contrary to a wide range of commitments that Pacific Island governments have made to achieving equality between men and women, women's perspectives and contributions continue in many cases to be on the periphery of development and governance dialogue.

In terms of development approaches, there is some evidence that a WID approach took precedence in the 1980s and 1990s in Kiribati. Ngaebi et al. (1993, p. 269), wrote "[a] major deficiency in the strategy which is being used to improve the status of women is that it is neglecting the most important problem – men... Everything is being directed at women". The authors observed that increased efforts to educate women suggested an awareness of the challenges women faced, and yet they felt that there was no point in women discussing how to make improvements in their families, "when the 'boss' is not there" (Ngaebi et al., 1993, p. 269). It was felt that husbands would often react angrily to suggestions to try new

things and were resistant to change (Ngaebi et al., 1993), which illustrates how men can destabilise women's development initiatives if they are not engaged in some capacity, as was discussed earlier.

The argument that development initiatives focused on women-only is also supported by a 2001 study on gender conflict and cooperation in reproductive decision-making. Brewis (2001, p. 391) noted that, consistent with other Pacific governments, family planning had been a concern for the past two decades, but that "Kiribati's family planning service efforts have focused almost exclusively on women...".

More recently, the Kiribati Government has demonstrated political will to put women at the centre of development, and to actively address gender inequality. In 2011 a Women's Development Division (WDD) was established. It now sits within the Ministry for Women, Youth and Social Affairs (MWYSA), which was set up in 2013. 'Gender mainstreaming' is now applied across legislation, policy, and programmes, meaning potential impacts for women and men are assessed to promote equal opportunities and avoid perpetuating gender inequalities (Secretariat of the Pacific Community, 2015).

Further, in 2004 Kiribati ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Government is actively working to tackle the issue of violence against women through legislative processes. For example, in 2014 the Government passed into law the *Te Rau N Te Mwenga Act* (Kiribati Family Peace Act) to end sexual and GBV (Australian Aid, 2017).

While it is evident that real efforts are being made to prioritise I-Kiribati women's development needs, the extent to which the Government and civil society organisations are addressing the relational nature of gender is less obvious. A stocktake of the gender mainstreaming capacity of the Government of Kiribati conducted in 2015 determined that one of the barriers to mainstreaming gender is that people equate 'gender' with women (Secretariat of the Pacific Community, 2015). If gender is equated with women, then arguably a WID model will continue to be standard practice.

3.3 Women in Kiribati society

There is an extensive body of literature, including government and aid agency documents, policy briefs and reports (Government of Kiribati, 2005; Maneaba-ni-Maungatabu, 2015; Secretariat of the Pacific Community, 2010, 2015), that provides insights into the status of I-Kiribati women. This tends to be written according to 'development needs', often by those in the Global North. Aside from two theses that specifically focus on I-Kiribati women (Mansfield, 2013; S. Rose, 2014) recent academic literature on this theme is limited.

While I-Kiribati women have contributed to a number of books (Ngaebi et al., 1993; Talu, 1984), these are quite dated and alternative accounts of I-Kiribati women's lives, written from their own perspective, accessible in English, are less prominent. Insights into how I-Kiribati women see themselves can however be drawn from other sources, such as poetry and interviews, but these prove less easy to source. Arguably, Ngaebi et al.'s. description of the status of women from 1993, although 25 years old, still presents a reasonably accurate picture, as many of the points that the authors make also appear in contemporary sources.

A woman's marital status and age largely determines her place in Kiribati society and being married with children is considered prestigious (Government of Kiribati, 2005). Customarily, when I-Kiribati women marry they move to their husband's household where they tend to hold a subordinate position and are expected to carry out the bulk of the housework (Maneaba-ni-Maungatabu, 2015). In the past, both women and men could inherit land rights, from either parent (B. Macdonald, 2001; Tito, Tiata, Teanako, Uentabo, & Arobati, 1984). However, priority was given to the eldest son who was normally allocated the best land.

Generally, women would give up their land rights once they moved to their husband's home (B. Macdonald, 2001). Yet, exceptions did exist. In certain cases, women did not forfeit their rights completely, for example, in the event that a woman was the sole female heir to an estate or if she decided to live with her extended birth family (B. Macdonald, 2001). Furthermore, the eldest son could forgo his rights to the best land, if his parents perceived him to be negligent in their care in their old age (Tito et al., 1984). In which case, the land and home would be given to a junior family member. Moreover, on Maiana, an island to the south-west of Tarawa, the gender norms associated with land rights also varied. Historically, the eldest daughter would inherit her mother's best land (Tito et al., 1984). In

the case of larger families with less land to share, the daughters, apart from the eldest daughter, would often inherit a *babai pit*⁵ instead.

These examples illustrate that there were variations in the dominant gender order in Kiribati, in the past. Having said that, Kiribati is largely a patriarchal society and men generally hold the balance of power across all levels of society – in the household, at the village level (Maneaba-ni-Maungatabu, 2015) and in government. 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), and the main provider. Nonetheless households headed up by women do exist (Female Government Health Official, personal communication, January 19, 2018).

As noted in Chapter 1, although I-Kiribati women have community obligations too, often associated with the *maneaba*, the *unimane* or elder men normally dominate community decision-making (Ngaebi et al., 1993). Few women are in positions of political leadership at either the local or national levels. In the past, women were not permitted to speak in the *maneaba*, although they would be present, seated behind the men and were noted as whispering their thoughts to the men throughout the deliberations (Ngaebi et al., 1993). It is however becoming more acceptable for women to speak in the *maneaba*, particularly for women visiting in a professional capacity – such as medical professionals to present information or to deliver a message (Ngaebi et al., 1993) – which is something I observed first-hand during my fieldwork.

While publically men continue to be regarded as the primary decision-makers in Kiribati society, I-Kiribati women’s rights to speak in the *maneaba* and other factors suggest that gender norms, attitudes and roles are subject to change. For example, in the early 1990s it was noted that, increasingly, I-Kiribati parents were placing a higher value on their daughters compared with their sons, and this links to the point that Tito et al. made about the land-allocation implications for negligent sons (1984). Ngaebe et al. (1993, p. 269) stated:

Daughters are simply more reliable – they do not drink or waste money – and are more likely to be able to look after their parents in their old age. This is already

⁵ *Babai* is a large tuberous taro-like plant and *babai pit* is the place where it is grown.

happening, at least on South Tarawa, and is a major change in Kiribati attitudes and culture.

Many Pacific women acknowledge that effective change for their betterment cannot happen without men, but at the same time, call for “‘male conceived’ and ‘male-controlled’ ideological structures to be feminised – that is for women’s active input in policies at all levels of society” (Tusitala Marsh, 2000, p. 150). Tusitala Marsh says that increasingly Pacific women realise that they need to be involved in decision-making, especially when their lives are directly affected. Hon Maere Tekanene, Kiribati’s Former Minister for Education, illustrates this point. “Domestic violence issues and concerns of women are not that highly voiced. For me, it’s important to have women in that decision making circle” (Australian Aid, 2017, p. 1).

Women’s groups and associations have played an important role in championing women’s issues in Kiribati. They are attributed with helping women to have a ‘voice’ at the community level, and in improving their status in society more generally (Ngaebi et al., 1993; S. Rose, 2014).

A contemporary example of how gender norms and gender roles are changing is highlighted in the following excerpt from an interview with Ekeata Taawa, a former KFHA youth volunteer, for a Family Planning New Zealand on-line news article titled *Life in Kiribati: A Woman’s Perspective* (2016, para. 9). When Ekeata was asked “*What kind of attitudes do people have about relationships in Kiribati?*” she said the following:

Well in my opinion, I think it is both the man’s and the woman’s responsibility to use contraception and protect against STIs⁶. But I think unplanned pregnancies are often blamed on women. I feel sorry for those women who don’t know anything about SRHR. I think it’s our job to go and deliver our message to them. In Kiribati, the man is the most powerful person in the home - but according to me and my partner, we are equal!

Changes to the status of I-Kiribati women are occurring beyond the household and community too. For example, more girls now attend high school than boys (Australian Aid,

⁶ Sexually transmissible infection.

2017). Notably, within the public sector there are significantly more women in senior leadership roles than men (Australian Aid, 2017). In 2017, 73 women were high level government officials, compared with 66 men (Australian Aid, 2017). A summary of the 2015 Census suggests that a recent slowing in the population growth rate might in part be due to more women entering the workforce and opting to use contraception to control their fertility.

...it is not possible at this stage to conclude firmly what is happening but it is getting very obvious these days that many women are getting into the workforce, and in some government offices, staff are mostly—if not all, women (National Statistics Office, 2016, p. 13).

3.4 Gatekeepers of the gender order

Although real endeavours are being made to address gender inequality in Kiribati, tackling gender inequalities is particularly challenging, as Chapter 2 illustrated. Generally, in the Pacific men are more powerful (Underhill-Sem, 2011) and act as gatekeepers of current gender orders (Kaufman, 2004). Gender inequalities, which privilege men, foster formal and informal benefits, such as material rewards and interpersonal power (Flood, 2015). Therefore, those in power have much to lose (Underhill-Sem, 2011).

Maintaining ‘culture’ is often used as an argument for not addressing gender norms that disadvantage women and for not challenging inequitable gender relations (Tusitala Marsh, 2000; Underhill-Sem, 2011). An excerpt from a poem by the Ni-Vanuatu poet Grace Mera Molisa, beautifully articulates this point:

Inadvertently
misappropriating
‘Custom’
misapplied
bastardised
murdered
a frankenstein

corpse
conveniently
recalled
to intimidate
women (as cited in Tusitala Marsh, 2000, p. 152).

Molisa's poem challenges "selective patriarchal pickings and constructions of culture" that are detrimental to women (Tusitala Marsh, 2000, p. 152). According to Tusitala Marsh Molisa uses her poetry to problematise concepts such as 'tradition'. While Molisa does not reject 'custom' *per se* she wants readers to think critically about how ideas that come under the banner of 'culture' are used to reinforce oppressive male power structures and to justify certain actions against women, such as violence (Tusitala Marsh, 2000).

In Kiribati for example, "...traditional norms teach women to accept, tolerate and even rationalise violence" (Kiribati National Statistics Office et al., 2014, p. 16) and women report being more accepting of violence directed at them than men. Violence towards women is particularly acceptable for behaviour that is perceived to require correction (De Keijzer, 2004) – in other words when women do not comply with their prescribed gender roles (Secretariat of the Pacific Community, 2010). Women's disobedience, neglecting the children and infidelity are all given as legitimate reasons for men to use violence (Secretariat of the Pacific Community, 2010).

Gender inequality is not just restricted to GBV, however. It manifests itself in other wide ranging ways in Kiribati, including poor SRHR outcomes, as discussed in Chapter 1, and women assuming the heaviest workloads at home and in the traditional economy (Maneaba-ni-Maungatabu, 2015). I-Kiribati women, like women around the world, perform multiple roles. Moser (1989, p. 1801) says women globally have three key responsibilities – reproductive, productive and community management, which she describes as 'the triple role of women'. Women's 'reproductive work' involves caring for, and maintaining ones' families (Kabeer, 2003). 'Productive work' includes both formal and informal work and "comprises work done by both women and men for payment in cash or kind" (Moser, 1993, p. 31). 'Community managing' is, as the name suggests, work done "at the community level around the allocation, provisioning and managing of items for collective consumption"

(Moser, 1993, p. 34). I-Kiribati women appear to disproportionately perform these three roles, compared with men, suggesting that the division of labour is less equitable in Kiribati.

3.5 Beyond the vulnerability narrative – women’s agency

Although the seriousness of gender inequality in Kiribati should not be downplayed, it is also important to note that development discourse has the effect of rendering invisible other narratives about I-Kiribati women, and so while these concerning situations exist there are also other experiences that are rarely articulated. Factors such as gender, age, extended family group, marital and socio-economic status, religion, level of education, role in the community, island of birth, whether a person lives in an urban setting or on an outer island (Chetty & Faleatua, 2015; McEwan, 2001) all intersect to determine a person’s multi-faceted identities and positionalities in society (Davis, 2008); yet the dominant narrative tends to treat all I-Kiribati women as the same. Development discourse appears not only to homogenise I-Kiribati women, it consistently adopts a deficit model to describe their lived experiences, which is the case that Mansfield (2013, p. i) made in her research. She examined how discourses of vulnerability in relation to climate change and migration position I-Kiribati women and noted:

It is not new for either Pacific Islands or women to be framed as “vulnerable”; however with the increased attention to climate change, vulnerability discourses are being used with such frequency that it is virtually impossible to find literature on the Pacific and women that does not reference their vulnerability.

I concur with Mansfield and suggest that references to I-Kiribati women and the ‘vulnerability’ narrative run across many different issues more generally, including SRHR. In fact, a more comprehensive discourse analysis would likely highlight that negative depictions of I-Kiribati women appear the norm. Throughout the course of my research I too struggled to find literature that avoided universalisms and that did not frame I-Kiribati women as subordinate (to men), vulnerable (to climate change, teenage pregnancy, GBV and so on), without agency and as fundamentally disadvantaged, as the following excerpt from a journal article on HIV risk in Kiribati illustrates:

It is in this context of high unemployment, overcrowded living conditions, a culture of hardship and domestic oppression of young women, and the endemic nature of physical and sexual abuse that some young women ...choose to work on board foreign fishing vessels selling sex” (McMillan & Worth, 2014, p. 237).

According to Chant (2000), simplistic dualisms are often applied during the gender analysis process which frame women in one way and men in an oppositional way. “Women are established as a vulnerable group with limited ability to resist oppression by their ‘villainous’ male counterparts” (Chant, 2000, p. 10). Such an approach has the effect of discrediting women’s agency and ignores men who are actively practising more equitable relations. Further Mohanty (1991) argues that it objectifies women. Women are analysed in terms of the way they are affected or not affected by certain institutions or systems rather than acknowledging that women are produced through such relations and that they themselves are implicated in the formation of these relations. Mohanty, as with other feminists from the Global South, argue that Northern feminists too are complicit in generating these simplistic narratives.

Understandably, simplistic framings of women (and men) have real consequences for development research, policy and practice. “Conceptualizations of problems that treat women in the developing world as abject victims stripped of all agency lead to responses that prioritize the interveners’ judgement about what these women need” (Cronin-Furman, Gowrinathan, & Zakaria, 2017, p. 6). Mosedale (2005, p. 245) argues that instead, an “[a]nalysis of women’s position should ...be based on the realities of their lives rather than on a generalized assumption that they are oppressed”. This way of thinking is backed-up by Underhill-Sem (2011) who calls for dynamic understandings of gender and culture in the Pacific. She too, is critical of treating women as a homogeneous group and posits that “these practices conceal the more exciting opportunities for advancing women’s equality and overall human development” (Underhill-Sem, 2011, p. 4)

A less common articulation of I-Kiribati women, therefore, is that they are ‘agents of change’. S. Rose (2014) determined that I-Kiribati women played a pivotal role in the decolonisation process, prior to independence, and yet are absent from the historiography of the decolonisation of the Pacific. Tusitala Marsh (2000) supports Rose’s finding. Drawing on experiences of other women globally, she writes: “[w]omen have fought alongside men

in struggling for independence but are neither acknowledged nor rewarded with the same quality of benefits (pp. 149-150).

Mansfield (2013) also framed I-Kiribati women as active agents of change in her thesis; however, she concluded that women can be both vulnerable and agents of change and asserted that it is an oversimplification to position women as either 'vulnerable' or 'agents of change' in relation to climate change. Arguably, multiple variations exist between these two somewhat dualistic categorisations. In other words, women's experiences and positionalities are complex.

3.6 I-Kiribati men – hegemonic masculinities and beyond

Descriptions of I-Kiribati men, as with women, are also confined to certain narratives, and arguably these narratives are both heteronormative and premised on the notion of hegemonic masculinities, as noted in Chapter 2. In other words, the main thinking is that in Kiribati, consistent with the international literature, masculinities all comply with dominant attributes and behaviours and heterosexuality is both assumed and enforced as the norm (Connell, as cited in Jewkes et al., 2015, p. 1582). Whilst the topic of masculinities does not appear to have been explicitly addressed in Kiribati, studies from other parts of the Pacific would also support this argument. For example, Teaiwa (2005) found that hyper masculine activities, such as the military and rugby, represented cultural expressions of idealised masculinities in Fiji. It can therefore be inferred from the literature that I-Kiribati men conform to dominant notions of manhood and are expected to be: physically strong, breadwinners, decision-makers, powerful, to control women, and to be (hetero) sexually capable (Jewkes & Morrell, 2010; Sweetman, 2013).

In describing I-Kiribati men, Ngaebi et al., (1993, p. 266) wrote:

While the husband was the main provider of food through fishing and planting of *babai*⁷, he would have taken very little interest in the day-to-day happenings in the family. Politics, however, was officially men's work.

⁷ A large tuberous plant, like taro.

The notion of hegemonic masculinity is closely linked to heterosexual behaviour (ICRW, 2010). Research from a study conducted on Butaritari, an island to the north of Tarawa, revealed that male partners almost exclusively dictated the frequency and timing of sex, and that women were expected to comply (Brewis, 1993). The author noted “[f]requent requests for intercourse are one manner in which men signal their continuing domestic control” (Brewis, 1993, p. 606). Earlier research by Brewis (1992) found that families tolerated and even encouraged young men to gain sexual experience before marriage; however, young women were expected to be virgins.

Failure to conform to hegemonic masculinities through an inability to live up to what is socially expected, has significant consequences. When men are unable to gain employment or are underemployed, for example, they cannot perform their expected role as breadwinner or provider and are generally seen as failing (Ratele, 2015; Sweetman, 2013). In Kiribati, rates of suicide are highest for men, and particularly high for young men (Government of Kiribati, 2005). While it is believed that these high rates are due to mental health issues, relationship break-ups and heavy alcohol use, it is also likely that young men are caught between traditional and changing cultural expectations and that they possibly feel unable to effectively fulfil either.

Tensions around masculinities can also result in socially-condoned violence, particularly towards women and girls (Sweetman, 2013). South Tarawa has significantly more social problems than the outer islands, including unemployment, economic hardship and a higher cost of living (Secretariat of the Pacific Community, 2010), which can impact men’s feelings of self-worth and ability to provide for their families. Alcohol, which is also closely linked to heteronormative male behaviour (Lemle & Mishkind, 1989; Mullen, Watson, Swift, & Black, 2007), is also more readily available (Secretariat of the Pacific Community, 2010). These factors increase women’s risk of abuse. Perhaps unsurprisingly, levels of GBV are highest in South Tarawa, compared with rates on the outer islands (Secretariat of the Pacific Community, 2010).

Entrenched gender norms can reinforce hegemonic masculine behaviours and men, like women, can be harmed by these (Sonke Gender Justice Network, 2013). Men are less likely to utilise health services, including HIV and STI services; challenge violence against women and children; be actively engaged in their children’s lives; and support partners to access health services (Sonke Gender Justice Network, 2013). A study on HIV risk amongst I-Kiribati

seafarers also illustrates the link between entrenched gender norms and hegemonic masculine behaviours (McMillan & Worth, 2014, p. 236). The authors noted:

Kiribati seafarers typically subscribe to the traditional gender roles and attitudes that remain dominant in the region, and are resistant to talking openly about sex and sexual health or negotiating safe sex with their partners.

Moreover, rigid gender norms are also associated with high risk-taking behaviours, such as unsafe sexual practices and heavy drinking, which not only jeopardises men's health but also their partners', highlighting that dominant gender constructs can also be harmful to men (Sonke Gender Justice Network, 2013). Risk-taking behaviour is quite prevalent amongst seafarers, for example and includes "infrequent condom use in casual and paid sexual relationships" and heavy alcohol use (McMillan & Worth, 2014, p. 236). Yet, Correa and Jolly (2008) argue that development discourse invariably applies such essentialist framings to women's and men's sexualities. These authors suggest that men are often portrayed as having uncontrollable sexual desires, while women are positioned as 'innocent', especially in terms of issues of unsafe sex. Correa and Jolly contend that when sexualities are treated in this way gender stereotypes are reinforced, which can result in development interventions that are unable to adequately address SRHR issues and make women even more sexually constrained.

While the dominant narrative suggests that I-Kiribati men conform to heteronormative masculinity, arguably men's identities are multifaceted and other masculinities must exist. There is evidence that amongst seafarers, men display behaviours that challenge heteronormative constructs, such as feeling vulnerable. For example, an earlier study of seafarers found that men can experience extreme homesickness while being away from home for extended periods (Borovnik, 2005). One participant in the study said: "*I sort of started feeling lonely and started feeling very homesick*" (Borovnik, 2005, p. 150). When he was asked what he most missed about Kiribati, he said his family. I would contend that a man's willingness to openly discuss feeling homesick indicates that some men do not feel that they have to simply 'man-up'.

Further indication of men's vulnerability is their widely reported feelings of conjugal sexual jealousy known as *koko* (Brewis, 2001, p. 396). A number of studies have determined that men can be very resistant to their wives or partners using contraception as they fear

infidelity will occur (Brewis, 2001; Daube et al., 2016). While this obviously highlights men's power over women, it could be argued that it also indicates feelings of men's self-doubt or insecurity.

Applying universalisms to describe I-Kiribati men fails to capture the complexity of masculine constructs that exist in present-day Kiribati society. Men too are multi-faceted and as with women, their gendered identities have been shaped by many factors, that I described in Chapter 2. Wetherell and Edley (1999, p. 352) posit that when thinking about masculinities "[w]e need to consider the multiple and inconsistent discursive resources available for constructing hegemonic gender identities" and that an either/or analysis is limiting.

3.7 Conclusion

In this chapter, I reviewed local and international literature to provide insight into I-Kiribati women's and men's lives relative to one and other in Kiribati society. This analysis gave some sense of normative gender relations in Kiribati society. I situated Kiribati in terms of GAD theory and praxis and made connections with the literature previously addressed in Chapter 2. I also highlighted the way that gender roles and relations are not static and that women's lives are changing in Kiribati. I also showed that contradictions can also exist in women's lives and between women. Next, I explained why men can feel motivated to maintain the current gender order and how some men's inequitable power can and does result in gender inequalities that can harm women.

I critiqued the vulnerability narrative that is often applied to I-Kiribati women and drew on a range of feminists' viewpoints to explain why this is so commonplace in development discourse, and why this practice can be so limiting to development research, policy and practice. I then offered some alternative narratives. I ended the chapter by looking at I-Kiribati men's lives and applied their situations to widely understood notions of masculinities. Again, I critiqued the dominant narrative and suggested that as with women, alternative narratives must exist.

While I attempted to present multiple perspectives, move beyond generalisations which treat all women and men as a homogeneous group, I was constrained in part due to the

restricted narratives that exist in the literature about I-Kiribati women and men. The discussion in Chapter 3 provides context for the exploration of gender relations in subsequent chapters. In the next chapter, I will describe my methodology. I will then revisit aspects from this chapter in Chapters 5 and 6, when I introduce the participants' voices.

Chapter 4 – Methodology and fieldwork reflections

4.1 Introduction

This chapter provides an overview of my research methodology, supported by reflections from my fieldwork and the research process itself. I begin by describing my research methodology and rationale for using a qualitative approach. I then discuss case study research design and how it aligns with both a qualitative approach and a feminist framework, making it ideal for this study.

Next, I describe my field research co-ordination, including relationship building. Subsequent sections focus on participant recruitment, the participants themselves and my rationale for undertaking in-depth interviews, focus group discussions and interviews with key informants. I weave my reflections, ethical practices and limitations into the body of this chapter rather than addressing these topics as stand-alone sections. I then explore how I generated the data and the methods that I used to analyse it. To conclude, I describe my acts of reciprocity.

4.2 Methodology

As described in Chapter 1, social constructivism and feminist theory informs my methodological approach. Feminist methodology provides a means to analyse the complex interrelationships between gender, race, sexuality and class which, although distinct, are also inextricably interlinked with dominant structures of power (Pillow & Mayo, 2007). As I acknowledged at the start of this thesis, I am an I-Matang researcher from a 'Western' institution, which is arguably problematic. While I cannot alter my non-indigenous status, I have tried to be true to a feminist approach and was therefore attentive to ethics, issues of power, and the politics of representation and knowledge production.

In keeping with my feminist framework, I used a qualitative approach. Creswell (2014) suggests qualitative research is used when the researcher seeks to understand how individuals or groups give meaning to a social or human 'problem' and make explicit complex situations. This approach allowed me to conduct an in-depth enquiry into the gendered "feelings, perceptions, attitudes, values, beliefs and experiences" (Kumar, 2014,

p.18) of participants in relation to decision-making in couples, and with regards to vasectomy; and to explore the complex socio-cultural processes underpinning their behaviours and practices (Kabagenyi et al., 2014). Further, a qualitative approach promoted flexibility in the research design, analysis and write-up (Creswell, 2014).

4.2.1 Case study approach

I explored connections between vasectomy acceptance and equitable gender relations using an embedded case study research design. Yin (2014, p. 16) defines a case study as: “[a]n empirical enquiry that: investigates a contemporary phenomenon... within its real-life context”, and that draws on multiple methods of data gathering and sources of evidence. Case study and feminist research approaches are particularly useful when the boundaries between the phenomenon and context are blurred (Yin, 2014), and both “can open up the research to a more complex and nuanced understanding of issues” (Sultana, 2007, p. 376). In addition, case study research is attentive to a variety of contextual influences at a variety of scales” (Baxter, 2010, p. 95). In other words, greater value is placed on context-dependent knowledge.

Yin (1989, p. 14) posits that a case study “...allows an investigation to retain the holistic and meaningful characteristics of real-life events”. Cases can be “a program, event, activity, process or one or more individuals” and “are bounded by time and activity” (Creswell, 2014, p. 14). A case study therefore enables an in-depth analysis of a bounded system (Merriam, 2009). “The case itself is important for what it reveals about the phenomenon and for what it might represent” (Merriam, 2009, p. 43). Moreover, a case study is defined by its ‘unit of analysis’, not the topic being explored (Merriam, 2009).

The unit of analysis for my study was the connections between vasectomy acceptance and equitable gender relations. I used an embedded case study design, since it included multiple cases within the broader case study (Yin, 1994) of vasectomy acceptance and equitable gender relations between married couples in Kiribati. In other words, the gender relationships of the five I-Kiribati couples in which the husband had had a vasectomy, and the six I-Kiribati couples in which the men had not been vasectomised, comprised 11 ‘embedded cases’ (Section 4.6) within the broader case study. I also analysed other sources

of evidence, including key informant interviews and secondary data. This data contributed to the comparative analysis that I carried out within, and between, the embedded cases in order to explore the phenomenon of vasectomy acceptance and equitable gender relations.

As a case study involves multiple methods and draws on multiple sources of evidence, it can produce an overwhelming amount of data that needs to be analysed (Hodkinson & Hodkinson, 2001; Yin, 1994). Unsurprisingly, this can result in case studies being time consuming and costly too. While the upside of using multiple sources of evidence is that a case study can result in rich, contextual insights of a phenomenon, the sheer volume of data can make analysis challenging. Hodkinson and Hodkinson (2001) note that case studies can bring to light complex situations, yet this complexity can be difficult to represent in an accessible and simple way. “When case studies are successful in revealing some of the complexities of social ... situations, there is often a problem of representation” (Hodkinson & Hodkinson, 2001, p. 9). These authors argue that this issue arises in part because writing is a linear process, but the information that comes from a case study is not.

A further critique of the case study is that the findings cannot be generalised to the wider population (Hodkinson & Hodkinson, 2001; Yin, 1994). It is important to note, however, that this is not the purpose of an exploratory case study, and that making generalisations about populations is something that feminist researchers seek to avoid so rather than limiting my research, this was actually a benefit. Additionally, although case study findings cannot be generalised in the conventional sense (Hodkinson & Hodkinson, 2001), the results are “generalizable to theoretical propositions” (Yin, 1994, p. 10).

Whilst the case study research design proved very effective given the complexity of this type of research, I was mindful of indigenous critiques of ‘Western’ research approaches and discourse (Smith 2012; Wesley-Smith, 2016). Methodologically, it was important to clearly define my unit of analysis and what constituted a case, and yet, referring to participants as ‘cases’ arguably dehumanises and objectifies them.

Wesley-Smith (2016, pp. 156-157) has coined the term ‘laboratory rationale’ to describe one of the justifications given for studying the Pacific. He argues that “the ‘laboratory rationale’ values the Pacific Islands and Pacific Islanders primarily as objects for study” (Wesley-Smith, 2016, pp. 156-157). Being conscious of this critique, I adopted a research ethos that is

implicit in the following quote by Epele Hau'ofa (as cited in Wesley-Smith, 2016, p. 158), who was a Tongan Fijian academic:

We must devise ways . . . to tap instead of suppress the subjectivity to which I have referred and thereby humanise our study of the condition of the peoples and cultures of the Pacific.

Further, I refrain from using Westernised case study discourse throughout the rest of my thesis and refer to my participants as 'couples' or by their individual pseudonyms rather than saying Case 1,2, 3 and so on.

4.3 Developing my research design

This research evolved through collaboration with Family Planning New Zealand and KFHA. Both organisations are full-members of International Planned Parenthood Federation (IPPF) and have an existing relationship with each other. KFHA, a non-government organisation, is the leading provider of SRHR services in Kiribati, including vasectomy provision.

Ideally, I would have worked with KFHA on the research design from the outset since feminist and indigenous research practices encourage a collaborative approach (Came, 2013; Sultana, 2007; Vaioleti, 2006), but was limited by time and geographical constraints. I was fortunate, though, to draw on the knowledge and contextual experience of two visiting KFHA staff members prior to going to Kiribati, which contributed to my research design.

Additionally, I established relationships with two students from Kiribati attending my university in Wellington – a female undergraduate, and a male postgraduate – to develop my cultural competency. Our meetings over a six-month period proved invaluable and thoroughly prepared me for fieldwork. I learnt about culturally appropriate behaviour, and expectations of I-Matang researchers, and gained practical tips about living in Kiribati. Engaging with a young woman and a more mature male was beneficial since they had different perspectives, and it also gave me early insights into gender roles and relations in Kiribati.

Before travelling to Kiribati, I received Victoria University of Wellington Human Ethics Committee approval, and was granted a field research visa from the Kiribati Government.

However, the ethical framework for this research went beyond institutional requirements. Fundamentally, principles from feminist research practices, as detailed in Chapter 1, guided my research conduct.

Consistent with ‘emergent design’, I applied the following research methods adaptively: informal in-depth interviews, focus group discussions and key informant interviews. Creswell (2014, p. 186) writes that methods cannot be “tightly prescribed”, as aspects of the research may change after entering the field and once the researcher starts collecting data. Consequently, I only finalised how I applied my methods in practice after I had collaborated with KFHA staff in Kiribati. After data collection started, I also made adjustments according to ongoing feedback from KFHA and the participants themselves. Being willing to have an organic and evolving research design allowed me to be flexible in the field, uphold feminist research principles, and, most importantly, be more respectful of I-Kiribati cultural practices.

4.4 Collaborating with KFHA in the field

I arrived in Kiribati in early January 2017 with my husband Adrian Kearns. Adrian had agreed to provide voluntary IT support to KFHA for two weeks at the start of my field research. We were invited to base ourselves at KFHA, which allowed full immersion in Kiribati culture and to gain insights into the provision of SRH services in Kiribati. I took time at the start to grow my relationships with KFHA staff and build their trust. I recognised their expertise and was guided by their local knowledge so my research design was ultimately more sensitive to the Kiribati context.

Starting slowly also enabled me to honour the principle of reciprocity, a concept from feminist and indigenous research practices, which is underpinned by the notion that research is a two-way process and that researchers should not simply serve their own needs (Came, 2013; England, 2008). Therefore, I endeavoured to show my commitment to KFHA through my everyday actions, such as helping staff to edit reports. Further, my husband’s voluntary work with the IT Officer and wider organisation went a long way towards cementing our solid relationship with KFHA.

Consequently, I had KFHA’s full support. The staff acted as translators, focus group facilitators and note-takers in addition to recruiting participants, setting up interviews and

related activities. I worked closest with one of the male nurses, Abureti⁸, a highly experienced nurse in his late fifties, who specialised in vasectomy procedures. Given the sensitive nature of the research it was particularly beneficial working with Abureti, since he had an established relationship with all the participants.

The KFHA staff significantly aided the research process. Staff were comfortable discussing SRH topics and understood the need to protect participants' confidentiality, since this was a requirement of their work. Furthermore, they were of a similar age and life-stage as the participants. Any KFHA staff member who worked directly with the participants signed a confidentiality agreement (Appendix C).

My schedule was loosely guided by a research programme that KFHA's Executive Director, Tekarei⁹, asked me to generate. Things did not always go to plan, but I remained flexible so that I could more readily accommodate last-minute changes; for example, there were a few occasions when other staff had to step in at short notice to support me. I valued the time commitment that KFHA was making on my behalf, and was mindful that I should be the one to fit in, and not the other way round.

4.5 Cultural guide/ research assistant

David Kakiakia¹⁰ a former SRHR Peer Educator with Kiribati Youth Initiative Association (KYIA), acted as a paid cultural guide and research assistant and complemented KFHA's support. I hired David to minimise the demands that I placed on KFHA staff. Since we had met previously in 2015, it did not take us long to establish an effective working relationship.

I gave David some basic training in qualitative research and created a position description to formalise the role. David had considerable experience running workshops and took the lead in coordinating the focus group meetings allowing me to concentrate on the in-depth interviews. Additionally, he assumed the position of note-taker (men's focus group only),

⁸ Pseudonym.

⁹ Pseudonym.

¹⁰ I asked David if he wanted me to use a pseudonym to hide his identity in this thesis as I have for the KFHA staff and participants, but he said that he would like to be identified. Consistent with his wishes, I use his first and last name.

translator and transcriber, as well as providing ongoing cultural advice during my data analysis and write up. As with the KFHA staff, David signed a confidentiality agreement.

I valued David's knowledge and prior expertise facilitating workshops. David was very comfortable being direct with me, which was refreshing. He shared his ideas with confidence, and willingly voiced any concerns he had with my ideas. Unlike some of my other working relationships, there were no noticeable power inequalities in our relationship, even though he was considerably younger, and we had markedly different backgrounds.

4.6 Participants

KFHA staff identified and recruited participants using purposive sampling, which involved finding participants who had relevant knowledge of the research topic, and who were willing to participate (Kumar, 2014). More important was finding variation amongst participants so that a range of views and experiences was more likely to be revealed. Each of the methods that I used required a slightly different approach to participant recruitment (see Sections 4.7 – 4.9).

The in-depth interview and focus group participants were drawn from communities across South Tarawa, including: Banraeaba, Betio, Bikenibeu, Eita, Nowerewere, Teaoraereke, and Temaiku. Participants ranged in age from 25 – 55 years, and each had from two – eight children. The average age of the male in-depth interview participants was 43 years, closely matching the average, of 44 years, for the men who took part in the focus group discussion. Equally, the women's ages were also similar across the two participant types: the in-depth interview participants were on average 38 years old, while the average age of the women from the focus group was 39 years. The average number of children was also similar. On average, the in-depth interview participants had four children, while the focus group participants had four and a half children each.

On average, the 10 in-depth participants completed formal schooling in Form 3 (three years of junior high school), whilst the majority of focus group participants did not have formal schooling beyond primary level. Of the in-depth interview participants, only one person was in formal employment and one couple had a business. Similarly, most of the 17 focus group

participants did not have formal employment. Three participants had jobs, and three participants had their own business or were self-employed.

Participants' details and detailed demographic information are shown in Tables 5.1 – 5.5 in Chapter 5. I did not, however, collect demographic information for the key informants, but sometimes this was voluntarily divulged.

4.6.1 Ethical considerations

Participation in the research was voluntary. During participant recruitment, KFHA's client list was not shared with me to protect client privacy. Provisions I had expected to put in place to prevent the in-depth interview participants feeling coerced to participate became unnecessary, since it was clear that Abureti, the male nurse, had integrity, and at no point did I feel his former clients had felt pressured to take part. Further, the mutual respect they had for each other was evident.

All participants received an information sheet translated into Kiribati (Appendix A), as well as having the contents explained to them in the Kiribati language. In all instances, participants' rights were reiterated at the beginning of each session and participants then signed a consent form (Appendix B). All agreed to have their interview recorded.

To protect participants' identities, I have used pseudonyms and other descriptors unless participants requested otherwise, and, where necessary, have masked other identifying characteristics (Dowling, 2010). Key informants are described by their professional capacity, such as 'health professional', to provide contextual information. Whilst KFHA staff are named in my acknowledgements, I have only used pseudonyms or described staff by their position for the remainder of my thesis. In both cases I confirmed with them that this was appropriate.

4.7 Informal semi-structured in-depth interviews

4.7.1 Participants and participant recruitment

I had intended interviewing four to six couples where the husband had had a vasectomy and five couples agreed to take part. Although I planned to interview men with recent experiences of vasectomy – in the last two years – cross-cultural miscommunication meant this did not happen in practice. Across the five couples, the length of time since the men had been vasectomised varied from as recent as the previous year, to over five years ago.

4.7.2 In-depth interviews

In keeping with my qualitative methodology, I used semi-structured in-depth interviews, as this method allowed the participants to share their own views and experiences, express what was relevant to them within the context of their lives (Dunn, 2010), and to give rich and detailed answers (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). Since informal interviewing is also more personal, it was appropriate for my sensitive research topic and more easily adapted to the Kiribati setting.

Moreover, semi-structured in-depth interviews promote flexibility, since open-ended questions are used; not all questions are pre-determined; and other themes that emerge during the interviews can be explored (Barbara & Benjamin, 2006). I created a question guide with input from Abureti, (Appendix D), gaining ideas for suitable questions from a study on vasectomy uptake in Papua New Guinea (Drysdale, 2015) and one conducted in India (Scott, Alam, & Raman 2011).

In keeping with my qualitative methodology, I used semi-structured in-depth interviews, as this method allowed the participants to share their own views and experiences, express what was relevant to them within the context of their lives (Dunn, 2010), and to give rich and detailed answers (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). Since informal interviewing is also more personal, it was appropriate for my sensitive research topic and more easily adapted to the Kiribati setting.

Moreover, semi-structured in-depth interviews promote flexibility, since open-ended questions are used; not all questions are pre-determined; and other themes that emerge

during the interviews can be explored (Barbara & Benjamin, 2006). I created a question guide with input from Abureti, (Appendix D), gaining ideas for suitable questions from a study on vasectomy uptake in Papua New Guinea (Drysdale, 2015) and one conducted in India (Scott, Alam, & Raman 2011).

Whilst in-depth semi-structured interviews have many advantages, the method is not without its limitations. The researcher is not neutral (discussed in Section 1.7) and an interview is not a neutral process either. As Hammersley (2008, pp. 98-99) argues, an interview is shaped in part “by the questions they [the participants] are asked; by conventions about what can be spoken about, by whom and to whom, and so on”. Furthermore, participants will not necessarily provide answers that reflect what they think and feel about the issue, but might respond according to what they think the researcher wants to hear or “by what they believe he or she would approve or disapprove of” (Hammersley, 2008, pp. 98-99). Consequently, Hammersley (2008, p. 99) encourages researchers to “take account of the interactional dynamics of any interview in interpreting the data”.

It is also important to acknowledge that an interview is quite different from a ‘normal’ conversation (Hammersley, 2008). Moving between questions and answers can pose a challenge and it is by no means a straight forward process (O’Leary, 2017). As O’Leary (2017, p. 241) notes “[m]isunderstandings and misinterpretation are all too common”. Additionally, conducting a semi-structured interview can limit the variation in responses, since the questions are standardised (Hancock & Algozzine, 2006).

Although it was not possible to eliminate these limitations, I did take steps to address them where possible. For example, I did not rely solely on my interview data but instead triangulated data from diverse sources, which is a practice Hammersley (2008) recommends. Just as importantly, I adopted reflexive practices throughout the interview process and was conscious of the limitations during the data analysis and write-up. Nicholls (2009, p. 118) maintains that undertaking counter-colonial research requires going beyond self-reflexivity to “...engage with reflexive evaluation of collective and negotiated design, data collection and data analysis to consider the interpersonal and collective dynamics during the research process...”.

After the interviews started, I realised some of the questions were too abstract, making it hard to elicit responses. Moreover, my efforts to use indirect questions to avoid causing participants discomfort when discussing sensitive issues frequently caused ambiguity. I therefore worked iteratively by modifying my questions and, up to the last interviews, made changes.

The translators also adapted the questions and became adept at rephrasing questions to better suit the Kiribati language, or the level of comprehension and education of the participants. At times the translator also struggled to understand the question, so interpretation was involved. Conducting the interviews was a learning exercise for me, but also for the KFHA staff, and it was as much about negotiating my relationship with the translator, as it was about my relationship with the participants.

I conducted a total of 15 informal semi-structured in-depth interviews, including five couple interviews, and then 10 interviews with each husband and wife individually. These interviews were conducted in their homes, so couples could feel more at ease. At the initial interview each spouse was present, and it generally took 45 minutes. On a later date, we interviewed the husband and wife separately, and these interviews varied in length from 30 minutes to one hour.

Abureti accompanied me to interview the couples, and to most interviews with the men, while a female member of the KFHA staff attended the wives' interviews. In keeping with Kiribati culture, we sat on the ground, generally on a woven mat. I used the first interview with each couple to build trust and to give them an opportunity to learn something about me.

As I discussed in Chapter 3, I-Kiribati women generally defer to their husbands, so it was unsurprising that the husbands led most of the responses in all but one case during their joint interviews. During individual interviews, women could more readily convey their own thoughts. Individual interviews also highlighted divergences in views between partners, and between other men and women. According to Mack et al. (2005), semi-structured in-depth interviews should bring to light nuances and contradictions in participants' views, and this proved true in my research. For example, I noted in the interviews with the wives on their own, and with only women present, that they disclosed things that they may not have divulged if a man had been present, or they were in the presence of their husband.

Given that I attended the men-only interviews, this may have also prevented the men talking as freely, although surprisingly, some men still revealed some quite personal information. It is unclear whether this would have occurred if an I-Kiribati woman was present, so in this instance my 'outsider' status was perhaps an advantage.

Feminist and indigenous research practices encourage the researcher to be mindful of issues of power during all the stages of the research process, but particularly when the researcher is working directly with the research participants (Came, 2013; Chacko, 2004; England, 2008; Farrelly & Nabobo-Baba, 2014; Sultana, 2007; Vaioleti, 2013). Power is, however, a complex phenomenon, and I had to be mindful that it was operating across multiple relationships during the interview process. Power did not just exist between the participants and me, it was also present between the translator and me; the translator and the participants; and between the husband and wife themselves. .

Although I could not eliminate any unevenness in power between myself and the participants, I attempted to lessen my power by acting with cultural integrity, being humble and by meeting the couples on their terms. Working respectfully alongside a staff member from KFHA also changed the power dynamic. I was aware, however, that some of my power was destabilised by my inability to speak the Kiribati language. The translator and couples could choose, consciously or unconsciously, to exclude me from their conversations, and the translator controlled what was then shared with me, which was a research limitation. However, this also highlights how participants and indigenous research assistants can assert their agency in the research process. I used these reflections to shape subsequent interviews.

4.7.3 Ethical considerations

My formal ethical obligations were sometimes at odds with the realities of conducting research in Kiribati. While I made provision to ensure participant privacy during the field research, it soon became clear that concepts of privacy in Kiribati culture differed from 'Western' notions of confidentiality. Sultana (2007, p. 374) argues that,

there are critical disjunctures between aspects of everyday behaviour in the field and the University's institutional frameworks that aim to guide/enforce good ethical

practice, as the conduct of fieldwork is always contextual, relational, embodied, and politicized.

This resonated with my experience, and did cause me some tension. Few of the houses in which I conducted the interviews had separate rooms and rooms served multiple purposes. Additionally, Kiribati has a communal culture, so if people were home they were generally together. Naturally children and others were around. For example, in one home, the participant's wife and women friends were making garlands; during another interview, a second male nurse performed a circumcision on the participants' son while we interviewed the couple. When family or friends were present, I took my cue from the participants. If the participants were comfortable speaking about sensitive things in front of others, I respected their 'agency' in the process. If participants wanted them to leave, they initiated this themselves.

My ability to achieve complete privacy was further diminished by the open construction of some of the houses. Passers-by could have easily heard conversations from outside.

4.8 Focus group discussions

4.8.1 Participants and participant recruitment

I held two same-sex focus group discussions with couples in which the man was not vasectomised, and with their wives. Given the research topic, it was culturally appropriate to run the discussions separately. The men shared similar characteristics with vasectomised men and I used the key universal characteristics of vasectomised men globally to inform my selection criteria. Young, single or elderly men were excluded. Accordingly, I sought men who were over 30 years of age, in a committed relationship (marriage or partnered), and with multiple children (Perry et al., 2016). As with the in-depth interviews, some of the original selection criteria were not met. After the focus group sessions started, we learnt that one male participant had had a vasectomy, and one of the men was only in his twenties.

The focus group discussions were held at KFHA in a private room, and sessions ran for approximately one and a half hours. The first brought together the wives of the men who met the selection criteria, and 11 women attended. Their husbands were invited to

participate the following day, and only six men turned up. Therefore, only six of the 11 couples recruited participated; however this fitted with my initial aim of five – eight couples. Although we had expected some ‘no-shows’, we did not expect this within couples.

There is a range of explanations for some men choosing not to participate. Possibly, some men had work commitments, since the discussion was during work hours. Further, some wives may have disregarded the confidentiality agreement they signed and talked with their husbands about the topics the women discussed, which might have dissuaded their husbands from attending. A further explanation that the male facilitator provided is that some I-Kiribati men believe that workshops and focus group discussions are something that only women do, and some men feel that their time is more valuable.

4.8.2 Focus group discussions

The purpose of a focus group is to bring together a small group of people to discuss a topic or issues on the research theme through a facilitated process (Cameron, 2010). My rationale for using this method was that it enabled a broad range of views to be obtained (Mack et al., 2005) from a group of women and men who were both similar to, but also different from, the in-depth interview participants. The aim was not to achieve group consensus. The two discussions highlighted normative attitudes, practices and behaviours but also revealed opinions that did not fit with wider thinking.

Focus group discussions are also advantageous in that the group dynamic stimulates the conversation and participants’ reactions (Mack et al., 2005). Kitzinger (1995, p. 299) suggests that people’s knowledge and attitudes are unlikely to be “entirely encapsulated in reasoned responses to direct questions”, yet focus groups allow researchers to tap into other forms of communication, such as anecdotes, teasing and arguing. “Everyday forms of communication may tell us as much, if not more, about what people know or experience. In this sense focus groups reach the parts that other methods cannot reach” (Kitzinger, 1995, p. 299).

Analysing different forms of interpersonal communication can highlight group norms and (sub) cultural values, including ones that are hegemonic (Kitzinger, 1995). Focus groups are therefore useful, for example, for “exposing dominant narratives about sexuality” (Kitzinger,

1995, p. 300). Moreover, since the focus group is particularly sensitive to cultural variables it is a valuable data collection technique for cross cultural research.

The group dynamics fostered by the focus group method can be both simultaneously beneficial, yet also problematic. For example, socially accepted opinions can overshadow other views (Smithson, 2000); in other words, the articulation of group norms can silence the 'voices' of those whose thinking does not align with popular views (Kitzinger, 1995). This was particularly evident during the women's focus group discussion in my research. Sometimes there was consensus in opinion between the women, and yet at times some of the women's body language suggested otherwise. This may have been because these women held conflicting opinions but lacked confidence to challenge widely-held views or possibly reflected some women's unwillingness to impart personal information.

The women's discomfort in speaking up was equally revealing and illustrates the points that Kitzinger (1995) makes about the value of analysing other forms of communication. I had anticipated that some focus group participants might feel uncomfortable talking openly during the discussions, given the sensitive nature of my research. While Mack et al. (2005) note that focus groups are not necessarily the best method for discussing sensitive topics, Kitzinger (1995, p. 300) states that focus groups can be no less inhibiting than a private interview, and, if anything, focus groups can actually "facilitate the discussion of taboo topics because the less inhibited members of the group break the ice for shyer participants", which definitely occurred during the men's discussion. Interestingly, the men also seemed more willing to challenge each other.

In both the women's and men's discussion, participants also fed off each other's ideas. Generally, both the women and men spoke quite openly, even when potentially awkward questions were raised, yet some participants were more vocal than others. According to Smithson (2000) certain types of participants tend to dominate the research process, which is a further limitation of focus group discussions. Smithson (2000) argues that, while there are ways to mitigate some of these limitations through the facilitation process, it is also extremely important to be mindful of these limitations when analysing the focus group data.

Despite some of the limitations of using this method, the benefits outweighed any disadvantages. The focus group discussions provided the greatest opportunity for collaboration with KFHA staff, and they were integral in adapting the method for the Kiribati

context. We based the programme on one of KFHA's workshop formats (Figure 4.1), which included Kiribati customary practices, *Te katei*. All the people taking part in the discussions sat on the floor. The sessions, conducted in the Kiribati language, started with songs and a prayer, then each person stood, said who they were and their home island, and also how many children they had. I received abridged translations.

Figure 4.1 Focus group programme.

Following introductions, I outlined the research, and discussed participants' rights while referring to a displayed translated version (Figure 4.2).

Figure 4.2 Focus group participants' rights translated into Kiribati.

The question guide included structured questions on the key themes I wanted the groups to discuss (Appendix D). I also allowed for flexibility so that other ideas or topics that came out of the discussions could be explored. Once the discussion proper commenced, the only people who remained in the room were the same gender. Participants determined their own ground rules, which meant that they took ownership of them. Figure 4.3 shows women's agreed rules.

In the women's session, I co-facilitated with an experienced female staff member. One of the female nurses acted as notetaker. I asked questions in English and then the facilitator would translate and often adapt the question to make it clearer in the Kiribati language. The facilitator would then translate back into English so that I was able to follow the discussion.

Ground Rules

- E tabu te maroro
 - E tabu te moko u tain te maroro
 - E tabu te wene
 - E kaun gahi te titiraki
 - E tabuahi te kamangau
 - E tabu te bwainingsa
-
- No talking during the session
 - No smoking
 - No lying down
 - Encourage everyone to ask questions
 - Do not disturb (the discussion)
 - Do not make fun of others

Figure 4.3: The ground rules determined by the women's focus group discussion participants.

Ground rules.

- ① Akea te ngare (Bwainigare)
- ② E tabu te mama
- ③ Maroro n takatoka
- ④ Akea winanti.
- ⑤ E tabu te karariki.
- ⑥

- 1) No making fun of someone
- 2) Don't be shy
- 3) It's okay to speak sitting down
- 4) Don't say anything behind people's backs
- 5) Use the correct words. Be direct

Figure 4.4: The ground rules determined by the men's focus group discussion participants.

I decided not to be present during the men's discussion, and left once they were about to start. The men agreed on similar rules to the women (Figure 4.4). I felt that my presence may have prevented the men talking as freely, particularly given the sensitive nature of the research. This was not without complication, as I could not control what was asked or how the questions were being framed, but, arguably, even when I was present the translators altered questions. In spite of some of these limitations, the men's focus group discussion resulted in a rich dialogue, and the men divulged some extremely personal information that is unlikely to have come out had I been there.

Abureti, the male nurse, spoke at the conclusion of each discussion, to ensure participants went away with correct SRHR information, following advice from Mack et al. (2005), experienced SRH researchers. These researchers recommend that participants are not corrected during a focus group discussion even when misinformation is shared, since diverse perspectives should be sought, including views which are incorrect. However, any inaccurate information should be noted and factual information provided to participants once the discussion has finished (Mack et al., 2005). Whilst both facilitators knew that participants would receive accurate information at the end of the discussion, they sometimes struggled to remain neutral and would slip into their roles as health professionals.

Kiribati traditions were also followed when each focus group discussion ended; therefore, lunch was served. Speeches, songs, and a prayer concluded the men's discussion. This closing ceremony allowed everyone to acknowledge how they benefited from the discussions. Additionally, collective learnings were recognised, highlighting how a focus group method can foster the co-construction of knowledge (Cameron, 2010), a concept that underpins a number of indigenous methodologies (Came, 2013; Farrelly & Nabobo-Baba, 2014; Vaiioleti, 2013). A focus group should not only serve to "'mine' 'uncover' and 'extract' existing knowledges" (Gibson-Graham as cited in Cameron, 2010, p. 157), it also has the capacity to develop and construct new knowledges and understandings not only for the researcher but also the participants, and in this case for the KFHA staff too.

4.8.3 Ethical considerations

Focus group participants signed a confidentiality agreement (Appendix C), and the importance of maintaining confidentiality was further reiterated when the discussions started. However, these sessions also challenged my ability to uphold my institutional ethical obligations. The KFHA facilitators asked that participants were not given the option to leave the discussions, although this would breach participants' rights, highlighting the way that institutional research ethics are not always compatible with the wishes of the local community. Understandably, the facilitators were concerned that permitting people to leave might set a precedent, potentially impacting future activities KFHA hosted. I explained that, ethically, I could not make anyone stay if they did not feel comfortable.

As it turned out, the facilitator did not translate the right of participants to leave the first discussion, which I only learnt subsequently. The facilitators' disregard of my request and intentional choice to protect their own wishes demonstrated their agency. As previously noted, my inability to speak the Kiribati language reduced my control over the research process while affording KFHA staff greater control, and illustrates how power can be exercised through silent 'acts of rebellion'.

4.9 Key informants

4.9.1 Participants and participant recruitment

KFHA, Family Planning New Zealand and a health specialist from the New Zealand High Commission suggested suitable key informants. KFHA approached them on my behalf and invited health professionals, a community leader, a Member of Parliament, and a senior member of local government to participate. Coincidentally, the three male key informants had all been vasectomised. KFHA would not have been aware of this in every case.

4.9.2 Key informant interviews

Key informant interviews added contextual understandings of vasectomy in Kiribati. I wanted to learn of participants' personal experiences and opinions regarding vasectomy but

also their views regarding community perceptions of vasectomy. These interviews followed a semi-structured format, and tended to be more formal according to the position of the person being interviewed. I met my key informants in a range of private settings.

I used a set of pre-determined open-ended questions (Appendix D), which KFHA staff approved. The questions built on the insights gained from the in-depth semi-structured interviews, and vice versa.

4.10 Data generation

The in-depth interviews were translated in situ, from English to Kiribati and back again.

Given the complexity of working across cultures and languages, capturing the participant's exact words was not always feasible. For example, culturally-specific sayings or ideas would not always readily translate into English, and I had to rely on an interpretation rather than a direct translation.

Occasionally, I knew the translator omitted information because I would recognise a Kiribati word but it would not come through in the translation, or a participant's laughter was at odds with what was conveyed. As Haraway (1991, p. 195) notes, "[t]ranslation is always interpretative, critical and partial".

Consequently, the person acting as the translator played a significant role in shaping the data. "The act of translation in cross-cultural research moves concepts, events, and opinions from one language to another, from one culture to another and, in some projects back again" (Cleary, 2013, p. 114). The translator can help to "clarify" and "explicate" a question or a participant's response, particularly when an understanding of the cultural context is important, but also has the ability to "distort or even delete information that is important to understanding during analysis" (Cleary, 2013, p. 116). Further, the person acting as translator may have unconscious bias that can affect how they interpret what is being said (Cleary, 2013), in the same way that the researcher's bias, unconscious or otherwise, impacts the research process, and therefore the translator's positionality is equally as important. As Chapter 1 noted, our race, class, gender, level of education, religion and other distinct attributes influence how we interpret the world around us (Mullings, 1999).

The key informant interviews were conducted in English. The in-depth and key informant interviews were audio-recorded, and then transcribed. I transcribed the in-depth interview participants' translated responses. The process of interpretation and translation has meant that some of the participants' original comments were lost. Initially, I transcribed the translated interviews verbatim, including 'ums' and 'arghs' but stopped once I realised that these reflected the translator's hesitancy, and not the thoughts of the participants. Additionally, I transcribed the participants' responses in the first person, even when the translator said "she said..he said..", to make it clearer who was voicing the ideas. Although it was not realistic to comprehensively double-check all the translations, I checked the women's focus group transcript with the audio-recording, and conducted an informal review with my research assistant.

The focus group discussions were audio-recorded and a note-taker recorded each session. The facilitator, research assistant, note-taker and I debriefed after each discussion. The research assistant then translated and transcribed both discussions as accurately as was feasible. It is unlikely to be verbatim because of the challenges in capturing everything during a discussion.

From the outset, I kept a fieldwork diary to encourage reflexivity and iterative practices. I documented observations, ideas and thoughts. I was able to draw on these valuable reflections during my data analysis and write-up, and most importantly they provided the foundation of key themes that underpin this research.

4.11 Data analysis methods

This case study is also informed by secondary data. Prior to commencing fieldwork, I undertook an initial literature review. Once I started fieldwork, I began rudimentary data analysis and did this concurrently with the data generation (Barbara & Benjamin, 2006). This process, combined with initially hand-coding transcripts, meant I had an emerging understanding of my research themes.

I identified broad themes including: norms, gender roles and gender relations, decision-making, family planning, vasectomy and had a miscellaneous category for divergent items, such as migration. Once the overarching themes were established, I grouped all the topics

that appeared to fall under these headings, but was also mindful that many topics applied across themes. I mind-mapped my thinking on a white-board (Figure 4.5). Mind-mapping and grouping themes also helped me to unearth a logical thesis structure.

Figure 4.5: Data analysis, mind-mapping to uncover key themes and interconnected ideas.

I then replicated my data analysis framework in NVivo, a qualitative data analysis software. From this point I coded the transcripts thematically, using NVivo. The advantage of using NVivo is that it allows text-rich data, such as the participants' statements, to be grouped according to themes or patterns, which enabled me to identify connections (Cope, 2010). NVivo is also very powerful in that ideas can be grouped according to more than one theme, which again can bring to light the interconnectivity of themes.

I worked interchangeably between NVivo and the hand-coded transcripts as I wrote the findings chapters. This approach allowed for an in-depth exploration and analysis of the data (Cope, 2010) aligning with my methodology. I also triangulated my own data with the 2009 KDHS and other SRHR studies in Kiribati. It is important to note, however, that since I am not I-Kiribati, my analysis is not grounded in a deeply embedded understanding of Kiribati culture.

4.12 Final reflections

4.12.1 Reciprocity

Throughout my research journey I felt obligated to the participants and KFHA staff, because this research is in large part their work too. The principle of reciprocity (Section 4.4) demands 'reporting back' and 'sharing knowledge' (Smith, 2012). Smith posits there are many ways to ensure 'knowledge' reaches the people who helped to make it, and says this should be done in a culturally appropriate way and in a language that can be understood.

Accordingly, I have written a report for KFHA about vasectomy uptake in Kiribati to help inform their work. The report addresses more themes than I tackle in this thesis, and because it has a practical application, is likely to bring about some positive change. Unfortunately, the report is written in English, but I hope KFHA will share a summary of the study orally with participants.

KFHA will be acknowledged in any future publications or presentations, and these may provide opportunities for further collaboration. Participants will have the opportunity to receive a summary of the thesis and a copy of KFHA's report.

4.13 Conclusion

In this chapter, I described my qualitative case study approach, and explained how this method aligns with feminist theory and research practice. I explained how I worked iteratively to create my research design, including seeking input from KFHA. I discussed collaborating with KFHA to recruit participants. Much of the chapter focused on the methods applied in this study; and my rationale, reflections, limitations and ethical considerations for each method. I then described my data generation and analysis process, and concluded the chapter with ethical concerns that had not been previously addressed.

Chapter 5 – The Kiribati gender order: through the participants’ eyes

5.1 Introduction

In this chapter, I explore gender roles and attitudes of I-Kiribati men and women drawing on the ‘voices’ of the five men who had had a vasectomy and of their wives. The views of these couples are also compared with those of the focus group participants and key informants, and positioned against Kiribati’s prevailing gender order, as introduced in Chapter 3.

Additionally, comparisons are made with trends in the Pacific, and globally.

To start I introduce the participants. I then look at the gender roles of I-Kiribati women and men in the family and community, and explore gender roles associated with decision-making. Following this, I examine where gender roles are blurred. Further, I offer suggestions about factors which may precipitate gender roles being challenged. I conclude this section by describing ‘the triple role of women’, and compare these women’s experiences with other Pacific women, and women globally.

I address gender norms that relate to child-preference and land-rights. Finally, I look at gendered expectations for I-Kiribati women and men in terms of their behaviour and attitudes, highlighting where there is consensus but also some divergent views.

5.2 Introducing the participants

Tables 5.1 to 5.4 include the pseudonyms that the participant-couples and the focus group participants assumed and their demographic details. I have included participants’ household and livelihood activities as they described them. Table 5.5 describes each key informant’s professional capacity¹¹, and their gender. Whilst I have included participants’ formal education, this does not reflect their indigenous knowledges.

¹¹ As used in this thesis.

Table 5-1: Women's demographic details - in-depth interview participants (IDIP).

Couple	Pseudonym	Gender	Age	Number of children	Level of education ¹²	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 makes garlands
IDIP 5	Marva	F	38	6	Primary (Class 7)	Not in formal employment but makes and sells local food

Table 5-2: 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

¹² 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 5-3: Women's demographic details - focus group (FG).

Couples	Pseudonym	Gender	Age	Number of children	Level of education ¹³	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 5-4: 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

¹³ Stage of completing primary school was not always divulged.

Table 5-5: Key informants (KI).

Key informants	Gender
Member of Parliament	M
Local Government Executive	M
Women's Community Leader	F
Government Health Official	F
Executive Health Professional	F
Health Professional	F
Health Professional	M

5.3 Women's gender roles – family

As noted in Chapter 2, gender roles are socially constructed roles, behaviours, activities and attributes that are widely considered appropriate for men and women (UN Women Training Centre, n.d.). Gender roles and gender norms are closely inter-linked, since gender norms are unwritten rules that determine how men and women should behave, and their roles in society (Barker et al., 2010; Jewkes, Flood & Lang, 2015). In other words, gender norms have a significant bearing on gender roles.

Oreti, Arotita, Anatia, Teraitabo and Marva had an inherent understanding of their roles as I-Kiribati women, and what was expected of them as wives. Put simply, their gender roles were clearly defined. These women were primarily responsible for taking care of their children and household tasks and their gender roles were reflective of those of most I-Kiribati women, as Chapter 3 highlighted. For example, when I asked Itaaka's wife Teraitabo what sort of things she did around the home she said: *"I spend most of my time in the home doing the laundry and the cooking and looking after the children"*, views that were shared by most of the women I interviewed and that are also consistent with the literature.

Ngaebi et al. (1993) suggest that the focus of an I-Kiribati woman's life is her role as a mother, wife and daughter, and traditionally a woman's place is in the home caring for families, preparing food, and looking after the family members both young and old. The situation for I-Kiribati women is not unique. Globally, women tend to assume this role, as was noted in Chapter 3. A significant aspect of 'reproductive work' is caring for others, particularly children (Kabeer, 2003). In other words, women's reproductive work extends beyond biological reproduction.

It is therefore unsurprising that Oreti, Anatia and Teraitabo said that looking after their children was one of their main roles. Although Arotita's children were young adults and required less active care, she still spoke of her duty to teach her daughters how to keep themselves safe. Both Oreti and Arotita recognised that women play an important role in passing on to their daughters what is expected of them as a woman in Kiribati society. Oreti noted *"for the girls - I teach them what really the girls should do, like cleaning dishes and sweeping around the place"*. There are 'rules' that apply to what girls and women should and should not do, and ones which "govern behaviour in a thousand situations including work, food gathering and preparation, decision-making, courting, weddings and funerals" (Caulson, 1993, p. 259). Young women, as well as young men "grow up constantly learning the ways of the Kiribati family and the expectations placed on its members" (Caulson, 1993, p. 259). Although Caulson was writing 25 years ago, these normative behaviours are still relevant today; yet, as this research demonstrates gender norms also evolve.

Consistent with Teraitabo's earlier comment, the other women also indicated that they prepared food and cooked, did the laundry, and cleaned. Oreti, Arotita, and Marva shared household tasks with their daughters, while Anatia felt her daughters were too young to contribute, and Teraitabo's children were very young boys.

Teuarei explained that his wife Marva contributed in the following ways:

She gets our daughters, I mean the girls, to take care of the laundry, cooking and cleaning and she bakes flour and we prepare local foods for the local market to get money.

I-Kiribati women are acknowledged for their role in the family and, according to Ngaebi et al. (1993) are the most important single figure in the household, as they have to manage all the problems. Awi, a male focus group participant, echoed this view:

Woman are the key to the happy and healthy families because they are the ones to look after the whole family, and we all know that we feel comfort if we have woman in the family. So if the woman sick then the family will be slowing down.

Other activities identified as 'women's work' included shopping, sewing and producing local food and crafts. Local skills were highly valued for both women and men, as these skills

were intrinsic to Kiribati culture and provided a means of generating a livelihood. Arotita wove baskets and mats from pandanus and coconut leaves, while Teraitabo made garlands also of pandanus leaves and flowers, which are worn during special occasions. Oreti made *tiibuta*, a loose fitting cotton smocked blouse worn by women, and, together with her husband, Teuarei, Marva produced a local cake made from coconut. I also observed women selling fish and other produce on the road-sides.

Although Oreti said she mainly cared for her children and did household tasks, she also contributed her time to running the local shop that she shared with her husband Taomati. Of the five wives, Anatia was the only woman in formal work outside the home. She was a shopkeeper working for a South Tarawa business. However, Oreti, Arotita, and Marva were all engaged in activities that generated cash for their families, and each of these women also performed what Moser describes as a 'productive role' (Chapter 3). Productive work for both women and men in Kiribati, often appears to be undertaken communally, such as crafts and fishing, however, earnings are not always for community purposes but go to individual families instead.

5.4 Women's gender roles – community

The division of labour at the community level is also markedly gendered. Oreti, Arotita and Teraitabo explained that they had women's groups in their respective communities and that the women would come together to produce local goods and to garden for income. Oreti described the activities women did in her community:

... we have a women's group here, the community, and all these women we are not employed, not working now but we try to make local things. Like the tiibuta, the shirts and we also have the garden. We grow cabbages. We sell-out so that we can get cash from it so that it can support our family, each family in this community. That's our main role.

When Arotita was still living on her home island she said that she collaborated with other women to earn money:

...the women they go and collect the pandanus leaves and they make a roof from it, they sell it and also the... you know... the string, the fibre, they make it and also sell it

for what they need and want. That's how on the outer islands they make money, earn money those locals.

AH¹⁴: *And the mats? As well, this is the women's? The women make these?*

[Referring to what we are sitting on].

Yes, they weave it and they sell it to the Island Council.

Great importance is placed on the ability of I-Kiribati women to make local crafts, which can then be sold for cash, since this enables I-Kiribati women to contribute not only to the wider community but also to the local economy (Government of Kiribati, 2005). Generating cash also helps women to fulfil their fundraising obligations. For example, Anatia said that women in her community were involved with fundraising for the church and that, although most women were in formal employment and therefore have a source of income to contribute to the church, some women also sold ice-blocks to raise additional money. Anatia's experience appears consistent with I-Kiribati women more broadly.

Meeting community obligations fits with women's community managing role, as described in Chapter 3, is seen as an extension of women's reproductive responsibilities and there is an expectation that women will fulfil these duties, in other words, it is "seen as 'naturally' women's work" (Moser, 1993, p. 34).

5.5 Men's gender roles – family

Chapter 3 gave insights into I-Kiribati men's roles in society – namely, head of household and key decision-maker. Traditionally, they were also expected to be the main provider (Ngaebi et al., 1993), which appears still relevant today. Providing for their families was raised by most of the men that I interviewed. I-Kiribati understandings of being able to provide for the family, however, was not necessarily associated with being in formal employment. What seems of more importance was that men know how to execute local skills.

Taomati, Auati, Toriua, Itaaka and Teuarei said that they performed a number of tasks for their families, but what was consistent across each of the five men is that they all undertook

¹⁴ AH are my initials, to indicate when I am speaking.

local skills, including cutting toddy¹⁵ and fishing. None of the men was in formal employment at the time of interviewing. Toriua described the activities of men in his community by saying: *“there is a group of men. They go fishing and sell-out the fish and they have toddy too. They cut toddy too, especially for their children to drink”*.

Taomati made pig food from a by-product of coconut processing, which he sold alongside everyday items, such as food and cleaning materials, in his shop. Auati had only recently settled in South Tarawa. When he was still living in the outer islands he would cut copra:

...on the outer islands we used to cut copra to earn money from that and also we sell-out fish and sometimes we joined the Island Council labour to earn some money. We did not work but we earned money.

Itaaka had a range of endeavours to earn money:

....I sell-out young coconuts. I collect them and sell them. The same with the pandanus fruits, I also sell them to get money and I am also engaged with one of the kava bars. I assist in that bar and get money afterwards, when it closes. The owner pays cash. It is in the community.

Taomati and Auati felt that fathers had a responsibility to teach their sons what is expected of them as boys, and in their future roles as husbands and fathers. Auati explained:

...I teach my boys how to look after their family in the future. I told them what is the number of children for a good family, so it will be easy for them to look after their family. Yeah, I also teach the boys on the skills, the local skills – the fishing and the toddy and the good life. I mean they have to, they should live in a good manner.

Taomati and Auati's views about their role as fathers are consistent with expectations of many men globally. Kabeer (2003, p. 50) contends that in the cases where men do assist with household activities, it generally involves training boys in 'how to be men'. The section earlier described how mothers play an important role in instilling in their children, particularly their daughters, gendered expectations to allow them to function in Kiribati society, and the same is also true of fathers with their sons.

¹⁵ Toddy is produced from the sap of an unripe coconut flower and is tapped from the end of the 'spathe'. 'Cutting toddy' refers to tapping the spathe. Toddy is served fresh, boiled or fermented. Children drink fresh toddy.

5.6 Men's gender roles – community

As I discussed in Chapter 3, men lead community decision-making. While women perform 'community managing roles', men undertake 'community politics', which Moser (1993, p. 34) argues carries greater reward, in terms of status, power and even sometimes payment. Reflections made by the Women's Community Leader resonate with Moser's point: *"In our country, it's like what, it's a male country. All the decisions are from the man and we [women] are to achieve or implement what they say"*.

Although none of the male in-depth interview participants mentioned having leadership responsibilities in their communities, both male and female key informants talked of this being a man's role. Activities such as fishing are sometimes undertaken in groups of men. The church is also central to community activities, which is reflected in Toriua's comments about what men did in his community: *"... we fully engage with the church as well. Fundraising"*, and mirror what his wife, Anatia, said regarding women's activities in the community. Interestingly, Taomati did not recognise that both men and women perform roles at a community level. He said: *"In regard to men in this community, each family they have their own roles"*. His comments perhaps indicate changing family structures and attitudes towards Kiribati's collectivist society.

5.7 Decision-making

The key informants and focus group participants consistently spoke of the role I-Kiribati men assume as primary decision-maker within their families. Of note, however, is that women were perceived to be capable of influencing men's decisions, and not only in the home. A female Executive Health Professional reflected:

... when the President was Anote Tong, you know you can say Nei Meme Tong, the wife, is the leader of the country [laugh] because she will be there sitting as a wife but she will talk and influence that guy [laugh]. Yeah, very influential in the decision-making but maybe when it comes to an issue that is very controversial and um, yeah sometimes they will argue on it [ummm]. But normally it will be the man that will finalise, make the final decision but when in all the of the general matters for the family and all that, it is the women, is leading behind. Maybe the face behind the

scene, is the women, making all the work and the decisions and all that but the man is just at the front.

None of the five husbands involved in the in-depth interviews explicitly articulated their role as head of household, but during the interviews with the couples the husband generally took the lead in responding to my questions, and Arotita, Teraitabo and Marva tended to defer to their husbands when answering questions. The only exception was with Anatia and Toriua, in which the discussion was led by Anatia. Anatia, as mentioned early, was the main breadwinner in her household and had also received significantly more formal education than her husband. Yet, Toriua may have had considerable indigenous knowledges but this is not something I am equipped to comment on. It did appear, however, that Anatia assumed the role of decision-maker in their relationship and it was clear during the interviews that her husband Toriua looked to her for guidance.

That Anatia seemed to take more control in her relationship with her husband is less surprising when it is compared with the results of the 2009 KDHS that found that 51 per cent of women who were in employment participated in making all household decisions (Kiribati National Statistics Office et al., 2010). This suggests that there is a link between women earning an income, either a wage or salary, and increased decision-making power (Kiribati National Statistics Office et al., 2010).

As I explained in Chapter 2, to be empowered means having the capacity to exercise choice over resources and to make strategic life-decisions (Kabeer, 1999). A woman's status in her family, and her ability to make decisions that affect her health and well-being, her family and household, and even her community, are a determinant of her agency and empowerment (Malhotra & Schuler, 2005). Arguably, these indicators would not exist without gender equality and so provide insights into the nature of gendered relationships between couples. The in-depth interview participants were therefore asked to respond to questions about decision-making more generally and to share how they made decisions about their land, family size, money and health. During the interviews with the couples together, all of the five couples said that decision-making was a shared activity between husband and wife. The responses each couple gave during their individual interviews reinforced this. In some instances, however, it appeared that couples consulted each other about a plan, but the husband would make the final decision depending on the nature of

what was being decided, which is consistent with the comment made by the key informants comments, described at the start of this section.

Household decision-making ranged from planning the timing and number of children to have, making financial decisions, determining how to allocate their land, and decisions about the well-being of their children. For example, Teuarei, Marva's husband, said:

Every decision we sit together, we plan, we plan what to do and with the boys or girls, what to do for the family. And we.. like.. because we have the second boy - he was not paid from the government the money, the fee to meet the expenses [for his education] so we sit together and have agreed on what, what we will ...how do we get the money to support his fee, the books, the clothes, and the uniform.

Anatia also spoke of sitting with her husband, Toriua, to make decisions: *"We sit together and decide and plan what are the things to support the children. We do the planning together"*.

Shared decision-making between couples, however, is not the norm in Kiribati. According to the 2009 KDHS, less than half of the women surveyed, 47 per cent, reported that household decisions were made jointly, and most I-Kiribati women do not make household decisions independently. One quarter of the women 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).

Notably, the 2009 KDHS also determined that men with a higher level of formal education are more likely to believe that their wife should be involved in household decision-making, and that men who are employed, live in an urban area and are from the most wealthy household think that women should participate in the five decision-making areas¹⁶ identified in the study (Kiribati National Statistics Office et al., 2010). In contrast, although all of the in-depth interview participants lived in what would be classified as urban areas, none of the five husbands was in formal employment, or had completed formal schooling beyond Form 3, and did not appear outwardly wealthy. This suggests that their views may be unusual and not what would be expected based on their backgrounds.

¹⁶ The five household decisions that were examined in the 2009 KDHS included: 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.

As this section has highlighted, gender roles associated with family decision-making are clearly not as rigid, as publically conveyed in Kiribati. Moreover, there was even some blurring of gender roles amongst the participant-couples.

5.8 Blurring of gender roles

While there were clear expectations of what women and men did within each family and at the community level, there was also some repositioning in gender roles amongst the in-depth interview and the focus group participants. In some cases, men undertook duties that were traditionally seen as ‘women’s work’, and in contrast women assumed the role of main breadwinner. This was most evident for Anatia and Toriua. As mentioned earlier, Anatia worked in formal employment as a shopkeeper, and appeared to be the main decision-maker in her family. Her husband, Toriua, was not formally employed so cared for the children, as well as making hand-rolled cigarettes from pandanus leaves that he sold to generate some income. Toriua explained: *“I am not working at the moment so I started looking after the children and the home and sometimes I go fishing to support the children in the family”*.

Anatia reported that in their community many women had exchanged roles with their husbands. The women were in paid employment while their husbands cared for the children:

AH: Just going back to the question before when we were talking about the different roles of men and women and you said your husband looks after the children. Is that very common for men to look after children in Kiribati?

Anatia: Yes, it is, especially with the husbands that are not working. They exchange their roles. The woman is working, getting the money.

Women taking on the role of main breadwinner for the family was not limited to Anatia and Toriua either. Arotita and Auati and their children were financially supported by their eldest daughter. She was the sole breadwinner in the family and was employed in the formal economy. Gender roles were blurred in some of the other participants’ families too. Several other men spoke of sharing household tasks with their wives. Taomati said that he assisted his wife with food preparation, while Teuarei said that he helped Marva with the

cleaning and also preparing the local food that the family sold to generate an income. On several occasions over the six weeks of my fieldwork, I observed young men hanging out washing, but only ever saw women actually doing the washing.

Mwemwe, one of the husbands from the focus group discussion, assumed complete responsibility for caring for his children from their birth through to adulthood, as he said his wife was not in a position to do so:

My wife didn't look after the baby as she's sick [after giving birth]. I have looked after all my children from my eldest to my youngest one since from their childhood until becoming an adult. I couldn't breastfeed so I use bottle of milk instead. Looking after them consumes my time and lessen my entertaining time – when I went to drink kava in kava bar, I hurriedly came back after a very short time. My role seems like all about caring about my baby. I looked after them from my eldest to my youngest since from their childhood until adulthood.

Mwemwe's first-hand experience of raising babies had evidently increased his awareness of how much time and energy is actually involved in this type of work. He voiced the constraints that childcare placed on his free-time and entertainment, and in a subsequent comment spoke of the challenges of looking after a baby. However, at no point did Mwemwe acknowledge that this is the norm for women:

I realize that looking after a baby is a big deal and a very big challenge in my life, so I never want to get my wife pregnant. I give up getting another baby or else I would be the one again to look after them.

Facilitator: *You're responsible to look after them eh?*

Yes, my wife has a problem when she's giving birth. She can't do anything like washing our baby's diaper, and not even want to check on our baby when our baby is crying at late night. So there comes again my responsibility – just to look after our baby until falling asleep. Sometimes I got angry.

As this section illustrates, there are variations in gender roles that go beyond the dominant narratives about I-Kiribati women and men, and, further, that gender norms and gender roles are not static. It also highlights the ways in which women and men can both challenge

gender norms and also comply with them simultaneously. In other words, gender roles are not black and white, or necessarily limited to one gender alone. Yet, international literature suggests that the gendered division of labour has historically been (Moser, 1993), and arguably is still perceived as, rigid and universal.

This thinking appears true for the wider Pacific. Underhill-Sem (2011) emphasises that the most pervasive understanding of gender in the Pacific is that of women and men working co-operatively to fulfil their livelihood activities – women as the homemakers and carers, while men engage in physical labours. Further, the complementarity of women's and men's roles is reinforced by Christian references. And yet, despite academic evidence to suggest that alternative gender regimes exist, many regional reports perpetuate this understanding of Pacific women's and men's lives which, according to Underhill-Sem (2011, p. 16), is "an injustice to women and men who, in their routine activities, are equally proficient and competent in physical and nurturing activities". Other feminists too, have long argued that there is no reason why gender should determine the social division of labour, apart from the actual process of childbearing, and, as with Underhill-Sem, challenge the idea that the gendered division of labour is based on a "perceived complementarity of roles for men and women, who are 'different but equal'" (Moser, 1993, p. 28).

5.9 Societal changes impacting I-Kiribati families

A range of factors is likely causing gender norms to evolve and the normative gendered division of labour to undergo transformation within some families in South Tarawa. As highlighted in Chapter 1, societies are not static and, even before the arrival of Europeans, the I-Kiribati population adapted and adjusted to changing circumstances (B. Macdonald, 2001).

Notably each of the five participant-couples lived as nuclear families. Even in the early 1990s, it was observed that the traditional extended family was less common in urban areas in Kiribati (Ngaebi et al., 1993). Migration from the outer islands to South Tarawa is likely to be driving the numbers of families living as a nuclear unit. However, of the couples interviewed, only Arotita and Auati said they had recently moved from their home island and, at the time, I did not clarify why the other couples lived alone. Living as a nuclear

family, without extended family support, has real implications for the gendered division of labour.

The change in family structure, combined with women entering formal employment, can present childcare issues. Ngaebi et al. (1993) said that in the past grandparents would typically care for their grandchildren. Now it is more common for grandparents to live at a distance, often on the outer islands, which can present challenges for working women. As Anatia and Toriua demonstrated, husbands are sometimes required to take on childcare duties and assume a 'reproductive' role, which reinforces the notion that gender roles and gender norms are not fixed but evolving, as I discussed in Chapters 2 and 3.

Being engaged in paid work can also increase the burden on women if their husbands do not provide support with work in the home. As I explained earlier, Anatia continued to be responsible for the cooking and cleaning, in addition to working in the formal economy. Ngaebi et al. (1993, p. 267) commented "[w]omen who work are also handicapped because men in many cases have not adjusted to the new role which their wives now have assumed". This did not appear to apply in Toriua's case, as he seemed very accepting of his wife working and his caring for their children. Given that gender roles are so deeply ingrained it is possible that Toriua had not even considered assuming the housework too.

As mentioned previously, gender norms and the resultant gender behaviours and relationships are both dynamic and complex, and in some instances changes in gendered activities might be partial, or in other cases a more obvious reversal of roles might occur. What does appear consistent is that the nuclear family structure does precipitate change. For example, gender roles can also be challenged in the context of a nuclear family if the wife is unable to carry out work that is normally undertaken by women, as was the case for Mwemwe, the focus group participant who said he raised his children:

I am aware of my role in my family since my parents and her parents don't live with us – only myself and my wife. Looking after my baby is a big challenge for me... so when I have a baby, that would resist me for drinking kava in the kava bar.

5.10 'The triple role of women'

As I have shown, gender roles and gender relations are not straightforward. Although some of the male participants said that they contributed in the home, for the most part it

appeared that the women still undertook the greatest load in terms of both paid and unpaid work. Taomati's assertion that he assisted with food preparation was not consistent with the response that his wife Oreti gave.

When I asked Oreti why people in Kiribati used family planning she replied:

[Laughter]

[Translator: She compares with her own experience]. *I am using family planning to space the number of children and ah, because I have no-one to help me with the children so that is why I use family planning, and the third is my husband. He is younger than me and when I try to discuss with him or talk to him, in terms of trying to help me [with childcare and housework], sometimes he never listens so that is why I decided to have family planning.*

Teraitabo, Itaaka's wife, gave a very similar response:

In my opinion, from my own experience, I need family planning because I do not have spacing between my children, and my husband is very lazy not contributing in taking care of the children. That is why I decided to use family planning because most of the work is done by myself.

Teuarei seemed unique in his willingness to contribute to activities typically associated with 'women's work'. Marva, independently of Teuarei, said that he helped her with housework and childcare. Yet, it can also be inferred from one of Arotita's comments, that her husband Auati also contributed to work normally undertaken by women. She felt a man's vasectomy meant that couples: "*can share the load at home*". As noted in Chapter 2, processes that generate shifts in consciousness, including "contesting the institutions of everyday life that sustain inequality" (Cornwall, 2016, p. 345), empower women in transformational ways.

Having said that, even though Toriua cared for the children when his wife Anatia was engaged in paid work, he did not manage all the household tasks. Anatia continued to prepare the food and do the laundry, which illustrates the way that gender relations are multifaceted. While Anatia was the only in-depth interview participant working in the formal economy, each of the other women also contributed to their family's livelihood, and yet they also performed the bulk of the household tasks. As the earlier sections demonstrated, these women's experiences are consistent with the notion that many

women globally perform at least three key roles, namely 'reproductive', 'productive' and 'community manager' roles (Moser, 1989, p. 1801), that I described in Chapter 3.

Moreover, their experiences are not uncommon, and align with experiences of many Pacific women. A report written for the 13th Triennial Conference of Pacific Women (Pacific Community, 2017, p. 12), states: "As in the rest of the world, Pacific women assume most of the responsibilities for unpaid care work while also undertaking productive work, whether paid or not".

Expanding on this, the report notes:

[I]n many societies, economically active women have a 'double workday' – combining responsibilities for home and family with their economic activities. For example, in Papua New Guinea, women work on average nearly twice as many hours as men, and in Tonga, they spend 50% more hours than men on non-economic activities each week.

5.11 Gender norms

As described in Chapter 2, gender norms not only determine how men and women should behave, and their roles in society, they also define how they are valued (Barker et al., 2010; Jewkes et al., 2015). Cultural beliefs and practices largely determine gender norms and as the earlier sections of this chapter have shown, gender norms are multifaceted and not fixed.

Responses from the in-depth interview participants and key informants would suggest that girls and boys are valued equally in Kiribati society, but for different reasons. According to a female senior health professional and her male staff member, large family sizes can sometimes be attributed to couples continuing to have children until they are able to have a child of the opposite sex, as their dialogue illustrates:

Health Professional:... *they have six boys and they want to get, to have a girl and the seventh is a boy*

Executive Health Professional: *they keep on because they want a boy or a girl. As soon as they get one they stop! They stop!*

[laughter, in unison]

Executive Health Professional: *but sometimes very late – nine or 10.*

Nine or 10. [said in unison/laughter].

Executive Health Professional: *We have cases like that. That is the reason why. They do not want to take vasectomy because they want a boy or girl so they keep searching for the boy or the girl.* [Laughter].

Auati too, made a similar comment:

From my experience, most people they really need a girl and a boy. If say for example a couple have a boy and a girl, they start thinking of planning their children. If not, they will continue on until they get what they need – the boy or the girl. Because most people on the outer island, they really have detailed information on the importance of family planning but the problem is that if they have boys only they will continue on until they have a girl. But if they have a boy and a girl that is the time they start thinking of spacing their children.

The perceived need for a child of each sex appears driven by a range of motivations including the transfer of land-rights and by the need for provision of care in old age. Auati said land is normally passed to the sons with the first born son receiving priority since it is customary for sons to stay with their parents and the daughters to go to their husband's family to live following marriage, which is consistent with the literature, as described in Chapter 3. Auati explained:

We will wait until their kids get married and that is the time for us to allocate or give them a place to build a house.

AH: *so you would give land to all of your children? Or how does it work with the land?*

[Husband responds]

Auati: *Yeah, because we have been given the land from our... those lands, I mean we have the land and the land is for our children. They, it's like boys should have the land and the girls, also girls because when they get married they go with the husband*

but they have the room for when they come back. In case they come back to the family, they still have a place but the priority is the first boy, second boy.

In Chapter 3, I illustrated that variations to land rights that countered dominant gender norms existed, historically. Seemingly, this still might be the case today. For example, Marva and Teuarei did not appear to prioritise their sons' rights to land over their daughters'. When I asked Marva and Teuarei a similar question about the allocation of land to their children, Teuarei, the husband, responded quite differently to Auati's earlier comment:

AH: so, when it comes to your land, passing your land on to your children, do you give your land to your boys or your girls?

[Husband responds]

No, we agree that each of our children will have a home here, around here.

Even when daughters have moved away from their family home after marriage some parents expect that their daughters will care for them in their old age, and will therefore move in with their daughters later in life. Auati suggested that this is also in part why parents wanted to have girls, as well as boys:

....in Kiribati, our culture is when we get old, we trust our own daughter. That's the time for us to move to our own daughter because they are our own. Like, like ah we have a son and the wife. We don't trust the wife because she is not really our family.

[Personal comment from translator: *That is really good?*]

Auati: That is why they sometimes they really, they need more children because of that idea. Especially the girls because we will go to them when we reach that age say 70, 60, 70 because we are not sure of our son's wife, as she is not related to our family.

AH: And may not want to care in the same way?

Care in the same way as our own daughter.

As highlighted in Chapter 3, daughters are increasingly being seen as more reliable than sons, and although historically parents would be cared for by their son's family, this appears

to have evolved, which Ngaebi et al. (1993) argue is a sign of the growing respect for women in Kiribati society.

5.11.1 Expectations of I-Kiribati girls and women

As the previous sections highlighted, I-Kiribati girls and women are expected to undertake certain duties in the home and the community, however, there is also evidence that some expectations are changing.

Couples were prompted to think about the characteristics that they looked for when seeking a husband or wife, and also to reflect on the type of man they would want their daughter to marry or the type of woman they would hope their son would marry. The participants' responses provided insights into concepts of femininity and masculinity in Kiribati culture but also highlighted what is desired behaviour for women and men. Responses from wives and husbands, and between couples, were often consistent.

Women were valued for their skills in the home, and were expected to be kind and to show respect for Kiribati culture, elders, family and the community, as Taomati's comments demonstrate:

Like here in Kiribati [women] are expected to talk polite, not shouting. They should wear the skirt, the tiibuta as well. That is how I feel when I look at the woman. So, talk nice and wear the local I-Kiribati wear. And the same with the men, they can use the lava lava. They can talk like a man and make good decisions for the community and their families as well.

When Toriua, Anatia's husband, was thinking about marriage he said that he expected the following from his future wife:

..... she will be very active; can do the housework. She will be kind with my family when she gets married to me. Just the two things. She is kind, very smart. I expect her to be very smart in the home. She can do the cooking and the cleaning and the laundry. That is what I expect and that is how I started approaching the person that I married.

These views about a suitable wife were similar to those expressed by Itaaka:

At first I was attracted by her because she is very skilled. And it is because she is from the south. You know, the southern people – women and men they are very skilful in the local skills..crafts

So, my sister told me she is the right woman, woman, to take, to be my wife because she is very supportive and she used to stay at home doing the housework with my family. That is the time for me to ask her to marry.

The wives responded similarly. Toriua's wife, Anatia, said she felt women should:

...respect the community and the family. Mostly the Kiribati culture, she will respect that. That is what I am thinking about that... as Kiribati people because our culture the people are very kind. They are active in the home. They will be very skilled in local skills.

Teraitabo, Itaaka's wife, had consistent ideas:

From experience, yeah experience, the I-Kiribati women should respect Kiribati culture and the same she will be skilled and respect the elders and she will be very smart in the home.

Responses about expectations of future daughters-in-law were more varied. Whilst Arotita's ideas about future daughters-in-law were consistent with ideas about I-Kiribati women more generally, two of the male participants, including her husband gave quite different answers. When I asked Arotita what type of women she would like her sons to marry she laughed, and then said the following:

She will be respectful and she will respect the family [some further discussion between translator and Arotita] she will be kind and she will be very supportive to the family when she marries to the sons. Very supporting in every way – she can do, she's the one does the laundry and the cooking, and the cleaning. That is what I expect from my sons. I have already told them not to pick the girls who not respect, girls who are rude and not very supportive.

Interestingly, her husband Auati said that he expected a future daughter-in-law to be talented and working. He spoke of how expectations have changed over time:

... in the past, families when they have the boy and they plan the son to have a wife they look for the girl who is the only one in the family; and the other one, the other idea she has many lands but now they start to move away from this idea. Now they look for the job, they change now but that was before but nowadays when the girl has a talent – she is working. That is what I plan for my sons' partners.

Given that women who were the sole female heir, or sole heir to an estate did not forgo their land rights, as I talked about in Chapter 3, it is not surprising that, historically, parents would want their sons to marry women who met these criteria. Although owning land and having a professional occupation are two very different attributes a woman can bring to a relationship, what is consistent is that they both represent status, and arguably afford a better standard of living.

While Auati placed value on a women's occupation and professional ability, which differs considerably from the value that Taomati, Toriua, Itaaka, Anatia, Teraitabo and Arotita placed on domestic and local skills, Marva's husband Teuarei, had an even more divergent response. Unlike the others, Teuarei was more concerned that his sons loved the women whom they intended to marry and supported his sons' autonomy in the decision-process:

No matter whether she is what, but the important thing is their son. If their son says he loves her very much, that is it. They don't bother whether she is good for their son.

AH: *you want your sons to be happy with their choice?*

Yes.

This section revealed the way gender norms have shaped expectations for I-Kiribati women, and provided further evidence that gender norms evolve over time.

5.11.2 Expectations of I-Kiribati men

As with women, men are expected to be competent in local skills, and to show respect for Kiribati culture. Both men and women expressed concern about certain behaviours that were perceived as negative in a relationship, such as violence and drunkenness.

When Anatia, Toriua's wife, was asked about the characteristics that she looked for when seeking a husband, she said:

I expected him to be very skilful in local skills – like fishing, cutting toddy and he will have no time to waste, to go out. I want him to be in the family looking after the home. Spending time with the family.

Teraitabo the wife of Itaaka, said:

I expect that the men are flexible, not tough, not very strict and very skilful in local skills – fishing and toddy.

AH: *So when you say flexible, what do you mean by flexible?*

[Translator speaks to couple – they both laugh]

Teraitabo: *I mentioned flexible because flexible to my understanding, a flexible guy is kind [laughter from wife]. He will never beat me and he is ready to support, in everything I need. That is what I mean by flexible.*

Teuarei's wife Marva, also placed a value on finding a husband who was kind and did not use violence:

I expect my husband to be really kind. Very flexible, not very tough in decisions and I will look for, I am looking for someone who is very helpful. No violence. I will marry.

Marva's views about desired behaviours of men were consistent with those of her husband Teuarei. Although he said his boys should marry for love, he was clear that his daughters should marry men who behaved in a certain way and who could support his daughters:

....they will talk with their daughters to remind them to choose the boys that are not violent. Not drunken boys. She will select the guy, the boy that is, that he can provide comfortably and that they will live happily in the family. That is what they expect for their daughter. All those things. Someone who is kind, who's not drinking and is really skilful.

Having a concern for his daughters' well-being was also conveyed by Auati, who said:

... because I have daughters and I want my daughters to marry good men, in regards to their behaviour, so he does not drink or make, he is not making violence when they settle down with his daughters.

This section has not only highlighted gendered expectations of I-Kiribati men, it has also provided insight into concepts of manhood. A number of the participants made reference to what they perceived as unfavourable behaviours often associated with heteronormative masculinities, such as drunkenness and violence that I addressed in Chapters 2 and 3. Furthermore, some of these negative behaviours are also indicative of gender inequitable behaviours.

5.12 Conclusion

This chapter has shown that, while I-Kiribati women and men have distinct gender roles within their families and at the community level, these are not fixed or universal and in some cases there is blurring in what women and men do. Given that societies are not static, it is to be expected that gender norms and roles evolve as society changes, such as adjusting to life as a nuclear family. Gender norms and roles are, however, extremely complex and as this chapter has demonstrated, women and men can both comply with, and counter, gender norms and gender roles simultaneously. I also highlighted women's three roles – reproductive, productive and community work, and argued that while, in a number of cases the husbands had undertaken work traditionally associated with women, their wives continued to perform the bulk of the work.

I concluded the chapter by exploring gender norms, particularly those related to child-preference and land-rights to provide insights into the ways women and men are valued in Kiribati society. I explored the way that cultural practices are linked to gender norms and again reinforced the fact that gender norms are not immutable. The concluding section revealed that both women and men of the participant-couples did not support inequitable gender norms, and, moreover, disapproved of behaviours associated with hegemonic masculinities.

Chapter 6 – The complex nature of gender relations

This chapter starts by exploring participants' perceptions of contraceptive and reproductive responsibilities, notions of manhood, spousal communication and family planning decision-making. I examine the gendered nature of family planning and how gender norms define I-Kiribati women's reproductive role.

I compare the in-depth interview participants' views with those of the focus group and key informant participants and with studies conducted previously within Kiribati. This allows me to provide insights into the ways that the participant-couples, where the husband has had a vasectomy, either challenge or comply with prevailing I-Kiribati gender norms, attitudes and practices relating to contraceptive and reproductive responsibilities. Additionally, I draw on international research to determine how my results compare with the situation globally.

I pay particular attention to the concept of 'agency'. I examine women's lack of agency, specifically addressing sexual coercion. Conversely, I look at connections between women's agency and equitable gender relations, and how this applies in relationships in which the husband has had a vasectomy. Next, I discuss the ways women are perceived to benefit from their husband's vasectomy, linking this to concepts of agency and empowerment addressed in Chapter 2. To conclude, I show how vasectomy can also be a consequence of, and cause, less equitable gender relations.

6.1 The gendered nature of family planning

As with other roles within I-Kiribati families, the responsibility for family planning is significantly gendered and women's 'reproductive role' not only involves managing the home and family but extends to family planning too. I-Kiribati women are generally expected to assume the role of controlling their fertility, either by natural or modern family planning methods. "[L]ike other forms of domestic labor, the time, attention, stress and physical burden associated with avoiding pregnancy lies primarily on the shoulders of women" (Bertotti, 2013, p. 13). Contraception and reproduction, in the biological sense, are not normally considered a man's responsibility, and both women and men ascribe to these hegemonic gender norms.

This thinking was made explicit by both key informants and focus group participants who consistently associated family planning with women's methods and as a role primarily undertaken by women, as the following observation suggests:

I get the impression that when it comes to family planning that it always tends to be the role of the women. Most of the family planning things. 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).

The following insights were shared by a female Government Health Official who explained: *"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'".*

Even amongst some of the in-depth interview participants this thinking held. For example, there was little mention of the two modern contraceptive methods that exist for men. Only Taomati and Auati talked about the 'condom' and only Toriua talked about 'vasectomy', and none of the women discussed either of these male-methods. Few participant-couples reported having used condoms prior to their vasectomy, further supporting the notion that family planning is primarily managed by I-Kiribati women. Taomati and Auati were the exception amongst the other men, since they both said that before their vasectomy they had used condoms together with other female family planning methods. The other participant-couples had either relied on methods that are specifically for women, such as contraceptive pills, or had not used any contraception previously.

While it is unsurprising that participant-couples mentioned female forms of contraception more frequently, it is surprising that most failed to identify their partner's or their own vasectomy as a form of contraception. Clearly what immediately came to most participant-couples' minds did not align with their lived reality, given all the men were vasectomised. Notwithstanding the pervasive thinking about family planning being a women's role, some men in Kiribati have vasectomies which challenges hegemonic gender norms associated with contraception. Moreover, two men explicitly stated that husbands have contraceptive responsibilities, as my conversation with Teuarei illustrates:

AH: *What do you think people in your community feel about this family planning method [meaning vasectomy]? What you think, not what you know?*

Teuarei: *Men have to share with the wife. It is not only the wife to have family planning.*

AH: *They have to share the responsibility?*

Teuarei: *Yes*

AH: *And do you think other men in this community would think the same as you?*

Teuarei: *No idea. [laughter]*

One of the key informants, a Member of Parliament, shared Teuarei's views. As he recounted his perceptions of vasectomy to me, he too argued that men have to play a role with family planning. He said vasectomy is:

Less invasive that is the word. Less invasive. It is more easy to do. And even that, we don't understand. As I said, here we tend to think family planning it is an issue of the women when in fact it is an issue for men as well.

These views counter trends not only in Kiribati but also globally. Men's limited contraceptive responsibility is reflected in the results of the 2009 KDHS, which found that, while just over half of all men aged 15-49 years who were surveyed had used a male-orientated contraceptive method at some time, only 40 per cent of married men were using a male method (Kiribati National Statistics Office et al., 2010). The survey results also showed that the rates for vasectomy were almost non-existent in 2009, with less than three per cent of men having been sterilised at that time (Chapter 1).

In turn, my research findings and these results from the 2009 KDHS are consistent with studies from other countries, not only in the Global South, which indicate that in many cultures family planning is seen as 'women's business' (Bertotti, 2013; Drysdale, 2015; MacDonald et al., 2013; Perry et al., 2016). Although I-Kiribati women are generally expected to assume the role of family planning, paradoxically they do not always have autonomy over contraceptive choices or even whether they can control their fertility, since men tend to dominate decision-making, as discussed in previous chapters (Brewis, 2001; Kiribati National Statistics Office et al., 2010).

Deeply embedded normative views regarding contraception in Kiribati are also closely linked to notions of masculinity and femininity, and are arguably heteronormative (Chapters 2 and

3). If men assume responsibility for contraception, gender normative behaviours associated with contraception are challenged, which has the potential to undermine their manhood.

6.2 Challenges to men's masculinity

Across the participant groups, women and men in my study perceived that vasectomy could threaten a man's masculinity, but at no point was it suggested that women's femininity is impacted if their husband assumes the role of managing contraception. As noted in Chapter 3, physical strength, (hetero)sexual prowess, the ability to father children and to provide economically for one's family, are all markers of masculinity (Jewkes & Morrell, 2010; Sweetman, 2013), which participants perceived could be negatively impacted by vasectomy.

Arotita, the wife of Auati, said: *"The number one is misconception of using vasectomy because sometimes men they say they will have less power when they have vasectomy"*. Auati made a similar comment independently of Arotita. He said: *"... women want to go with men who have not had a vasectomy. Vasectomy make men weak"*.

Both female and male participants saw a reduction in sexual prowess as an undesirable consequence of vasectomy, as the exchange between Mwemwe and Peter during the focus group discussion illustrates:

Mwemwe: *My brother told me that his wife didn't enjoy just sex, she thinks there are different feeling for a woman towards someone who have a vasectomy and who have not have a vasectomy. She found the pleasure with the one who have hadn't a vasectomy.*

Peter: *Yeah the woman get bored as the husband emotion changed.*

Mwemwe: *Eheh and sometimes when the wife doesn't enjoy sex with her husband she might think of having sex with other men.*

Male and female participants in the study conducted on vasectomy in Papua New Guinea shared this concern. Like Mwemwe's and Peter's views, some Papua New Guinean participants thought that their wives would go with other men if they had a vasectomy, as it could reduce their sexual performance (Drysdale, 2015). A number of the in-depth interview participants in my study, attributed their diminishing sex drive, or their husband's,

to the vasectomy. The male nurse, Abureti, said that this issue was more likely to be age-related, however, since this can occur as a natural part of aging. Associating a diminishing sex drive with vasectomy was quite pervasive thinking amongst participants in this research and in international studies.

Having a vasectomy was also seen as a significant affront to masculinity because it prevents men from fathering their own children, and even worse: *“The women may get pregnant from other men so that is why they do not take vasectomy”*, Itaaka stated. Mawaruru, a male focus group participant commented: *“So it seems like having vasectomy means you are less important - as you can't produce any more children”*, highlighting the way that a man's importance is associated with their ability to father children.

A study of barriers to male contraception usage in Uganda also found that vasectomy was thought to challenge manhood. The authors said “[t]he permanence and irreversibility of vasectomy was noted, in particular, as unacceptable [sic] among men and consistent with losing one's masculinity” (Kabagenyi et al., 2014, p. 4). Similarly, studies from other parts of Africa, (Adongo et al., 2014), Asia (Dahal, Padmadas & Hinde, 2008), and South America (Marván et al., 2017), produced similar findings.

Karoua, another male focus group participant, described how his vasectomy had caused people to suspect that he was unable to provide for his family:

I faced lots of challenges when I had a vasectomy. People thought I had a vasectomy because I couldn't bear my responsibility to feed my family members.... [pauses and laughs]. People thought like ‘Why he has a vasectomy? Seems like he couldn't feed his family members anymore’. Maybe they thought and said these words, as they misunderstood what myself and wife had agreed on. Aha [laugh].

Karoua's comments were not shared by other participants, nor were they evident in the Papua New Guinean study. In that study some participants were concerned that the perceived weakness from a vasectomy could impact their ability to conduct physical work or provide for their families (Drysdale, 2015). While Karoua said people thought he needed a vasectomy because he could not provide for his family, conversely the Papua New Guinean participants thought a vasectomy would prevent a man from providing for their family. This section has highlighted the complex ways that a man's masculinity can be seen to be challenged by the act of having a vasectomy, and yet despite these perceived barriers small

numbers of men in Kiribati are still willing to have one.

6.3 Spousal communication and family planning decision-making

Contrary to dominant views regarding I-Kiribati men's control over all aspects of family life, as noted in previous chapters the in-depth interview participants, regardless of gender, shared the opinion that spouses should talk about family planning as a couple, and that decisions about contraceptive choices should be made together. The five husbands and wives gave the same responses to questions on this theme independently of each other, suggesting that, in each instance, decisions around family size and uptake of family planning were negotiated between the husband and wife. When I asked Arotita, the wife of Auati, whom she believed made the decision to use family planning in her community she said:

Both the husband and the wife [further discussion]. It is the same for other families, so in the community 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.

Teuarei's wife Marva shared a similar view and said that husbands and wives should make family planning decisions together because: *"I believe in having a good relationship and communicating well. There will be no issues later"*.

The husbands' responses mirrored those given by the women. Taomati's comments reflect this:

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.

Perhaps surprisingly, these participants' views are not unique. Inter-spousal communication regarding contraception usage is relatively common in Kiribati (Brewis, 2001; Kiribati National Statistics Office et al., 2010), in spite of men's perceived position of control that arguably could prevent this from happening. An in-depth study on reproductive decision-making in Kiribati found that women and men believed both spouses should reach agreement regarding family planning (Brewis, 2001). A number of Brewis' participants said it was the sign of a healthy marriage, which reflects the comment that Marva made earlier.

While almost 70 per cent of married women surveyed for the 2009 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. Responses from the male focus group participants in this research suggest that inter-spousal dialogue does not necessarily equate with equitable decision-making, despite this inference being made by the 2009 KDHS.

In this case study research, the men gave mixed responses and there was not consensus in the men's focus group. Some of the men believed it was the man's responsibility to decide if his wife could use family planning, yet others countered this opinion, as Awi's comment illustrates: *"More decisions are made by women because they know what is good for them to use and men should support his wife's decision"*.

Awi's beliefs contrast with the experiences that two of the women recounted in their focus group discussion. When the women were asked if husbands and wives talk about family planning in their family or community, Uebou commented: *"For me, no..... I already have an injection without my husband knowing it. I am hiding it from him because he refuses me to have family planning"*. Raimoa said: *"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"*.

Uebou and Raimoa made a decision to use contraception independently from their husbands, suggesting that even women who lack power in their gender relations, have a form of agency, which I described in Chapter 2. Kabeer (1999, p. 438) reasons that 'agency' can take on many other forms, such as "deception and manipulation, subversion and resistance". While it is clear that Uebou and Raimoa had agency according to Kabeer's definition, the fact that they had to conceal their actions from their husbands also implies that they lacked equitable gender relations, particularly in terms of their own health.

Subversive contraception use is higher amongst I-Kiribati women who have experienced intimate partner violence, and men who subject their partner to violence are more likely to refuse to use, or prevent their partner from using, family planning (Secretariat of the Pacific Community, 2010). It is not surprising that women who have experienced violence are also more likely to have experienced controlling behaviour that affects their SRHR (Secretariat of the Pacific Community, 2010, 2015).

Although Uebou and Raimoa did not divulge in the focus group discussion whether they had, themselves, experienced violence, it is likely that, if their husbands were to find out that they had acted without their knowledge, the women risked negative repercussions from their husbands. Inter-spousal conflict in relation to contraception usage was an issue that was raised by the in-depth interview participants, the focus group participants and the key informants, and more often than not it was attributed either to women acting without their husbands' knowledge, or to the fact that men hold the balance of power in decision-making, both of which are inter-related.

The implications of I-Kiribati couples not talking together about family planning choices were often serious. Participants recounted that fights and other relationship issues were not uncommon in this situation, and, more often, women were perceived as being at fault, as Itaaka's views indicate:

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.

Brewis (2001, p. 396) noted in her I-Kiribati study that, although spousal agreement regarding family planning was seen as ideal, in reality achieving it was viewed publically as both difficult and rare because of:

...the culturally defined divergent natures of men and women. Contraceptive use is repeatedly cited in public fora as a major cause of conflict within the marital relationship, especially where women want to use it and their husbands disapprove or forbid it.

Brewis' observation was also reflected in a comment by a key informant in my research, who said:

Men are the bosses at home. Sometimes they are like selfish, if the wife is asking for family planning, because the wife has to ask permission first, because they are the boss [the men] so if the man does not want the method he can be very strong to tell the women not to take even if it is necessary for the women's health. Sometimes that is culture because men are dominant in the family (Female Government Health Offical).

This health professional's views were shared by two other health professionals. They were unanimous in their opinion that I-Kiribati men ultimately control decision-making regarding family planning, even if there is discussion between partners. The following dialogue with a senior female health professional and her male staff member both demonstrates this and reveals some contradictions:

AH: *Who is generally responsible for deciding to use family planning in relationships?*

Female Executive Health Professional: *Who decides? The final is the husband.*

Male Health Professional: *The husband, yeah.*

Female Executive Health Professional: *They can talk about it, both of them, but the final will be him. But maybe there are cases where some of the women can really...are very powerful and they can say "I need it and I have to do it. You are not looking after this kid. I am taking all the...[laugh] I am doing all the hard work and I have to do it". Maybe there are cases like that also ...eh?*

Male Health Professional: *Yes, especially with women who are [pauses]*

Female Executive Health Professional: *Women who are working*

Male Health Professional: *Working and they have medical problems - hypertension or diabetes. That helps the women to decide.*

While the message about men's role as primary decision-maker came through very strongly, it is also interesting that the senior health professional speculated that there are some women who may challenge this. Gender relations are extremely complex and as this section has illustrated, variations do exist within relationships. Furthermore, public perceptions of inter-spousal decision-making regarding contraception that favour I-Kiribati men's position of power do not always align with the reality within the couples' relationships, as this study and Brewis' demonstrated.

Brewis concluded that, contrary to the public perception of marital relationships in Kiribati society being fraught with contention, particularly in terms of reproductive issues, the vast majority of couples she interviewed "reported highly collaborative strategies for reproductive decision-making" (2001, p. 396), which is consistent with the in-depth

interview participants' responses. All the vasectomised men supported equitable decision-making in principle, both in terms of decisions that affected their families, as discussed in Chapter 5, and with regards to family planning.

Gender relations, however, are not straightforward, and again it is important to stress that inter-spousal communication should not necessarily be equated with equitable decision-making. At times the men's remarks indicated less equitable thinking. For example, Taomati's earlier comment suggests the husband is fundamentally in control: *"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"*. And yet, the fact that the couples made decisions collectively, also suggests that there was still room for negotiation and dialogue in their relationships, and that arguably their wives had agency.

6.4 Sexual coercion and women's lack of agency

Although I did not set out to examine sexual coercion, this topic was raised by the male focus group participants. Some of the men's thinking provides insight into how men can use their position of power in relationships. The focus group participants were asked to reflect on who decides to use family planning, which led to a discussion about abstinence during a woman's fertile period for couples who are unable to use modern contraception for religious reasons. This prompted Mwemwe to say that: *"Men usually take woman for sex by force"*, which was followed by laughter from the other male participants. Karoua also expressed this view:

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.... [bahab.. – sound followed by laughter]

As Section 2.1 highlighted, sexual coercion is a form of controlling power, which some men exercise over women. It involves men asserting their 'power over' their spouse through the use of coercion, violence or threat and in so doing compromising the agency of their wives or partners (Kabeer, 1999; Rowlands, 1998; Willis, 2005). Sexual coercion therefore undermines gender equality, which would explain why 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).

Results from the 2009 KDHS and Brewis' (1992) research indicate that I-Kiribati women's and men's attitudes towards a woman's right to refuse sex differ. Fewer women think that women are justified in refusing to have sex with their husbands or partners, which highlights how women also perpetuate socially and culturally accepted inequitable gender norms (Cornwall, 2006), and the ways in which gender norms are reproduced through relationships (Jewkes et al., 2015).

The fact that during the focus group discussion, Mwemwe and Karoua were willing to openly discuss forcing their wives to have sex, would suggest this behaviour is socially acceptable in Kiribati. Had this not been the case, it seems unlikely that the men would have been comfortable in discussing this practice. De Keizer argues that men's "violent responses, often seen as [a] legitimate 'correction' of female behaviour" (2004, p. 29), are socially and culturally validated, reinforcing the points that I made in Section 2.1.

Entrenched gender norms, which are shaped by cultural beliefs and practices, can reinforce hegemonic masculine behaviours, and one outcome of this is that men are less likely to challenge violence against women (Sonke Gender Justice Network, 2013), an issue discussed in Chapter 3. Mwemwe and Karoua's views demonstrate a sense of entitlement, which is, as De Keizer suggests, their exercising their privilege as men (2004). This privilege can lead men to believe that "they are entitled to greater rights and authority, and services from women" (De Keijzer, 2004, p. 30) throughout women's lives. For example, an earlier study on Butaritari, noted in Section 3.5, found that men generally dictated both the timing and frequency of sex while women were always expected to acquiesce, and that frequent requests were in part men asserting their control over their wives (Brewis, 1992).

In the case of the men in Brewis' study, and also according to the views shared by Mwemwe and Karoua, 'sex' is 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). Withholding sex was therefore seen as justification for using force.

Although it is not clear why, Mwemwe did subsequently diverge from his earlier comment and went on to say that: *"Sometimes the man asks for his wife's consent when he wants to*

have sex with his wife". This could be an example of the facilitator using his influence as a health promoter to discourage certain behaviour, as I discussed in Chapter 4.

During the focus group discussion, not all the men spoke up when the topic of sexual coercion was raised, which perhaps indicates not all the men wanted to reveal their own attitudes and behaviours or that they did not agree with this practice. For example, based on a comment Awi expressed earlier in the discussion, it is possible to infer that he supported his wife having more control in SRH decision-making. Awi, like the in-depth participants, believed that husbands and wives should discuss family planning together and advocated for this because: *"Woman know their fertile period, so in that way they can ask their husband when they should and shouldn't have sex"*. Awi did not appear to favour sexual coercion meaning that his wife, Taake, could control when she did not want to have sex, and yet Awi's remarks also suggest that Taake may have lacked agency in terms of initiating sex.

The extent to which the in-depth interview participants' views varied from those expressed by the two men during the focus group discussion was not made evident. Nonetheless, their interview responses generally suggest that they did not condone the use of violence in relationships, since violence against women was frequently cited as undesirable behaviour (Chapter 5). Whether this thinking included sexual coercion, however, is not clear, since sexual coercion may not be perceived as a form of violence. This section has again highlighted that gender relations are complex. Karoua's comments reveal that his wife, Mawaruru, was not always treated equitably, and yet, in other respects, she evidently had agency and was an equitable partner in her husband's decision to have a vasectomy, as the next section demonstrates.

6.5 Women's agency and vasectomy decision-making

Vasectomy decision-making was seemingly an equitable process and reflected the way the in-depth participants made other decisions that directly affected their families (Chapter 5). Pulerwitz and Barker (2008) found that, when men support more equitable gender norms, their wives' contraceptive usage is higher. This mirrors the findings of the 2009 KDHS that established a connection between women's level of decision-making in the family and

contraceptive uptake (2010). “It is evident from the data that 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).

Although the 2009 KDHS did not report a correlation between women’s level of decision-making and men’s contraception usage, this research suggests that it is highly likely one exists, particularly in terms of vasectomy. Further, the fact that the male in-depth interview participants collaborated with their wives about significant decisions is arguably a reflection of their acceptance of more equitable gender norms.

Of note is that the wives played a key role in the vasectomy decision-making process too. In each instance, the wife and husband said that they sat together as a couple to talk about the procedure and the implications for their families and that the decision-making was a shared activity. Responses were consistent between each spouse, and across the couples.

Taomati said:

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.

Two key informants and Karoua, one of the focus group participants, responded similarly. When Karoua was asked how he had made the decision to have a vasectomy he reflected:

... The decision was made by me and my wife. We both discussed that. Our children space is two years in between, and while my wife gave birth to our third child, then we decided that I had to have a vasectomy.

Of the people interviewed 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 decides, given that it affects him directly and because of his status as the ‘boss’ and head of the household. Comments Peter made during the men’s focus group discussion reflect this thinking. When he was asked who should be involved in the decision to have a vasectomy, he 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 (Scott, Alam, & Raman, 2011). Reflective of Peter's thoughts, a small group of men felt that it was their decision alone and they could not be influenced (Scott et al., 2011). Peter had not, however, himself had a vasectomy, and his position and that of the men in India is not in keeping with the responses from the in-depth interview participants.

KFHA provides counselling to the husband and wife together as part of the vasectomy decision-making process, irrespective of which spouse initiates the idea. It is probable that couple-counselling in itself fosters a more equitable decision-making process and demonstrates how institutions can reinforce equitable gender norms. Couple counselling is not universal in vasectomy provision, however. Had the men in Scott et al's study gone through this process, it would be interesting to see if all of them would have maintained their position.

For the in-depth interview participants, there were instances where the husband suggested having a vasectomy and in two cases the wife proposed the idea to her husband. Wives appeared more likely to initiate the idea with their husbands if they had received medical guidance to discuss permanent contraception options, as the following dialogue with Oreti illustrates:

AH: *So can you tell me how involved you were in the decision?*

Oreti: *I was really involved and I was the one also encouraging him. Because at first I was going to be given the TL but the nurse promoted to me if the husband can have the vasectomy. And, one reason is because of my Hepatitis B.*

AH: *For health reasons? So you really encouraged your husband and discussed with him?*

Oreti: *Yes, but he is the one deciding.*

Husbands, on the other hand, were prompted to consider a vasectomy for a broader range of reasons (Section 6.6).

Though many findings from a study of vasectomy uptake in Tanzania are consistent with this research, a point of difference is that both the Tanzanian men and women said that husbands would resist the procedure if the wife was the one to raise the idea (Bunce et al., 2007). Whilst none of the I-Kiribati wives whose husbands had had a vasectomy reported resistance from their husbands, it is likely that the same would be true in Kiribati, given the position that men hold as the primary decision-maker in the family, and since my research did not capture the views of men who may have considered a vasectomy but had opted not to go ahead.

Further, this notion is also supported by comments made by three key informants, including two medical professionals, who said that women often are required to find ways to get their husbands to accept ideas that may be sensitive, or that challenge the man's control in their relationship. A female Government Health Official reflected:

I do know some of these cases where they want to stop getting pregnant but they have to discuss it with their husband and if they say 'no' they have to really stay on it until they say 'yes'.

A Women's Community Leader echoed these comments:

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. They need to know how to talk nicely, and counsel each other.

Contrary to these comments, all the couples who had undergone a vasectomy said that they had no issue discussing it with each other. While spousal communication and the wife being engaged in the decision-making process was the norm, some women and men said that the husband made the final decision to have the vasectomy. For example, Marva did not know her husband, Teuarei, had had a vasectomy until after the procedure was completed:

I did not even know that my husband has a vasectomy. I just asked when Abureti¹⁷ left and I asked him 'what is that operation you were given?' and so the husband just explained it to her. [laughter]

AH: *oh wow, so you just found out afterwards? How did you feel when you heard?*

[talking very softly, whispering and some laughter]

Marva: *I was so surprised when I heard that he has a vasectomy and I asked, 'why are you having a vasectomy?'*

However, Teuarei, her husband, said that they had talked about his vasectomy beforehand, but consistent with Marva's comment, he was the one who finalised the decision. Unlike some of the other couples, Teuarei initially discussed the idea with his friends before speaking with Marva. He said: *"So I was discussing with my friends and then I came back and talked with the wife and then we made the final decision"*. Following their decision, Teuarei contacted KFHA.

Irrespective of how the final decision was made, the wives played an active role in the decision-making process, including in some instances persuading their husbands to have the procedure. This is consistent with the findings of a study on vasectomy uptake in Papua New Guinea that determined men's wives were largely influential in the decision-making process (Drysdale, 2015). Like the participants in my research, nearly all the participants in the Papua New Guinean study had discussed the decision with their spouse, and Drysdale determined that, in some cases, obtaining their wife's approval was key. 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. This was reported by both women and men in the Tanzanian study and it was a theme that appeared in 21 of the 22 transcripts.

A woman's ability to influence her husband to have a vasectomy is arguably a measure of her agency. The role women play can be both explicit, that is that they directly request their husband to have a vasectomy and in this sense they are 'agents of change', and/or implicit (the husbands opted to be vasectomised out of concern for their wives' well-being). Men are often motivated to have a vasectomy out of concern for their wife, as is discussed in the

¹⁷ Pseudonym.

next section. 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 well-being, which would suggest that she has agency in her relationship.

6.6 Motivations to have a vasectomy

In-depth interview participants and key informants gave a number of reasons for having a vasectomy. Participants were not always motivated by one factor alone, and often the factors were interrelated. Key motivations expressed by the men included economic considerations, a desire to have a smaller family and a concern for their wife's health. Economic considerations and family size are closely linked. A number of participants said that a smaller family is more sustainable since there are fewer family members to support and it places less strain on the family's resources, including land. The issue of being unemployed was also raised as a motivating factor by one of the male in-depth participants, Itaaka and one of the female in-depth participants, Oreti.

Nearly all the husbands expressed an explicit concern for their wife's health in relation to their decision to have a vasectomy. The men's responses can be grouped into three categories: 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; and a tubal ligation would have a greater impact on a woman than a vasectomy has on a man.

For example, when I asked Itaaka to tell me who/what influenced his choice to have a vasectomy, he explained:

Because of my wife's health, and also there was a visit from the doctor during the last baby. During her last delivery she was warned not to have any more children because she is not strong. That is why I decided to take vasectomy.

AH: *They gave the advice about vasectomy?*

Itaaka: Yes

AH: *Did they also give advice about tubal ligation as well?*

Itaaka: *They both talk on tubal ligation and vasectomy but in the end we agreed on vasectomy.*

AH: *because of your wife's health?*

Itaaka: *Yeah*

Auati was worried about the effects of modern contraceptives on Arotia's health. He said that men on his home island were encouraged to have a vasectomy following a vasectomy awareness programme and recounted:

.. 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. So, they decided themselves to go and have vasectomy.

Marva's health meant that she was unable to use modern contraceptives. Once her husband discovered he could have a vasectomy, he pursued that option, as the following dialogue reveals:

AH: *and how did you decide? You said that you did decide. Why did you decide to stop at six [children]?*

[Husband responds, wife adds a few comments and laughs]

We already planned to space our children. We planned for two, for two children. But the problem is my wife, because she is having liver problems and she could not take any modern contraception so as time goes by we, she continues conceiving but at last I heard that KFHA can, can perform the vasectomy. So we approached the KFHA clinic and that is the time when I am taking the vasectomy. That is our choice.

Their wives echoed their husband's comments and said that it was out of a concern for their health that their husbands had had a vasectomy. For example, Teraitabo commented:

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.

Auati and Itaaka could also see the benefit of men having a vasectomy compared with their wives undergoing tubal ligation, as Auati's comment illustrates:

....the operation is very fast. It takes not an hour, it is less than an hour and the second thing is it is more simple than tubal ligation. And lastly, is because the vasectomy is just local and the tubal ligation they give you epidural so they prefer the vasectomy than taking the other one

Itaaka explained that his older brother, who had himself been vasectomised, persuaded him to have a vasectomy as opposed to his wife having tubal ligation:

So my brother influenced me too, rather than taking the tubal ligation because with the woman she will encounter several difficulties and will have to be very careful after the operation but with the vasectomy it is very simple and fast compared with tubal ligation. So that is why I was influenced and encouraged to take vasectomy and my wife was very supportive and happy I made that decision.

The three key health concerns identified by the I-Kiribati men in this research reflect the same concerns that men expressed in Papua New Guinea (Drysdale, 2015) and Tanzania (Bunce et al., 2007). Men's concern for their wives' health was consistently found to be a primary motivation, and was also true of studies from Rwanda (Shattuck et al., 2014) and New Zealand (Terry & Braun, 2011a).

While Marva mentioned that her husband, Teuarei, was prompted 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.

Men who accept a vasectomy out of concern for their wives' health challenge hegemonic masculine constructs. Development discourse, particularly discourse relating to sexual and reproductive health and rights, invariably frames men as "oppressors,...disinterested or violent" (Barker et al., 2010, p. 540). Although there is overwhelming evidence to substantiate this description of men, the failure to acknowledge the complexity of gender

relations renders other masculinities largely invisible, as argued in Chapters 2 and 3. This messaging about men can also serve to perpetuate gender norms in practice, thus reinforcing the notion that family planning is women's responsibility.

While it is possible that some men want to be involved in SRH decision-making so that they can maintain control over 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. "Despite 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" (MacDonald et al., 2013, p. 41).

A theme that is constant throughout this research is 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, (see Chapter 5), 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.

6.7 Perceived benefits for women

Both the wives and husbands from the in-depth interview participants perceived that women benefitted from their spouses' vasectomy. Many of the benefits were seen as unique to women and ranged from being able to actively participate in the local women's group, increased opportunity to generate an income or work in the formal economy, improved health, reduced childcare and household duties, and increased support from their husbands with household duties.

Auati and Arotita said that the vasectomy had enabled Arotita to pursue leadership roles in the women's group since she had fewer children to support, had stopped childbearing and her children were older, and therefore she had more free time. Auati reflected:

I believe that my wife now has more time with the women, women's group. She can go to, she is joining other functions, the parties because she knows that she will not

have more children. That means she is free now. Not like before when she spends most of the time with the children in the home, she never goes out.

AH: *so it gives her more freedom? And to go to the parties, bootaki¹⁸?*

Auati: *Yes, bootaki and to meet her friends. You know the partners of men who have vasectomised, they have more privilege. They were given more opportunities to be like say the lead, or they will attend the meetings and they are really thankful to their husbands because before they have no time. They spend their time in the home but after the operation they are free, able now to join the women's group, attend the meetings...*

AH: *so, being more active in the community?*

Auati: *Yeah. And they are more privileged than those whose husbands have not been vasectomised because they have small children to look after and they used to say 'give it to that lady because she has no children [small children], because of the husband'.*

Arotita echoed her husband's comments also adding: *"...I can go anywhere I want"*.

Male and female participants from across the participant groups felt vasectomy reduced women's workload, since having fewer children to manage reduced women's duties and responsibilities in the home. Although it was acknowledged that women would have more time, interestingly 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) actually increased. Increased 'free time' therefore did not necessarily equate with reduced responsibilities for women, as Taomati's comments about his wife Oreti illustrate: *"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"*. Oreti independently admitted that she felt that Taomati's vasectomy had meant an improved workload, but this was the only benefit she mentioned.

¹⁸ *Bootaki* – means to come together as a group, for example, for a meeting or a party.

Anatia, Toriua's wife, said that her husband's vasectomy had improved her employment opportunities. Anatia reflected: *"I can work and get more money, than being pregnant – I had to stay at home"*.

Vasectomy was also seen by one participant as enabling women to advance professionally, free from the fear and consequence of further pregnancies and children, as the following dialogue with a Local Government Executive reveals:

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.

AH: *so she could focus on her career?*

Local Government Executive: *Yes, not worry more about the kids. That kind of stuff. I really recommend to my friends but I think women, my former wife, was happy about it.*

Marva, attributed her husband Teuarei's vasectomy to positive behavioural changes and felt that since his vasectomy he contributed more in the home. She spoke of his support: *"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"*. During my three visits to Marva and Teuarei's home, I also observed Teuarei's active parenting and the way he lovingly interacted with his children. Arotita, too, responded similarly to Marva. She said that a man's vasectomy meant that couples: *"can share the load at home"*.

Gender norms can be particularly hard to shift, since they are constantly reinforced throughout a person's life (Mosedale, 2005) and they can become deeply embedded. However, Marva's reflections on the way Teuarei adopted activities that are normally associated with women's work illustrates the argument that gender relations are not immutable, as was discussed in Chapter 3 (Agarwal, 1997; Mosedale, 2005).

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 (2011, 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. A study across eight countries globally determined men with higher levels of education and married men had more equitable gender attitudes, whereas unmarried men had the least (Fleming et al., as cited in Flood, 2015, p. 16). According to Flood (2015), 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.

Terry and Braun (2011), however, argue that changes in men's behaviour and attitudes as a consequence of marriage or an intimate partnership with a woman, do not necessarily mean that male privilege is eliminated or undermined.

In contrast to Marva's reflections about her perceived benefits which were completely unique, health was raised among all the couples. Most participants, both male and female, felt that a husband's vasectomy contributed to women's health and the perceived health benefits generally aligned with men's motivations for having a vasectomy.

Increased sexual pleasure was another perceived benefit. I had not anticipated I-Kiribati women would openly discuss this topic and was therefore surprised that it came up during the focus group discussion. The women said they thought that one way women benefitted if a spouse had a vasectomy was that sex became more enjoyable. Marva too, shared this thinking and described how she felt following Teuarei's vasectomy:

Using this method, we have been benefited, myself because I never have the pain during the delivery.

AH: *Not having any more babies?*

Marva: *Yes. 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!

Expressing an enjoyment of sex implies a woman has a certain degree of agency. As I discussed in Chapter 2, "control over sexual relations" is a measure of women's empowerment (Malhotra & Schuler, 2005), and yet Correa and Jolly (2008) argue that development discourse invariably fails to recognise women's agency and desires in sex.

Although vasectomy alone would not result in women's empowerment, being free from the fear of pregnancy, having fewer children and fewer household responsibilities is arguably empowering. The vasectomy resulted in a significant change in the participants' lives, which opened up new opportunities for some of the women, and it was in effect a catalyst for change. Even amongst this small group of participants, activities that could be associated with women's empowerment were identified, for example the ability to generate an income, to advance professionally, to become a women's leader, and to enjoy sex. It was even reported to result in more equitable distribution of domestic work.

That being said, women's 'reproductive role' does not necessarily diminish following their spouse's vasectomy, and can in fact mean women's responsibilities increase, as noted previously. A study of New Zealand men who had had a vasectomy, showed that, while men felt that the exchange of reproductive responsibility from women to men was a natural life-course process, the research suggested otherwise (Terry & Braun, 2011).

Whilst reproductive responsibility in the true sense of reproductive activity ended, studies indicate that "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, 2011, p. 491). This appeared to be the lived experience of many of the I-Kiribati women in this study. On the one hand, a husband's vasectomy can result in positive outcomes for women, which are potentially empowering, and yet on the other hand, the underlying power dynamics in a relationship and resulting gender relations can remain unchanged.

6.8 Vasectomy – a 'measure' of less equitable relationships?

For these reasons, while vasectomy could be perceived to empower women, the views expressed by participants imply that it can also be associated with inequitable behaviour. Across the participant groups, participants consistently remarked that vasectomised man can more readily have extramarital relationships, which is not gender equitable behaviour. It is an oversimplification to suggest that vasectomy causes men to have affairs, since presumably men would already need to subscribe to this kind of behaviour, but it does allow someone who already endorses this type of behaviour to do so more freely.

The link between vasectomy, infidelity and feelings of jealousy in relationships was made explicit by both male and female participants from across the different participant groups, and this was a recurring theme throughout the interviews and even in informal conversations with people outside the study.

Marva said that one of the reasons her husband, Teuarei, gave for having a vasectomy was so that he could have relationships with other women without the risk of them becoming pregnant. Marva recounted to me that he had said to her: *“Because of your health and if I want to go to another one, another woman, there is no problem, I can’t have a baby with her”*. Marva’s views were not consistent with her husband’s. When I interviewed Teuarei, however, he gave a slightly contradictory response. While Teuarei acknowledged that being vasectomised enabled men to have relationships with other women, he said that this is more desirable for younger men and it was not something he practised: *“But for me, I am older, I do not think about going to another woman”*.

A female Government Health Official also raised the issue of men seeking relationships outside their marriage, and suggested that this may be why there is resistance from women to their husbands having the procedure. She 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”*. This response is supported by a comment made by Teete, a woman involved in the focus group discussion, who said: *“I don’t want my husband to have a vasectomy because he’s had affairs before and that might get me jealous as he’s free then to have sex with other women”*.

It is a view that was also shared by Arotita, the wife of Auati, and by Marva, Teuarei’s wife. When I asked Arotita who or what would discourage men from considering a vasectomy in her community, she talked about misconceptions, but she also identified wives as another barrier *“...sometimes they will get jealous because when the husband has a vasectomy they can go around with other women”*.

Karoua, a male focus group participant, openly said that he had had a relationship outside of marriage, but this appeared to pre-date his vasectomy. The fact that he was willing to divulge his affair in the presence of other men, however, suggests that extra-marital relationships are considered acceptable in Kiribati culture.

Although most of the attention was on men having sexual relationships outside marriage after a vasectomy, some participants felt women, too, may seek another relationship if they felt dissatisfied with their husband's sexual performance or wanted more children. This was reflected in Mwemwe's comments during the focus group discussion: *"Sometimes when the wife doesn't enjoy sex with her husband she might think of having sex with other men"*.

Jealousy was not only given as a reason for women not wanting their husbands to have a vasectomy. Participants also felt that men could become jealous of their wives, which is highlighted in Auati's comments: *"Another thing is that they think – men, after they have been vasectomised they think their wives will go with other men, it is like they are jealous"*.

In other Kiribati studies, conjugal sexual jealousy, known as koko, appears to be more commonly associated with women's perceived infidelity (Brewis, 2001). Koko is seen as a significant barrier to I-Kiribati women being able to use contraception (Brewis, 2001; Daube et al., 2016). For example, a recent study determined that one of the main reasons I-Kiribati men did not want their wives using family planning was due to jealousy and the perception that it somehow facilitated infidelity (Daube et al., 2016). The difference with my study is that the jealousy was associated with male contraceptive usage, and yet, the issue of women's perceived infidelity remained consistent.

Several participants knew of men who had undertaken a vasectomy as a form of control over their spouse, again as a consequence of jealousy. These men 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 having sexual relationships with other men, and that they will feel good if they have a vasectomy *"...because if their wife goes with other men then they will know because she will get pregnant and they will know"*.

One of the women in the focus group, Raimoa, said that she knew of a man who had had a vasectomy, rather than his wife having a tubal ligation. According to Raimoa, the man felt that if his wife had a tubal ligation she would have freedom to have sex outside the marriage. *"Whenever she decides to have sex, even with other men, she's free to, as she won't get pregnant anymore"*. She went on to say *"he thought the wife might have affairs with other men, so he's happy to have a vasectomy...he's not trusting her"*.

It is important to note that these findings are unusual when compared with the studies on vasectomy that informed my literature review. None of these studies appears to have found vasectomy being used to counter perceived threats of women's infidelity. It is, however, likely that this has occurred elsewhere, since De Keizer states that there is research that indicates men decide to have a vasectomy as a way of controlling their partner's sexuality (De Keijzer, 2004). Unfortunately, it was not clear which research De Keizer was referencing, so I was unable to compare the findings.

Although this finding from my research appears to be an anomaly, it is consistent in other ways. Responses by I-Kiribati men and women are reflective of those by male and female participants in many other countries including Papua New Guinea, Ghana, Cambodia and Tanzania. These studies also found connections between vasectomy and perceived issues of men and women's infidelity (Adongo et al., 2014; Bunce et al., 2007; Drysdale, 2015; Perry et al., 2016).

6.9 Conclusion

This chapter compared the views and experiences of the participant-couples with those of the focus group participants and key informants to determine how the participant-couples either conformed to, or challenged the dominant gender order. I looked at attitudes associated with masculinity, family planning, spousal communication and family planning decision-making. I placed participants' views and experiences within the context of Kiribati and international literature.

I suggested that women's reproductive role goes beyond work in the domestic sphere. I showed that across the participant groups family planning was seen as 'women's business', or is associated with women-orientated contraceptive methods, consistent with international findings. Yet, I also noted that what some participants said and what they did, did not always align, given some men had had a vasectomy. The vasectomised men were willing to challenge hegemonic gender norms associated with contraception. Moreover, some men made it explicit that men too, must share contraceptive responsibilities in their relationships. I discussed connections between vasectomy and masculinities. I argued that

it is unsurprising vasectomy is feared by both women and men, since it is believed to threaten masculinity. I noted that vasectomy was not, however, seen to impact femininity.

I looked at different manifestations of women's agency in connection to sexual coercion, subversive contraception usage and vasectomy decision-making, and made links to Kabeer's understandings of agency (Chapter 2). I found that the I-Kiribati's men's motivations for having a vasectomy were often out of egalitarian concerns. I demonstrated that vasectomy can have wide ranging benefits for women, which are empowering. I concluded by looking at the ways vasectomy is linked to inequitable practices in relationships.

In summary, this chapter has shown that connections do exist between vasectomy and gender equitable outcomes; however, arguably in the cases of the five couples, their relationships were already more equitable when compared with the wider population. Vasectomy therefore appears to be both a cause and a consequence of gender equitable relations. Yet, gender relations are complex. Vasectomy is also associated with less equitable gender relations. Moreover, women's 'reproductive role' does not necessarily diminish following their spouse's vasectomy.

Chapter 7 – Conclusion

This thesis used a social constructivist epistemology within a feminist framework to explore connections between vasectomy acceptance and equitable gender relations amongst participant-couples in Kiribati. Principles from indigenous methodologies also imbued the research approach. Using a qualitative case study, I drew on the lived experiences of five vasectomised I-Kiribati men and their wives through semi-structured informal interviews. Couples were interviewed together and separately. The participant-couples' responses were also triangulated with focus group participants' and key informants' views, and findings from the 2009 KDHS. This comparative analysis provided insights into the ways in which the couples either challenged, or complied with, the prevailing Kiribati gender order. This analysis then allowed me to explore links between vasectomy and equitable gender relations.

In this chapter, I review the key elements of each chapter and then discuss my overall findings in relation to my research questions. This discussion also considers research implications. I reflect on some more general limitations of this study. I note the strengths and academic contributions of my research. I make recommendations for policy and practice and offer some ideas for future studies. I end with final reflections about what my research means for gender and development research, policy and practice.

7.1 Summary of thesis

Chapter 1 made explicit the link between engaging men in sexual and reproductive health and rights, particularly vasectomy, and gender equality, and explained why this topic is of relevance to development research, policy and practice. I explained my intended research topic and supporting research questions. Further, the chapter set the context for this thesis by providing a brief overview of Kiribati and its development; and by addressing vasectomy trends globally, and in Kiribati. I also explained the rationale behind my epistemology, gave a brief introduction to my methodology and concluded by reflecting on my positionality.

In Chapter 2 I described socially-constructed concepts of gender and power that formed the foundation of this thesis, and was attentive to their relational nature. I reviewed

international and Pacific literature to explore women's and men's 'place' in development theory and practice since the 1960s. I explained that there is a disjuncture between gender and development theory and practice. I noted that many programmes continue to focus on women even though addressing gender inequalities requires a relational analysis. Further, I highlighted why targeting women-only is problematic – women's and men's lives are inextricably interconnected – and men's efforts to uphold the gender order can present significant obstructions. I looked at connections between gender equality, gender norms and family planning praxis. I demonstrated that women and men are typically framed dualistically (women as vulnerable, men as aggressors), specifically in relation to SRHR and explained why this approach is so limiting. I concluded by examining links between vasectomy and gender equity. Further, this chapter highlighted the gaps that this thesis addresses.

Chapter 3 gave a more in-depth analysis of the literature that exists on I-Kiribati women and men to provide insights into their lives in relation to one another. Through this analysis I revealed normative gender relations in Kiribati society. I situated Kiribati in terms of GAD theory and praxis and linked this to the literature previously addressed in Chapter 2. I highlighted how I-Kiribati women are frequently framed as vulnerable, particularly in terms of SRHR issues, whilst men are more generally viewed as upholding hegemonic masculine behaviours and attributes. I argued that the dominant discourse fails to capture the diversity of lived experiences of I-Kiribati women and men, which I supported with feminist arguments. I explained why feminists challenge the dualistic categorisations of gender and gender relations that are often conveyed in development discourse, and related their arguments to the Kiribati context.

My methodology in Chapter 4 provided the rationale for undertaking a case study approach. I described my collaborative relationship with KFHA and how this significantly aided my research process and outcomes. Throughout this chapter, I demonstrated how I upheld feminist and indigenous research principles. I gave a detailed description of each of my methods and explained my rationale for using: in-depth interviews, focus group discussions, key informant interviews and observations. I said how I had generated the data and described my analysis process. Although I addressed some more general ethical concerns at the end of the chapter, reflections and ethical considerations concerning my methods are also embedded within the chapter.

In Chapter 5 I introduced the participants and focused on the views of the participant-couples while also comparing these with the other participants' views. I included details of the names that the participants had assumed and the demographic details of the participant-couples and the focus group participants. This chapter melded my findings with a discussion that focused on gender roles within the family and community, and built on the literature that was reviewed in Chapter 3. I argued that while it was clear that I-Kiribati women and men had defined gender roles, these were not fixed or universal. In some cases, women's and men's roles blurred. This blurring served to highlight the way that gender norms are mutable and gender roles can evolve in response to societal changes, for example, adjusting to life as a nuclear family. My analysis of gender roles in Kiribati also demonstrated that gender roles and gender relations are more complex than dominant discourses might suggest.

Additionally, I looked at the multiple roles women fulfil in Kiribati society, namely reproductive, productive and community work, which linked to concepts introduced in Chapters 2 and 3. I analysed gender norms to determine how women are valued in Kiribati society and found that, for the most part, there is no child preference for a particular gender, but land rights advantage men, yet there were also some inconsistencies in participants' views. I looked at the ways gender norms shaped expectations for I-Kiribati women and men. The chapter revealed that both women and men were expected to be competent in local skills and to value Kiribati society. Women were expected to be talented in homemaking skills, although, counter to the dominant views, one participant felt that women should have a good job. Notably, no participant-couple condoned violence or drunken behaviour in men. This general disapproval of violence does align with the notion that the men in these couples demonstrated more gender equitable behaviours.

Chapter 6 discussed my findings. I positioned the views and experiences of the participant-couples with those of the other participants and with the literature to determine the extent to which the participant-couples conformed with the dominant gender order. I examined the gendered nature of family planning and found that, across the participant groups, family planning was generally associated with women and in many instances was believed to be women's responsibility. My research also showed that women's reproductive role goes beyond their work in the household. However, some of the men from the participant-couples explicitly stated contraception was a man's responsibility too. I questioned why

vasectomy is considered a threat to masculinity, and found my participants' responses were consistent with international research on this theme.

I explored participants' perceptions on spousal communication and family planning decision-making. I determined that public perceptions of inter-spousal decision-making regarding family planning do not always align with the lived reality, and in the cases of the participant-couples, it was relatively equitable. I examined the concept of agency in terms of both sexual coercion and vasectomy decision-making, and highlighted the different manifestations of agency that I discussed in Chapter 2. I considered the links between vasectomy and less equitable gender relations, which showed that connections between vasectomy and gender equity are complex.

I will now expand on, and analyse, some of the key findings of this research.

7.2 Discussion

My thesis demonstrates that by *exploring connections between vasectomy acceptance and equitable gender relations among couples in Kiribati* using a case study, I was able to show that the links between these phenomena are complex, dynamic and problematic. This exploration involved examining:

- *I-Kiribati women's and men's roles and responsibilities within the household and community*
- *How women and men make important decisions that affect their families, including ones relating to their sexual and reproductive health, and*
- *The impacts of vasectomy for women.*

I showed that, contrary to gender normative behaviours in Kiribati, there are some I-Kiribati men who want to be actively involved in family planning decision-making and are willing to accept responsibility for contraception. Importantly, vasectomy acceptance by I-Kiribati men was both a consequence and cause of more equitable gender relations, reinforcing Jacobstein's point that, "with gender equity comes vasectomy and vice versa" (Jacobstein, 2015, p. 1). Each of the five participant-couples revealed 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.

The role the I-Kiribati women participants played in encouraging their husbands to have a vasectomy was both explicit (asking their husband directly to have a vasectomy) and/or implicit (the husbands opted to be vasectomised out of concern for their wives' well-being). As with equitable household decision-making, access to and control over family resources, the ability to make child-bearing decisions and use contraceptives are all indicative of women's empowerment (Malhotra & Schuler, 2005), arguably a woman's ability to influence her husband to have a vasectomy is a measure of her agency. Of note is that each of the wives in the participant-couples demonstrated agency with regards to these important decisions that affected their lives, which contrasts with popular views about I-Kiribati women (Chapter 3). My findings suggest therefore that both the women and men from the participant-couples supported more equitable gender norms, which has implications for development policy and practice that extend beyond the provision of SRHR programmes. In terms of vasectomy specifically, it is clear that promoting vasectomy to women is therefore equally important.

The husbands' motivations to have a vasectomy were often prompted by egalitarian concerns, such as wanting to protect their wives' health. This finding is consistent with 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). For the Kiribati participant-couples, the vasectomy resulted in outcomes which fostered wives' agency, either directly or indirectly, including: reduced childcare and household duties; being able to actively participate in the local women's group and accept leadership roles; increased opportunity to generate an income or work in the formal economy and for career advancement; and increased enjoyment of sex. Several wives even reported receiving greater support with household duties from their husbands following vasectomy. It was evident that women benefit in multiple ways when their husband or partner has a vasectomy. Vasectomy uptake therefore has wider implications for gender equality.

However, the connection between equitable relationships and vasectomy is complex. Some participants knew of instances where men used vasectomy as a means to behave less equitably, such as having relationships with women outside of their marriage, and as a form of power over their partners. There was also evidence to suggest that while vasectomy

frees women from reproduction in the biological sense, they continue to perform the bulk of 'reproductive' work in the home. 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 therefore empowering. In such cases, having additional responsibilities contributed positively to the women's lives, not negatively.

Vasectomy, in and of itself, however, is unlikely to change deeply-embedded inequitable practices, because 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 addressed 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 my thesis has demonstrated.

While gender equitable relationships appeared to be a pre-condition for the men in this research to consider vasectomy, other factors, such as financial considerations and family well-being, also influenced their final decision. Arguably, these men would have been less likely to contemplate having a vasectomy if they held inequitable views, since vasectomy uptake challenges entrenched gender norms regarding contraception. For vasectomy to become more widely accepted in Kiribati, messaging around SRHR should not perpetuate the notion that family planning is only for women or about women; and more fundamentally, it should also tackle structural inequalities across all levels of society.

Vasectomy is also unlikely to gain acceptance while women and men fear its perceived impacts. As this research has demonstrated, participants from across the participant groups believed vasectomy de-masculinises men. Since masculinity is tied up with ideas about a man's strength, sexual prowess, ability to father children, and provide for his family, it is unsurprising that vasectomy was not widely trusted by I-Kiribati women and men, particularly those who have little understanding of what the procedure actually involves. International studies from a range of geographical regions, including the Pacific (Drysdale, 2015), Africa (Adongo et al., 2014), Asia (Dahal et al, 2008) and South America (Marván et al., 2017), produced similar findings.

This research highlights the fact that individuals have multifaceted identities and their behaviour can be contradictory. For example, it could be argued that several of the husbands were demonstrably equitable towards their wives – they shared decision-making, the care of the children and duties in the home, and expressed real concern for their wives' health, and yet, they also displayed inequitable behaviours or attitudes, including seeking relationships outside marriage and endorsing sexual coercion.

It must also be acknowledged that since most I-Kiribati men appeared to maintain a position of control in their families and often acted as gatekeepers, at least publically, it is really important that KFHA and the Ministry of Health and Medical Services (MoHMS) continue to actively engage with men in their roles as partners, fathers and community leaders, as other studies have also identified (Daube et al, 2016; Macdonald et al., 2013).

Finally, as Chapters 5 and 6 demonstrated, aspects of this study reinforce findings from Pacific and international research on vasectomy uptake, and SRHR more generally. For example, my findings were consistent with other studies in terms of: gender norms associated with family planning responsibility; (misplaced) concerns that vasectomy de-masculinises men; men being motivated to have a vasectomy out of concern for their wives' health; women's key role in vasectomy decision-making; and concerns that vasectomy can enable both women's and men's infidelity.

While other international studies found that wives played a key role in the vasectomy decision-making process, as I noted in Chapter 6, these studies did not establish the extent to which the women had agency in other household decision-making so, unlike my study, no connections between women's agency and their husband's decision to have a vasectomy were made. Moreover, although some studies referred to the ways in which women benefitted from vasectomy, these were not analysed from a feminist perspective and therefore links between vasectomy, agency and empowerment were lacking. Additionally, unlike my case study, none of the studies that informed my literature review reported vasectomy being used to counter perceived threats of women's infidelity – in other words, a wife's pregnancy would "catch a wife out".

7.3 Limitations

It is important to acknowledge that this research was not without its limitations. While my methodology chapter (Chapter 4) addressed these, including exploring the limitations of case study research methodology and the methods I used, I want to conclude with some final reflections. Since I am not I-Kiribati, I do not have a lived-experience of Kiribati culture, which unquestionably is a limitation. Researching cross-culturally was extremely rewarding but also posed challenges in terms of data collection and analysis (Chapter 4).

Moreover, although the case study approach was not intended to produce generalisable findings, the research was limited to participants who lived in South Tarawa, the most urbanised island in Kiribati. The experiences of couples on the outer islands may have differed from those living in an urban environment. Participants were also selected by KFHA staff and asked if they wished to take part, rather than signing up independently. While the five participant-couples lived in diverse locations on South Tarawa, none of the men were in formal employment and their level of schooling was equally similar. By chance, three of the key informants had had a vasectomy. These men were employed and had a high level of education. Overall, the research might have been enhanced if men from more diverse backgrounds were included, to help to identify possible variations in gender equitable attitudes and behaviours according to background.

Although it was not possible to eliminate, or control, all the limitations, I did take steps to address them where possible, as I discuss in the following section.

7.4 Research strengths and academic contribution

The research's strength lies in the rich, contextual insights it has generated regarding gender norms, gender relations, attitudes and practices of the participant-couples, specifically in relation to vasectomy uptake in South Tarawa, Kiribati. My collaboration with KFHA and trusting relationship with them and the participants enabled the generation of very rich relevant data. The case study approach allowed me to manage a complex topic, and to differentiate 'vasectomy acceptance and equitable gender relations' from the context of a real-life situation in nuanced ways. I was able to bring together multiple sources of evidence using a range of methods, and to triangulate my findings with the results of the

2009 KDHS, other SRHR studies conducted in Kiribati, and international research to generate robust analysis and conclusions.

Although there is an increasing amount of research that addresses gender equality and engaging men and boys internationally, this is the first study of its kind to be conducted in Kiribati. Even within the Pacific region, this type of research is new. Further, much of the research on gender equality and engaging men and boys comes from the health field.

While there is increasing recognition of the relational aspect of gender in development studies, limited research focuses on couple participants and addresses male contraceptive methods. Finally, globally there are few studies on vasectomy and development, particularly from a gender perspective. Consequently, this thesis contributes to the international literature that critiques the absence of men in gender and development research, policy and practice; and literature that calls for more nuanced understandings of power within intimate gender relations.

7.5 Recommendations

A number of recommendations can be drawn from my study. Arguably, they have applicability beyond Kiribati; however, they need to be adapted for the cultural context. Further, some recommended actions are already being undertaken by service providers in Kiribati, and where this is the case, I would encourage the providers to build on their existing practices.

I recommend that:

- Service providers actively engage men in SRHR initiatives, both in their own right as contraception users (condoms and vasectomy), and as partners or allies in support of their wives/partners, daughters or community members using contraception.
- Couple-counselling is expanded to other family planning methods, not just vasectomy, contingent on a woman's approval.
- The topics of jealousy and infidelity are addressed during couple counselling, as these issues can act as a barrier to all forms of family planning uptake, not just vasectomy.
- Vasectomy is promoted to women as well as men.

- SRHR campaigns dispel the idea that family planning is only for women or about women, however, messaging should avoid reinforcing men's power over women.
- SRHR programmes work holistically to actively address gender equality, in culturally appropriate ways.
- Satisfied vasectomised clients are encouraged to participate in awareness campaigns, providing they are equipped with the correct information.
- Clear and accurate information about vasectomy, and men's sexual health more generally is provided, to dispel perceived threats to masculinity.
- Beyond the provision of SRHR, it is recognised that shared decision-making exists in some households in Kiribati, as this has implications for other development initiatives.

7.6 Suggested areas for further study

Suggested areas for further study include:

- Expanding the scope of this study to include:
 - experiences of couples on the outer islands
 - vasectomised men from more diverse backgrounds
 - experiences of couples in which the man considered a vasectomy but did not go ahead with the procedure
- Examining connections between equitable gender relations and female contraceptive usage
- Exploring the influence of men on other men, in terms of promoting contraception for men.

More generally, I recommend that future SRHR studies that focus on heterosexual relationships, address gender relations between couples, rather than focusing on women's experiences in isolation.

7.7 Final reflections

This research has shown that gender norms in South Tarawa, Kiribati are not fixed, and that even against a background of deeply-embedded cultural and religious beliefs and practices,

gender norms can evolve. Equally too, cultures evolve and changes in societal factors can impact gender norms and gender relations. Essentialist framings of gender, gender roles, gender relations, sexualities, masculinities and femininities can result in oversimplified development solutions which not only fail to recognise that gender inequality is not universal within a society, but also cannot effectively tackle gender inequality, and at their worst actually perpetuate inequalities.

Within the GAD research context, heterosexual men appear largely absent. Gender and development research, policy and practice requires a complex understanding of gender relations. It also demands that attention be paid to how power operates within relationships, and to concepts of intersectionality, acknowledging that people are multifaceted and that power is dynamic and operates in a relational way, between women and men, but also between women and women, and men and men.

Above all, my research showed that many aspects of development in relation to SRHR are complex. Failure to recognise this complexity can reinforce assumptions and limit the exploration of alternatives. Framing I-Kiribati women as passive victims without agency, and men as aggressors and a problem, is limiting. It perpetuates stereotypes and, most importantly, fails to acknowledge the diversity of the Kiribati population, which in turn can result in narrow programmatic solutions. Development actors should be encouraged to acknowledge I-Kiribati women's agency and recognise that there are women and men who support equitable gender norms. Learning from their experiences opens up space for alternative paths to sustainable development.

Appendix A – Information sheets

In-depth interview participants in English and Kiribati

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

Man tibwangan te ‘aine’ nakon tibwangan te ‘mwane’: te ukeuke imarenaia aomata ake a tia ni kainin ao aron te reitaki ao te irekereke i marenan te aine ao te mwane are e boboto iaon te boraoin irekereke imarenan te aine ao te mwane iaon Tarawa Teinainano ma Betio, Kiribati.

INFORMATION SHEET FOR IN-DEPTH INTERVIEW PARTICIPANTS

Beban rongorongo ibukin te tia titirakinaki n te aro ae tabwanin raoi

Thank you for your interest in this project. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to take part, thank you for considering my request.

Ko rabwa ibukin am kan ibuobuoki nakon te karikirake aei. Taiaoka wareka rongorongo aika a katauraaki ikai imwain ae ko iangoia raoi bwa ko na anga am ibuobuoki ke ko na aki. Ngkana ko kan anga am ibuobuoki ao ko bati n rabwa. Ngkana ko aki kan anga am ibuobuoki ao ko rabwa.

Who am I? Antai ngai?

My name is Alexandra (Alex) Hill and I am a Masters student in Development Studies at Victoria University of Wellington. This research project is work towards my thesis, and a report for Kiribati Family Health Association (KFHA).

Arau bon Alexandra (Alex) Hill ao bon temanna ngai ataein te reirei iaon te Mwatita te Katematebwai ibukin te rikirake n te kura n reirei ae rietata i Wellington, Nutiran. Te kamatebwai aio N na bon kabongana ibukin au koroboki are e na reke naba bwa te riiboti ae na kabongana te KFHA.

What is the aim of the project?

This project aims to learn about vasectomy awareness and experiences of i-Kiribati men and women, to understand if couples talk about decisions to have a vasectomy, and to find out how women are affected when men take on the role of contraception in a couple. The project will also provide Kiribati Family Health Association (KFHA) and Family Planning New Zealand with recommendations on how to increase awareness of vasectomy, as a family planning option, in Kiribati.

This research has been approved by the Victoria University of Wellington Human Ethics Committee 23625.

Tera te kantanninga man te mwakuri aei?

Ana takete te mwakuri aio bwa ena karekei aron te kaongora ma tetaneiai irouia I- Kiribati aika mwane ao aine, n ataia bwa ngkana taanga baireia bwa ana kainaki aia tabo ni kariki. Te mwakuri aio, ena kona n angan te Kiribati Family Health Association (KFHA) ao Babairean te utu Nutiran ma iango ioan aron karikirakean te atatai iaon kainan aia tabo ni kariki mwane bwa aia kawai iaon Kiribati.

How can you help?

If you agree to take part I will interview you together, as a couple, in your own home or a place you specify, with the assistance of KFHA staff. The interview is informal and all the questions will be translated into the Kiribati language. I will ask you questions about your family life and the different roles men and women have in your family. The interview will take 45 minutes to one hour. You do not have to answer any questions which make you feel uncomfortable. I will record the interview and write it up later. You can stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any point before 9 April 2017. If you withdraw, the information you provided will be destroyed or returned to you.

I would also like to have a follow-up interview with each of you separately, on another day, to discuss your experience of family planning and vasectomy. A same-sex KFHA will assist. Some of the questions may be difficult or sensitive to answer. You do not have to answer any questions which make you feel uncomfortable. I will record the interview and write it up later. You can stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any point before 9 April 2017. If you withdraw, the information you provided will be destroyed or returned to you.

Kona kanga ngkoe ni ibuobuoki?

Ngkana ko kariaia bwa kona riki naba bwa temanna ae nna kona ni maroro ngkami, bwa taanga, nimwengami ke te tabo are ko taku ni buokaki irouia kain te KFHA. Te maroro ae bebetae ao ni kabane titiraki a rairaki nakon te taetae ni Kiribati. Nna titirakiniko ibukin am utu ao kaokoron tibwangan tem wane ao te aine inanon am utu. Te maroro ena kabanea 45 te miniti nakon teauana te aia. Kona aki kaekai ni kabane titiraki akana ko namakinna bwa ko mwengabuaka ni kaekai. Nna tau i mwini te maroro ao ni korei imwina. Ko kona ni katoka te maroro nte tai are ko taku, n akea kaotan bukina. Kokona ni bubai man te kamatebwai man reitaki ma ngai imwain 9 n Eberi 2017. Ngkana ko bubai, te rogorongo are ko anga ena kabuaki ke kaokaki nakoim.

Nna tangiria naba n rimwin ara maroro n tatabemani ngkami, nte bong teuana ni maroro iaon aron otami ni kainan ana tabo ni kariki te mwane. Te mwane ane na ibuobuoki man KFHA. Tabeua titiraki ana matoatoa man nano kaekakia. Konaki kaekai titiraki akana ko taku bwa ko aki mwengaraai iai. Nna rawea ao man korea mwini te maroro imwina. Kokona ni katoka te maroro nte tai are ko taku, n aki kaota bukina. Kokona ni bubai man man te maroro imwain 9 n Eberi 2017. Ngkana ko bubai, te rogorongo are ko anga ana uruakaki ke ni kaokaki nakoim.

What will happen to the information you give?

Tera te bwai ae nariki nakon te rogorongo are ko anga?

This research is confidential. The Research Assistants have signed an agreement to say that they will not tell anyone that you have taken part in this study and that they are not allowed to discuss

anything you talk about, except with me. No one will be able to trace your answers back to you. Recordings of interviews, transcripts, field notes and summaries will be stored securely throughout the research process, and destroyed three years after the research ends. This information will only be shared with my academic supervisor. Any information disclosed to her will be treated in confidence.

E taburoroko ma ni kamanoaki raoi kanoan te kakae. Te tia ibuobuoki iaon te kakae e atia ni kariaia ae naki kona n tuanga temanna ae ngkoe kain te kamatebwai ao man aki kariaiakaki bwa ana maroroakinna te bwai are ko taekinna, ma ti ngai. Akea temanna ae na kona ni kakai am kaeka nakoim. Tauan mwin maroro, katoto, ma mwin te kakae ana kawakinaki raoi inanon karaoan te kakae, ao ana kakeaki teniua te ririki imwin banen te kakae. Te rongorongo aio ena bon ti kona ni tibwaki ma te tia kairiri nte kura. Ni kabana aekakin rongorongo ake ana kaotinakoaki nakon neiei ana bon karaoaki n angana aika mano.

What will the project produce?

Tera te bwai ae reke man te mwakuri?

The information from my research will be used in my Masters dissertation, and to produce a report for KFHA. The Masters dissertation will be made available online, and KFHA will have copies of the report. The research results may also be used for academic reports and conference presentations. I will ensure that you are not identified in any report or presentation.

Te rongorongo man au kakae ena kabonganaki inanon rongorongon au Matita, ao ni kaotinako te ribooti ibukin te KFHA. Te rongorongo iaon te Matita ena kona n reke iaon te intanete, ao ana iai naba ana katoto KFHA. Mwin te kakae ena kona ni kabonganaki ibukin te riboti nte reirei ao kaotakina nte maroro. I kakoaua bwa ko aki kinaki inanon te ribooti ke kaotakina.

If you accept this invitation, what are your rights as a research participant?

Ngkana ko kariaia te kakao, tera inaomatam ae kain te kakae?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

Ko naki kariaia te kakao aio ngkana ko aki tangiria. Ngkana ko bairei n riki bwa kaina, iai ianaomatam n:

- choose not to answer any question;
Rinea konaki kaekai aekan titiraki
- ask to stop the interview at any time;
tuangai bwa ena toki te maroro nte tai ane ko taku
- ask for the recorder to be turned off at any time during the interview;
Tuanga te tia rawerawe bwa ena kainna nte tai are k otaku ntain te maroro
- withdraw from the study before 9 April 2017;
Bubai man te kamatebwai imwain 9 n Eberi 2017
- ask any questions about the study at any time;
Titiraki ibukin te kamatebwai nte tai ane ko taku
- read over and comment on a written summary of your interview;
Warekia ma imoana ao koro am iango iaon rongorongon am maroro
- agree on another name for me to use rather than your real name;

kariaia iaon te ara tabeua ibukiu bwa nna kabongana nakon are oin aram

- be able to read any reports of this research by emailing the researcher to request a copy. If you do not have access to email or the internet, please ask KFHA to make contact on your behalf.

E na reke te ribooti man te kakae aio ngkana emery nakon te tia kakae ngkana ko tangira te katoto. Ngkana ko aki kona n reitaki nte emery ke intanet, taiaoka titiraki nakon KFHA bwa ena reitaki ibukim.

If you have any questions or problems, who can you contact?

Ngkana iai am titiraki ke am kanganga, antai ae kona reitaki mangaia?

If you have any questions, either now or in the future, please feel free to contact either:

Ngkana iai am titiraki, tao ngkai ke ntaai aika na roko, taiaoka reitaki ma:

Researcher:

Alexandra Hill

Supervisor:

Associate Professor Sara Kindon

School:

School of Geography, Environment and
Earth Sciences

University contact details:

alex.e.hill@vuw.ac.nz

University contact details:

sara.kindon@vuw.ac.nz

+64 4 463 6194

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convener: Associate Professor Susan Corbett. Email susan.corbett@vuw.ac.nz or telephone +64-4-463 5480.

Te rabwata ni kakoauai rongorongoia aomata

Ngkana arona ba iai am raraoma ni kaineti ma tuan kakoauan te kakae ao ko kona n reitaki ma te kuura n reirei ae rietata ae Uikitoria Uniwetiti HEC Te tia barongaia, te tia ibuobuoki ni burobetia ae Susan Cobett, ana meeri susan.corbett@gmail.com or tareboon +64-4-463 5480.

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

Man tibwangan te ‘aine’ nakon tibwangan te ‘mwane’: te ukeuke imarenaia aomata ake a tia ni kainin ao aron te reitaki ao te irekereke i marenan te aine ao te mwane are e boboto iaon te borao in irekereke imarenan te aine ao te mwane iaon Tarawa Teinainano ma Betio, Kiribati.

INFORMATION SHEET FOR FOCUS GROUP DISCUSSION PARTICIPANTS

Beban rongorongo ibukia kain taan maroro ni kurubu

Thank you for your interest in this project. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to take part, thank you for considering my request.

Ko rabwa ibukin am kan ibuobuoki nakon te karikirake aei. Taiaoka wareka rongorongo aika a katauraaki ikai imwain ae ko iangoia raoi bwa ko na anga am ibuobuoki ke ko na aki. Ngkana ko kan anga am ibuobuoki ao ko bati n rabwa. Ngkana ko aki kan anga am ibuobuoki ao ko rabwa.

Who am I? Antai ngai?

My name is Alexandra (Alex) Hill and I am a Masters student in Development Studies at Victoria University of Wellington. This research project is work towards my thesis, and a report for Kiribati Family Health Association (KFHA).

Arau bon Alexandra Hill ao bon temanna ngai ataein te reirei iaon te Mwatita te Katematebwai ibukin te rikirake n te kura n reirei ae rietata i Wellington, Nutiran. Te kamatebwai aio N na bon kabongana ibukin au koroboki are e na reke naba bwa te riiboti ae na kabongana te KFHA.

What is the aim of the project?

This project aims to learn about vasectomy awareness and experiences of i-Kiribati men and women, to understand if couples talk about decisions to have a vasectomy, and to find out how women are affected when men take on the role of contraception in a couple. The project will also provide Kiribati Family Health Association (KFHA) and Family Planning New Zealand with recommendations on how to increase awareness of vasectomy, as a family planning option, in Kiribati.

This research has been approved by the Victoria University of Wellington Human Ethics Committee 23625.

Tera te kantanninga man te mwakuri aei?

Ana takete te mwakuri aio bwa ena karekei aron te kaongora ma tetaneiai irouia I-Kiribati aika mwane ao aine, n ataia bwa ngkana taanga baireia bwa ana kainaki aia tabo ni kariki. Te mwakuri aio, ena kona n angan te Kiribati Family Health Association (KFHA) ao Babairean te utu Nutiran ma iango ioan aron karikirakean te atatai iaon kainan aia tabo ni kariki mwane bwa aia kawai iaon Kiribati.

How can you help?

If you agree to take part you will be involved in a focus group discussion at Kiribati Family Health Association, with a small group of same-sex participants (all men or all women). You are welcome to bring a support person, who is the same sex as you, to the focus group discussion. The focus group discussion will be led by a facilitator in the Kiribati language. You will discuss your knowledge and awareness of family planning, including vasectomy. The focus group will take one and a half hours with a short break for food and a drink in the middle. I will be attending the focus group with an i-Kiribati Research Assistant who will act as my translator and transcriber. You do not have to answer any questions which make you feel uncomfortable.

Ko na kanga n ibuobuoki

Ngkana ko kukurei ba ko na ira buakon te maroro ni kurubu n te Kiribati Family Health Association, n mwaitimi ae bon karako naba mwaitia (bon mwaane ao aine irouia). Ko rang butimwaeaki ni kona ni bon kaira tao raom n aine ke mwane ba e na buobuoki naba. Te maroro ni kurubu e na bon kairaki n te taetae Kiribati. Ko na bon maroroakini am atatai ao matatam ibukin babairean te utu, n ikotaki ma te korokoro ni kainin irouia mwaane. Te maroro ni kurubu e na bon ana teuana ao te iterana (1.30 hr) ao e na iai te motirawa ibukin te amwarake ao moo iimarenan tai. Nna bon rook n taint e maroro ni kurubu ma te tia buobuoki n te kakae ae ngaia e na riki ba te tia raira te taetae ni imtang nakon Kiribati ao koroboki naba. Ko aki kantanningaki ba ko na kaekai titiraki ake ko mwengabuaka iai.

What will happen to the information you give?

If you agree to participate you cannot withdraw any information you share in the discussion. You are welcome to leave at any point if you feel uncomfortable, however, any information that you provide, up to that point, will be kept. The focus group discussion will be recorded, and transcribed and written up later.

Ngkana ko kukurei ba ko na ira buakon aei ao ko aki kona ni bubuti kerikakin rongorongo ake ko a tia tibwatibwai n taai te maroro. Ko rang butimwaeaki ni kona ni mawa ngkana ko mwengabuaka, ma rongorongo ake ko a tia ni katauraai e na bon kawakinaki. Te maroro ni kurubu e na bon raweaki ao ni manga rairaki ao koreaki rongorongona imwina

This research is confidential. The Focus Group Facilitator and the Research Assistant have signed an agreement to say that they will not tell anyone that you have taken part in this study and that they are not allowed to discuss anything you talk about, except with me. No one will be able to trace your answers back to you. Recordings of interviews, transcripts, field notes and summaries will be stored securely throughout the research process, and destroyed three years after the research ends.

This information will only be shared with my academic supervisor. Any information disclosed to her will be treated in confidence.

E taburoroko ma ni kamanoaki raoi kanoan te kakae. Te tia ibuobuoki iaon te kakae e atia ni kariaia ae naki kona n tuanga temanna ae ngkoe kain te kamatebwai ao man aki kariaiakaki bwa ana maroroakinna te bwai are ko taekinna, ma ti ngai. Akea temanna ae na kona ni kakai am kaeka nakoim. Tauan mwin maroro, katoto, ma mwin te kakae ana kawakinaki raoi inanon karaaoan te kakae, ao ana kakeaki teniua te ririki imwin banen te kakae. Te rongorongon aio ena bon ti kona ni tibwaki ma te tia kairiri nte kura. Ni kabana aekakin rongorongon ake ana kaotinakoaki nakon neiei ana bon karaoaki n angana aika mano.

What will the project produce? (Tera te bwai ae reke man te mwakuri?)

The information from my research will be used in my Masters dissertation, and to produce a report for KFHA. The Masters dissertation will be made available online, and KFHA will have copies of the report. The research results may also be used for academic reports and conference presentations. I will ensure that you are not identified in any report or presentation.

Te rongorongon man au kakae ena kabonganaki inanon rongorongon au Matita, ao ni kaotinako te ribooti ibukin te KFHA. Te rongorongon iaon te Matita ena kona n reke iaon te intanete, ao ana iai naba ana katoto KFHA. Mwin te kakae ena kona ni kabonganaki ibukin te riboti nte reirei ao kaotakina nte maroro. I kakoaua bwa ko aki kinaki inanon te ribooti ke kaotakina.

If you accept this invitation, what are your rights as a research participant?

Ngkana ko kariaia te kakao, tera inaomatam ae kain te kakae?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

Ko naki kariaia te kakao aio ngkana ko aki tangiria. Ngkana ko bairei n riki bwa kaina, iai ianaomatam n:

- Bring a support person who is the same sex as you to the focus group discussion;
Kaira ae kona buobuoki ae bon raom n mwaane ke n aine nakon te maroro ni kurubu
- choose not to answer any question;
Titiraki ibukin te kamatebwai nte tai ane ko taku
- ask to leave the focus group discussion at any time;
Tuatua ba ko na kitana te maroro ni kurubu n te tai are ko bon taku
- ask any questions about the study at any time;
Titiraki ngkana iai ibukin te kamatebwai n tai are ko bon taku
- read over and comment on a written summary of your comments shared in the discussion;
Wareware riki ao kanako iango iaon mwin korean am maroro ni ibuobuoki n tan te maroro
- agree on another name for me to use rather than your real name;
Kariaia iaon te ara tabeua ibukiu bwa nna kabongana nakon are oin aram
- be able to read any reports of this research by emailing the researcher to request a copy. If you do not have access to email or the internet, please ask KFHA to make contact on your behalf.

E na reke te ribooti man te kakae aio ngkana emery nakon te tia kakae ngkana ko tangira te katoto. Ngkana ko aki kona n reitaki nte emery ke intanet, taiaoka titiraki nakon KFHA bwa ena reitaki ibukim

If you have any questions or problems, who can you contact?

Ngkana iai am titiraki ke am kanganga, antai ae kona reitaki mangaia?

If you have any questions, either now or in the future, please feel free to contact either:

Ngkana iai am titiraki, tao ngkai ke ntaai aika na roko, taiaoka reitaki ma:

Researcher: *(Te tia kakae)*

Alexandra Hill

University contact details: *(itoman ma te uniwetiti)*

alex.e.hill@vuw.ac.nz

Supervisor: *(Te tia tararua)*

Associate Professor Sara Kindon

School: *(Te reirei)*

School of Geography, Environment and Earth Sciences

University contact details *(itomam ma te uniwetiti)*

sara.kindon@vuw.ac.nz

+64 4 463 6194

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convener: Associate Professor Susan Corbett. Email susan.corbett@vuw.ac.nz or telephone +64-4-463 5480.

Te rabwata ni kakoauai rongorongoia aomata

Ngkana arona bwa iai am raraoma ni kaineti ma tuan kakoauan te kakae ao ko kona n reitaki ma te kuura n reirei ae rietata ae Uikitoria Uniwetiti HEC Te tia barongaia, te tia ibuobuoki ni burobetia ae Susan Corbett, ana meeri susan.corbett@vuw.ac.nz ke tareboon +64-4-463-5480.

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

INFORMATION SHEET FOR KEY INFORMANTS (COMMUNITY LEADERS) (This will be translated into Kiribati)

Thank you for your interest in this project. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to take part, thank you for considering my request.

Who am I?

My name is Alexandra (Alex) Hill and I am a Masters student in Development Studies at Victoria University of Wellington. This research project is work towards my thesis, and a report for Kiribati Family Health Association (KFHA).

What is the aim of the project?

This project aims to learn about vasectomy awareness and experiences of i-Kiribati men and women, to understand if couples talk about decisions to have a vasectomy, and to find out how women are affected when men take on the role of contraception in a couple. The project will also provide Kiribati Family Health Association (KFHA) and Family Planning New Zealand with recommendations on how to increase awareness of vasectomy as a family planning option in Kiribati.

This research has been approved by the Victoria University of Wellington Human Ethics Committee 23625.

How can you help?

If you agree to take part I will interview you either at your workplace, in your own home or a place you specify, with the assistance of an i-Kiribati Research Assistant. The interview is informal and all the questions will be translated into the Kiribati language. I will ask you questions about community awareness of family planning, including vasectomy. The interview will take 45 minutes to one hour. You do not have to answer any questions which make you feel uncomfortable. I will record the interview and write it up later. You can stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any point before 9 April 2017. If you withdraw, the information you provided will be destroyed or returned to you.

What will happen to the information you give?

This research is confidential. The Research Assistant has signed an agreement to say that they will not tell anyone that you have taken part in this study and that they are not allowed to discuss anything you talk about, except with me. No one will be able to trace your answers back to you.

Recordings of interviews, transcripts, field notes and summaries will be stored securely throughout the research process, and destroyed three years after the research ends. This information will only be shared with my academic supervisor. Any information disclosed to her will be treated in confidence.

What will the project produce?

The information from my research will be used in my Masters dissertation, and to produce a report for KFHA. The Masters dissertation will be made available online, and KFHA will have copies of the report. The research results may also be used for academic reports and conference presentations. I will ensure that you are not identified in any report or presentation.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
 - ask to stop the interview at any time;
 - ask for the recorder to be turned off at any time during the interview;
 - withdraw from the study before 9 April 2017;
 - ask any questions about the study at any time;
 - read over and comment on a written summary of your interview;
 - agree on another name for me to use rather than your real name;
 - be able to read any reports of this research by emailing the researcher to request a copy.
- If you do not have access to email or the internet, please ask KFHA to make contact on your behalf.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact either:

Researcher:

Alexandra Hill

University contact details:

alex.e.hill@vuw.ac.nz

Supervisor:

Associate Professor Sara Kindon

School:

School of Geography, Environment and Earth Sciences

University contact details:

sara.kindon@vuw.ac.nz

+64 4 463 6194

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convener: Associate Professor Susan Corbett. Email susan.corbett@vuw.ac.nz or telephone +64-4-463 5480.

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

INFORMATION SHEET FOR KEY INFORMANTS (SERVICE PROVIDERS)

Thank you for your interest in this project. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to take part, thank you for considering my request.

Who am I?

My name is Alexandra (Alex) Hill and I am a Masters student in Development Studies at Victoria University of Wellington. This research project is work towards my thesis, and a report for Kiribati Family Health Association (KFHA).

What is the aim of the project?

This project will explore connections between vasectomy acceptance and equitable gender relations between partners in Kiribati by examining the vasectomy experiences of i-Kiribati men and women. The key objectives are to: explore how couples negotiate gender norms that suggest contraception is ‘women’s business’, examine the role of spousal communication in their decision-making, and to investigate what implications vasectomy acceptance has on women, when men assume responsibility for contraception. The project will also provide Kiribati Family Health Association (KFHA) and Family Planning New Zealand with recommendations on how to increase awareness of vasectomy, as a family planning option, in Kiribati.

This research has been approved by the Victoria University of Wellington Human Ethics Committee 23625.

How can you help?

If you agree to take part I will interview you either at your workplace, or a place you specify. The interview is informal. I will ask you questions about vasectomy uptake in Kiribati; community awareness of family planning and vasectomy; spousal decision-making relating to vasectomy; and for your views on how you think men and women negotiate gender norms that can affect decisions around vasectomy up-take. The interview will take 45 minutes to one hour. I will record the interview and write it up later. You can stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any point before 9 April 2017. If you withdraw, the information you provided will be destroyed or returned to you.

What will happen to the information you give?

This research is confidential, unless you request to be named or to have your organisation named. Otherwise, no one will be able to trace your answers back to you. Recordings of interviews, transcripts, field notes and summaries will be stored securely throughout the research process, and destroyed three years after the research ends. This information will only be shared with my academic supervisor. Any information disclosed to her will be treated in confidence.

What will the project produce?

The information from my research will be used in my Masters dissertation, and to produce a report for KFHA. The Masters dissertation will be made available online, and KFHA will have copies of the report. The research results may also be used for academic reports and conference presentations. I will ensure that you are not identified in any report or presentation.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
 - ask to stop the interview at any time;
 - ask for the recorder to be turned off at any time during the interview;
 - withdraw from the study before 9 April 2017;
 - ask any questions about the study at any time;
 - read over and comment on a written summary of your interview;
 - agree on another name for me to use rather than your real name;
 - be able to read any reports of this research by emailing the researcher to request a copy.
- If you do not have access to email or the internet, please ask KFHA to make contact on your behalf.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact either:

Researcher:

Alexandra Hill

University contact details:

alex.e.hill@vuw.ac.nz

Supervisor:

Associate Professor Sara Kindon

School:

School of Geography, Environment and Earth Sciences

University contact details:

sara.kindon@vuw.ac.nz

+64 4 463 6194

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convener: Associate Professor Susan Corbett. Email susan.corbett@vuw.ac.nz or telephone +64-4-463 5480.

Appendix B – Consent forms

In-depth interview participants in English and Kiribati

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

Man tibangan ‘te aine’ nakon tibwangan te ‘mwane’: te kakae ae irekereke imarenaia aomata ake atia ni kainaki aia tabo ni kariki ao n reitaki ma te boraraoi imarenan te aine ao te mwane iaon Tarawa Teinainano ma Betio iaon Kiribati.

CONSENT TO INTERVIEW (Informal in-depth interview participants)
(kariaia ba e na karaoaki te titiraki ni maroronikawai – titirakinan te aomata n te aro ae rang teretere raoi)

This consent form will be held for five years. (Te kariaia e na kabonganaki ibukin nimaua (5) years

Researcher: Alexandra Hill, School of Geography, Environment and Earth Sciences, Victoria University of Wellington.

Te tia kakae: Alexandra Hill, te reirei ibukin rongorongon aonnaba, te otabwanin ma rabakau n aonnaba I Vikitoria n ana Kura ae rietata I Uerington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I atia ni wareka te rongorongo iaon te beba ao n tia kabwarabwaraki nakoiu te mwakuri ni kakae. Au titiraki a bane n tia ni kaekaki nakon are I kantaningaia. I matata raoi bwa I kona n titiraki riki nte tai are I bon taku.
- I agree to take part in an audio recorded interview.
- I kariaia bwa nna riki bwa temanna naba ngai ae na raweaki au maroro.

I understand that:

I matata raoi bwa:

- I may withdraw from this study at any point before 9 April 2017, and any information that I have provided will be returned to me or destroyed.

- I kona ni bubai man te kamatebwai nte tai are I taku imwain 9 April 2017, ao rongorongo ake I atia n anga ana kaokaki nakoiu ke ni kabuaki.
- The information I have provided will be destroyed three years after the research is finished.
- Rongorongo ake I atia n anga ana kona ni kamaunaki 3 te ririki imwin tian te kakae.
- Any information I provide will be kept confidential to the researcher and the supervisor. I understand that the results will be used for a Masters report and a summary of the results may be used in academic reports and/or presented at conferences.
- Ni kabane rongorongo ake I anga ana riai ni kawakinaki man kamanoaki raoi nakon te tia kakae ao te tia kairiri. I matata bwa mwin te kakae ana kabonganaki ibukin ana riboti te Matita ao rongorongo aika kakawaki iwmin te kamatebwai ana kabonganaki ibukin ribooti nte reirei ke ni kaotaki inanon te maroro.
- My name will not be used in reports, nor will any information that would identify me.
- E naki kabonganaki arau inanon te riboti ke nte rongorongo are nna ananga kinaki iai
- I would like a summary of my interview: Yes ☐ No ☐
- I tangirii mwin au maroro aika kakawaki Eng.... I aki.....
- I would like to receive a copy or a summary of the final report and have Yes ☐ No ☐ added my email address below.
- I tangiria ni karekea katoton ke rongorongo aika kakawaki man bwaninin te ribooti ao n tia n ikotaki nakon au meeri ane oti inano. Eng Tiaki

Signature of participant: _____

Tiaina:

Name of participant: _____

Aram:

Date: _____

Bongin te namwakaina:

Contact details: _____

Am tabo are komena iai:

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

Man tibangan ‘te aine’ nakon tibwangan te ‘mwane’: te kakae ae irekereke imarenaia aomata ake atia ni kainaki aia tabo ni kariki ao n reitaki ma te boraraoi imarenan te aine ao te mwane iaon Tarawa Teinainano ma Betio iaon Kiribati.

CONSENT TO INTERVIEW (Focus group participants)
Kariaia nakon te titirakinaki: taan taketenaki n te maroro ni kurubu

This consent form will be held for five years.
Te booma ni kariaia e na kariaiakaki ibukin Nimaaua te ririki

Researcher: Alexandra Hill, School of Geography, Environment and Earth Sciences, Victoria University of Wellington. *Te tia kakae: Alexandra Hill, te reirei ibukin rongorongon aonnaba, te otabwanin ma rabakau n aonnaba I Vikitoria n ana Kura ae rietata I Uerington.*

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
I atia ni wareka te rongorongo iaon te beba ao n tia kabwarabwaraki nakoia te mwakuri ni kakae. Au titiraki a bane n tia ni kaekaki nakon are I kantaningaia. I matata raoi bwa I kona n titiraki riki nte tai are I bon taku.
- I agree to take part in an audio recorded interview.
I kariaia bwa nna riki bwa temanna naba ngai ae na raweaki au maroro.
- I consent to the confidentiality rules and agree to sign the ‘Confidentiality Statement’.
I butimwaea tuan kamanoan kainan te rongorongo ao kukurei n tiaina te kaetieti ibukin kainan te rongorongo.

I understand that: *I matata raoi bwa:*

- I can bring a support person of the same sex as me to the focus group discussion.
I kona ni bon kaira ae na kona naba boutoka ae bon raou n aine ke ni mwane nakon te maroro ni kawai.
- I cannot withdraw any information that I share during the focus group discussion.
I bon aki kona ni buti rongorongo ake I tibwai n tain te maroro.
- I can ask to leave the focus group discussion, at any point, if I do not feel comfortable but any information that I have shared up to that point will be kept.

I kona n tuatua kitanakin te maroro n te tai are I namakina iai te mwengabuaka ao rongorongo ake I a tia n tibwatibwai a na bon tiku.

- The information I have provided will be destroyed three years after the research is finished.
Rongorongo ake I atia n anga ana kona ni kamaunaki 3 te ririki imwin tian te kakae.
- Any information I provide will be kept confidential to the researcher and the supervisor. I understand that the results will be used for a Masters report and a summary of the results may be used in academic reports and/or presented at conferences.
Ni kabane rongorongo ake I anga ana riai ni kawakinaki man kamanoaki raoi nakon te tia kakae ao te tia kairiri. I matata bwa mwin te kakae ana kabonganaki ibukin ana riboti te Matita ao rongorongo aika kakawaki iwmin te kamatebwai ana kabonganaki ibukin ribooti nte reirei ke ni kaotaki inanon te maroro.
- My name will not be used in reports, nor will any information that would identify me.
E naki kabonganaki arau inanon te riboti ke nte rongorongo are nna ananga kinaki iai.
- I would like a summary of my interview Yes ☐ No ☐
I tangirii mwin au maroro aika kakawaki
- I would like to receive a copy or a summary of the final report and have added my email address below. Yes ☐ No ☐
I tangiria ni karekea katoton ke rongorongo aika kakawaki man bwaninin te ribooti ao n tia n ikotaki nakon au meeri ane oti inano. (Eng / Tiaki)

Signature of participant: (Tiaina) _____

Name of participant: (Aram) _____

Date: (Bong namwakaina) _____

Contact details: (Am tabo kam mena iai) _____

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

CONSENT TO INTERVIEW (Key Informant Interviews)

This consent form will be held for five years.

Researcher: Alexandra Hill, School of Geography, Environment and Earth Sciences, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree to take part in an audio recorded interview.

I understand that:

- I may withdraw from this study at any point before 9 April 2017, and any information that I have provided will be returned to me or destroyed.
- The information I have provided will be destroyed three years after the research is finished.
- Any information I provide will be kept confidential to the researcher and the supervisor. I understand that the results will be used for a Masters report and a summary of the results may be used in academic reports and/or presented at conferences.
- I consent to information or opinions which I have given being attributed to me/my organisation in any reports on this research: Yes ☐ No ☐
If yes, please circle, as appropriate.
- I would like a summary of my interview: Yes ☐ No ☐
- I would like to receive a copy of the final report and have added my email address below. Yes ☐ No ☐

Signature of participant: _____

Name of participant/organisation: _____

Date: _____

Contact details: _____

Appendix C – Confidentiality agreements

Cultural guide/Research assistant

Confidentiality Agreement: Cultural Guide/Research Assistant

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

Principal Investigator: Alexandra Hill

I, _____, agree to ensure that the interviews/focus groups that I translate and the audiotapes I transcribe will remain confidential to Alexandra Hill and myself. I understand that the information gathered for this research project is sensitive, and should be treated with the highest confidentiality.

I agree to take the following precautions:

1. I will not divulge the identity/identities of the participants from the interviews or the focus group discussions.
2. I will not discuss any aspect of the interviews/focus group discussions with anyone, other than Alexandra Hill.
3. I will ensure that no person, other than Alexandra Hill, hears the recording.
4. I will ensure that no other person has access to the transcriptions on the computer that I will use.
5. I will delete the files from the computer once the transcription has been completed.
6. I will not discuss any aspect of the recording with anyone except Alexandra Hill.

Signature: _____

Date: _____

Confidentiality Statement: Focus Group Participants

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

Man tibangan 'te aine' nakon tibwangan te 'mwane': te kakae ae irekereke imarenaia aomata ake a tia ni kainaki aia tabo ni kariki ao n reitaki ma te borararaoi imarean te aine ao te mwane iaon Tarawa Teinainano ma Betio iaon Kiribati.

Principal Investigator: Alexandra Hill *(Te tia karaoa te kakae: Alexandra Hill)*

I, _____, agree to treat the information shared in the focus group confidentially, and I will not discuss it with others.

Ngai ae _____, I tauraoi ni butimwaei ao ni kaini rongorongoa ake a na tibwaki man maroroakinaki n taint e maroro, ao n aki maroroakini ma tabeman

I agree to take the following precautions:
I tauraoi ni iri kanoan taian kauring aikai:

1. I will not divulge the identity/identities of the participants from the focus group discussions. *(Nna aki taekini rongorongon temanna ma temanna man kanoan nako te maroro n ara tai maroronikawai)*
2. I will not discuss any aspect of the focus group discussions with anyone outside this discussion, other than Alexandra Hill and the Kiribati Family Health Association (KFHA) Facilitator. *(Nna bon aki naba taekini kanoan nako te maroro ni kawai ma aomata itinanikun te maroronikawai, bon ti kona maroro nakon Alexandra Hill ke taan anga reirei man te Kiribati Family Health Association)*

Signature (Tiaina): _____

Date (Bong n namwakaina): _____

Confidentiality Agreement: Focus Group Facilitator

From ‘women’s business’ to ‘men’s business’: exploring connections between vasectomy acceptance and equitable gender relations in South Tarawa, Kiribati.

Principal Investigator: Alexandra Hill

I, _____, agree to ensure that the focus groups that I facilitate will remain confidential to Alexandra Hill and myself. I understand that the information gathered for this research project is sensitive, and should be treated with the highest confidentiality.

I agree to take the following precautions:

1. I will not divulge the identity/identities of the participants from the focus group discussions.
2. I will not discuss any aspect of the focus group discussions with anyone, outside this discussion, other than Alexandra Hill.

Signature: _____

Date: _____

Appendix D - Questions guides

In-depth Participants

Informal in-depth interviews: couples in which the man has had a vasectomy

Theme: getting to know each other

Prompts

1. Sharing family stories, photos
2. Family characteristics eg ages, number of children, ages of children
3. Details re occupation/s

Theme: gender roles, attitudes and gender relations

Prompts

4. What kinds of household tasks do women do in your family? (including daughters, mothers, mothers-in-law)?
5. What kinds of household tasks do men do in your family? (including sons, fathers and father's in law)?
6. What kinds of paid or unpaid jobs do women do in your community?
7. What kinds of paid or unpaid jobs do men do in your community?
8. How are decisions made in your family?
9. How do you make decisions about things that are important to your family (eg land, animals, money)?
10. How are decisions made in your community?
11. What do you feel are important characteristics of an i-Kiribati woman?
12. What do you feel are important characteristics of an i-Kiribati man?
13. What do people in your community think is a good family size?
14. How are decisions around family size reached?
15. How are daughters valued in your community?
16. How are sons valued in your community?

Wrap up

17. Thank you for participating in this study. I'd like to set up a time that we can speak with each of you separately, with a same-sex staff member from KFHA, if you are comfortable participating in a second interview. Can you please advise when you

each would be available, in the week starting 30 January 2017? It does not have to be on the same day.

Informal in-depth interviews: men who have had a vasectomy

Introduction

Prompts

1. Conversational warm-up

Theme: sexual and reproductive health awareness, knowledge and experience

Prompts

2. Which family planning methods are you familiar with?
3. What do you think are the most common family planning methods used in Kiribati?
4. How do people in your community get information about their sexual and reproductive health?
5. Where do people in your community go for their sexual and reproductive health services (such as family planning; antenatal care; gynecological services; testing and treatment of sexually transmitted infections/HIV etc)?
6. Why do people in Kiribati use family planning? Which people use family planning?
7. Who or what would encourage people in your community to use a family planning method?
8. Who or what would discourage people in your community from using a family planning method?
9. Can you tell me about your family planning experience before you had a vasectomy?
Did you use any form of family planning before you had a vasectomy?

Theme: vasectomy awareness, attitudes, and knowledge

Prompts

10. Do you think people know about vasectomy in your community?
11. How do people learn about vasectomy in your community?
12. What do you think people in your community feel about this family planning method?
13. Who or what would encourage men in your community to have a vasectomy?
14. Who or what would discourage men in your community to have a vasectomy?

15. How did you find out about vasectomy?
16. What do you think about vasectomy services in Kiribati?

Theme: personal experience and decision-making regarding vasectomy

17. Can you share with me your vasectomy experience?
18. How long ago did you have a vasectomy?
19. Who/what influenced your choice to have a vasectomy?
20. Is vasectomy acceptable to Kiribati culture?
21. When you were thinking about having a vasectomy, did you discuss it with anyone else? (If yes, whom?)
22. Can you tell me how your wife responded, both before and after you had the procedure?
23. How easy/acceptable was it to talk with your wife about this decision?
24. Did you discuss this with your wife in the same way you make other decisions for your family?
25. How did you make the final decision?
26. Do you think it is important that husbands and wives talk to each other about family planning decisions?
27. What do you think are some benefits of having a vasectomy?
28. What do you think are some benefits for women?
29. What do you think i-Kiribati men feel about themselves after having had a vasectomy?
30. What do you think i-Kiribati women feel about their husbands after they have had a vasectomy?

Theme: perceptions of friends, family and community regarding vasectomy

31. Have you discussed your vasectomy with your friends, family or other members of your community?
32. If yes, with whom and how did they react?
33. Is it acceptable/easy to talk to other members of your community about vasectomy?
34. Would you encourage a friend or family member to have a vasectomy?
35. Why? / Why not? What would you say?
36. What do you think are some good ways to reach i-Kiribati men and women to tell them about vasectomy?

Wrap up

37. Do you have any other things you would like to tell me that we have not already talked about?
38. Thank you and reminders about their rights and next steps

Informal in-depth interviews: wives or partners of men who have had a vasectomy

Introduction

Prompts

1. Conversational warm-up (using a culturally appropriate way to start the conversation)

Theme: sexual and reproductive health awareness, knowledge and experience

Prompts

2. What do you know about ways to control when you have a baby (family planning)?
3. What are the most common ways that families in your community control when to have or not have baby?
4. How do people in your community get information about their sexual and reproductive health?
5. Where do people in your community go for their sexual and reproductive health services (such as family planning; antenatal care; gynecological services; testing and treatment of sexually transmitted infections/HIV etc)?
6. Who in your community decides to use family planning? [This could include choices relating to gender, religious beliefs, age, occupation, education etc]
7. How are family planning decisions made?
8. Who or what would encourage people in your community to use a family planning method?
9. Who or what would discourage people in your community from using a family planning method?
10. Can you tell me about your family planning experience before your husband had a vasectomy?

Theme: vasectomy awareness, attitudes, and knowledge

Prompts

11. What do people know about vasectomy in your community?
12. How do people learn about vasectomy in your community?
13. What do people in your community think/believe about this family planning method?
14. Who or what would encourage men in your community to have a vasectomy?
15. Who or what would discourage men in your community to have a vasectomy?
16. How did you find out about vasectomy?
17. What do you think about vasectomy services in Kiribati?

Theme: personal experience and decision-making regarding vasectomy

Prompts

18. Can you share with me about your husband's vasectomy experience?
19. Who/what influenced his choice to have a vasectomy?
20. Did your cultural beliefs and practices influence decisions around your husband's vasectomy? If so, how? If not, why?
21. How involved were you in the decision? [If yes, during which stages? If no, can you tell me why this might be the case?]
22. Can you tell me how you responded, both before and after he had the procedure?
23. How easy/acceptable was it to talk with your husband about this decision?
24. In your community, do wives and husbands talk to each other about family planning?
25. What do you think are some benefits for women if their husband/partner has a vasectomy?
26. What do you think are some benefits for men of having a vasectomy?
27. What do you think i-Kiribati women feel about their husbands after they have had a vasectomy?
28. What do you think i-Kiribati men feel about themselves after having had a vasectomy?

Theme: perceptions of friends, family and community regarding vasectomy

29. Have you discussed your husband's vasectomy with your friends, family or other members of your community?

- 30. If yes, with whom and how did they react?
- 31. Is it acceptable/easy to talk to other members of your community about vasectomy?
- 32. Would you encourage a friend or family member to talk with their husband about having a vasectomy? Why? / Why not? What would you say?
- 33. What do you think are some good ways to reach i-Kiribati men and women to tell them about vasectomy?

Wrap up

- 34. Do you have any other things you would like to tell me that we have not already talked about?
- 35. Thank you and reminders about their rights and next steps

Focus Groups

Focus group discussions: men who have not had a vasectomy

Introduction

Prompts

1. Introduction to study / agree on focus group rules (confidentiality, respect for other's opinions)
2. Conversational warm-up (using a culturally appropriate way to start the conversation)

Theme: sexual and reproductive health awareness, knowledge and experience

Prompts

3. Which family planning methods are you familiar with?
4. What do you think are the most common family planning methods used in Kiribati?
5. How do people in your community get information about their sexual and
6. reproductive health?
7. Where do people in your community go for their sexual and reproductive
8. health services (such as family planning; antenatal care; gynecological services; testing and treatment of sexually transmitted infections/HIV etc)?
9. Why do people in Kiribati use family planning? Which people use family planning?
10. Who or what would encourage people in your community to use a family
11. planning method?
12. Who or what would discourage people in your community from using a
13. family planning method?

Theme: vasectomy knowledge, awareness and attitudes

Prompts

14. One method of family planning is vasectomy. What do you know about vasectomy?
15. Do you know anyone who has had a vasectomy? If yes, did they say why they had one?
16. What do people in your community think/believe about vasectomy?
17. Who or what would encourage men in your community to have a vasectomy?
18. Who or what would discourage men in your community from having a vasectomy?

Theme: views on decision-making regarding vasectomy

Prompts

19. Who do you think should be involved in the decision to have a vasectomy?
20. Do you think cultural beliefs and practices would influence decisions to have a vasectomy? If so, how? If not, why?
21. In your community, do husbands and wives talk to each other about family planning?
22. What do you think are some benefits of having a vasectomy?
23. What do you think are some benefits for women when men have a vasectomy?
24. What do you think i-Kiribati men feel about themselves after having had a vasectomy?
25. What do you think i-Kiribati women feel about their husbands after they have had a vasectomy?
26. Would you consider a vasectomy as a family planning option? If no, why not? If yes, who/what would influence your choice?

Theme: views on raising awareness about vasectomy

Prompts

27. Do you think vasectomy should be promoted as a family planning option in your community? If no, why not? If yes, why?
28. What do you think are some good ways to reach i-Kiribati men and women to tell them about vasectomy?

Wrap up

29. Do you have any other things you would like to tell me that we have not already talked about?
30. Thank you and reminders about their rights and next steps

Focus group discussions: wives/partners of men who have not had a vasectomy

Introduction

Prompts

1. Introduction to study/ agree on focus group rules (confidentiality, respect for others' opinions)

2. Conversational warm-up (using a culturally appropriate way to start the conversation)

Theme: sexual and reproductive health awareness, knowledge and experience

Prompts

3. What do you know about ways to control when you have a baby (family planning)?
4. What are the most common ways that families in your community control when to have or not have baby?
5. How do people in your community get information about their sexual and reproductive health?
6. Where do people in your community go for their sexual and reproductive health services (such as family planning; antenatal care; gynecological services; testing and treatment of sexually transmitted infections/HIV etc)?
7. Who decides to use family planning or what method to use?
8. How are family planning decisions made?
9. Who or what would encourage people in your community to use a family planning method?
10. Who or what would discourage people in your community from using a family planning method?

Theme: vasectomy knowledge, awareness and attitudes

Prompts

11. One method of family planning is vasectomy. What do you know about vasectomy?
12. Do you know anyone who has had a vasectomy? If yes, do you know why they had one?
13. What do people in your community think/believe about vasectomy?
14. Who or what would encourage men in your community to have a vasectomy?
15. Who or what would discourage men in your community from having a vasectomy?

Theme: views on decision-making regarding vasectomy

16. Who do you think should be involved in the decision to have a vasectomy?
17. Do you think cultural beliefs and practices would influence decisions to have a vasectomy? If so, how? If not, why?
18. In your community, do husbands and wives talk to each other about family planning?
19. What do you think are some benefits for men of having a vasectomy?

- 20. What do you think are some benefits for women when men have a vasectomy?
- 21. What do you think i-Kiribati men feel about themselves after having had a vasectomy?
- 22. What do you think i-Kiribati women feel about their husbands after they have had a vasectomy?
- 23. Would you consider vasectomy as a family planning option? If no, why not? If yes, how easy/acceptable would it be to bring it up with your husband?

Theme: views on raising awareness about vasectomy

Prompts

- 24. Do you think vasectomy should be promoted as a family planning option in your community? If no, why not? If yes, why?
- 25. What do you think are some good ways to reach i-Kiribati men and women to tell them about vasectomy?

Wrap up

- 26. Do you have any other things you would like to tell me that we have not already talked about?
- 27. Thank you and reminders about their rights and next steps

Key Informants

Key informant interviews: Community leaders

Theme: sexual and reproductive health awareness and knowledge in the community

Prompts

1. What is your role in your community?
2. What do you know about ways women can control when to have a baby/not have a baby (family planning)?
3. What are the most common ways that families in your community control when to have or not have baby?
4. How do people in your community get information about their sexual and reproductive health?
5. Where do people in your community go for their sexual and reproductive health services (such as family planning; antenatal care; gynecological services; testing and treatment of sexually transmitted infections/HIV etc)?
6. Who decides to use family planning or what method to use?
7. How are family planning decisions made?
8. Who or what would encourage people in your community to use a family planning method?
9. Who or what would discourage people in your community from using a family planning method?

Theme: knowledge and perceptions of vasectomy and views on community awareness and perceptions

Prompt

10. Have you heard about vasectomy? If yes, what do you know about it?
11. What do people in your community think/believe about vasectomy?
12. Who or what would encourage men in your community to have a vasectomy?
13. Who or what would discourage men in your community from having a vasectomy?
14. Who do you think should be involved in the decision to have a vasectomy?
15. Do you think cultural beliefs and practices would influence couples' or men's decisions to have a vasectomy? If so, how? If not, why?
16. In your community, do husbands and wives talk to each other about family planning?

17. What do you think are some benefits for men of having a vasectomy?
18. What do you think are some benefits for women when men have a vasectomy?
19. What do you think i-Kiribati men feel about themselves after having had a vasectomy?
20. What do you think i-Kiribati women feel about their husbands after they have had a vasectomy?
21. Do you think vasectomy should be promoted as a family planning option in your community? If no, why not? If yes, why?
22. Would leaders in your community feel comfortable promoting this family planning option/ discussing it with community members? If no, why not? If yes, why?
23. If yes, what would enable you to provide accurate information to your community members?
24. What do you think are some good ways to reach i-Kiribati men and women to tell them about vasectomy?
25. Do you have any other things you would like to tell me that we have not already talked about?

Key informant interviews: Kiribati Family Health/Ministry of Health/United Nations Population Fund (UNFPA) Regional office representatives

Note: not all of these potential questions were relevant to each party. Questions were used as appropriate, and adjusted for the participant.

Theme: sexual and reproductive health awareness, knowledge and services in Kiribati

Prompts

1. How knowledgeable are community members [people in Kiribati] about sexual and reproductive health and rights, in the areas that you provide services?
2. Is practicing family planning acceptable in your community [Kiribati]?
3. What are barriers that some men and women face in terms of access to family planning? (cultural/social/availability)
4. What are the main family planning methods that you offer/are available in Kiribati?
5. Which methods is most readily used, and why do you think this is the case?
6. Who is generally responsible for deciding to use family planning or what method that is used? (Men/women/shared)

7. Do you think that this decision-making power is the same in other areas of people's lives?
8. How many male clients do you see? What services do they generally use?

Theme: vasectomy programme and types of clients, client motivations, characteristics

Prompts

9. Can you tell me about KFHA's vasectomy programme/vasectomy programmes run by the Ministry of Health? (length of time it has been running/ number of clients per year on average/ where service is delivered)
10. Are couples, in which the husband decides to have a vasectomy, normally using a family planning method before deciding to have a vasectomy? If so, what types?
11. What are the main reasons that men (couples) give for deciding to have a vasectomy?
12. What types of men have a vasectomy?

Theme: community knowledge and perceptions of vasectomy

Prompts

13. How well known is vasectomy as a family planning choice in your community/Kiribati?
14. What are the general views and attitudes towards vasectomy in Kiribati?
15. Do men's and women's attitudes to vasectomy differ? If so, in what ways?
16. What are some examples of misinformation that you have heard about vasectomy from community members/people in Kiribati?
17. What are some fears that men have about vasectomy?
18. What are some fears that women have about vasectomy?
19. What barriers do men face in having a vasectomy?
20. What things encourage or promote men to have a vasectomy?

Theme: spousal decision-making regarding vasectomy

Prompts

21. Who / what influences a man's decision to have a vasectomy?
22. Are wives involved in the decision for their partners to have a vasectomy?
23. In what ways are they involved?
24. What are the implications for women when men assume the role of contraception?
25. What do you think i-Kiribati men feel about themselves after having had a vasectomy?

26. What do you think i-Kiribati women feel about their husbands after they have had a vasectomy?
27. Can you think of effective ways to increase awareness of vasectomy in Kiribati?
28. Do you have any other things you would like to tell me that we have not already talked about?

Key informant interviews: Community leaders

Theme: sexual and reproductive health awareness and knowledge in the community

Prompts

1. What is your role in your community?
2. What do you know about ways women can control when to have a baby/not have a baby (family planning)?
3. What are the most common ways that families in your community control when to have or not have baby?
4. How do people in your community get information about their sexual and reproductive health?
5. Where do people in your community go for their sexual and reproductive health services (such as family planning; antenatal care; gynecological services; testing and treatment of sexually transmitted infections/HIV etc)?
6. Who decides to use family planning or what method to use?
7. How are family planning decisions made?
8. Who or what would encourage people in your community to use a family planning method?
9. Who or what would discourage people in your community from using a family planning method?

Theme: knowledge and perceptions of vasectomy and views on community awareness and perceptions

Prompt

10. Have you heard about vasectomy? If yes, what do you know about it?
11. What do people in your community think/believe about vasectomy?
12. Who or what would encourage men in your community to have a vasectomy?
13. Who or what would discourage men in your community from having a vasectomy?

14. Who do you think should be involved in the decision to have a vasectomy?
15. Do you think cultural beliefs and practices would influence couples' or men's decisions to have a vasectomy? If so, how? If not, why?
16. In your community, do husbands and wives talk to each other about family planning?
17. What do you think are some benefits for men of having a vasectomy?
18. What do you think are some benefits for women when men have a vasectomy?
19. What do you think i-Kiribati men feel about themselves after having had a vasectomy?
20. What do you think i-Kiribati women feel about their husbands after they have had a vasectomy?
21. Do you think vasectomy should be promoted as a family planning option in your community? If no, why not? If yes, why?
22. Would leaders in your community feel comfortable promoting this family planning option/ discussing it with community members? If no, why not? If yes, why?
23. If yes, what would enable you to provide accurate information to your community members?
24. What do you think are some good ways to reach i-Kiribati men and women to tell them about vasectomy?
25. Do you have any other things you would like to tell me that we have not already talked about?

References

- Adongo, P. B., Tapsoba, P., Phillips, J. F., Tabong, P. T.-N., Stone, A., Kuffour, E., . . . Akweongo, P. (2014). "If you do vasectomy and come back here weak, I will divorce you": A qualitative study of community perceptions about vasectomy in Southern Ghana. *BMC International Health and Human Rights*, 14(1), 16. <https://doi.org/10.1186/1472-698X-14-16>
- Agarwal, B. (1997). "Bargaining" and gender relations: Within and beyond the household. *Feminist Economics*, 3(1), 1-51. <https://doi.org/10.1080/135457097338799>
- Asia Development Bank. (2018). *ADB's Work in Kiribati*. Retrieved from <https://www.adb.org/countries/kiribati/overview>
- Australian Aid. (2017). *Pacific Women Shaping Pacific Development*. Retrieved from <https://pacificwomen.org/our-work/locations/kiribati/>
- Barbara, D. B., & Benjamin, C. (2006). Making sense of qualitative research: The qualitative research interview. *Medical Education*, 40, 314–321. <https://doi.org/10.1111/j.1365-2929.2006.02418.x>
- Barker, G., Ricardo, C., Nascimento, M., Olukoya, A., & Santos, C. (2010). Questioning gender norms with men to improve health outcomes: Evidence of impact. *Global Public Health*, 5(5), 539-553. <https://doi.org/10.1080/17441690902942464>
- Baxter, J. (2010). Case studies in qualitative research. In I. Hay (Ed.), *Qualitative Research Methods in Human Geography* (3rd ed., pp. 81-98). Oxford, England; New York, NY: Oxford University Press.
- Bertotti, A. M. (2013). Gendered divisions of fertility work: Socioeconomic predictors of female versus male sterilization. *Journal of Marriage and Family*, 75(1), 13-25. Retrieved from <https://search.proquest.com/docview/1324622876?accountid=14782>
- Borovnik, M. (2005). Seafarers' 'Maritime culture' and the 'i-Kiribati way of life': The formation of flexible identities? *Singapore Journal of Tropical Geography*, 26(2), 132-150. <https://doi.org/10.1111/j.0129-7619.2005.00210.x>
- Brewis, A. (1992). Sexually-transmitted disease risk in a Micronesian atoll population. *Health Transition Review*, 195-213. Retrieved from <http://www.jstor.org/stable/40651984>
- Brewis, A. (1993). Age and infertility in a Micronesian atoll population. *Human Biology*, 65(4), 593-609. Retrieved from <http://www.jstor.org/stable/41465126>

- Brewis, A. (2001). Gender conflict and co-operation in reproductive decision-making in Micronesia. *The Journal of the Polynesian Society*, 110(4), 391-400. Retrieved from <http://www.jstor.org/stable/20707021>
- Bunce, A., Guest, G., Searing, H., Frajzyngier, V., Riwa, P., Kanama, J., & Achwal, I. (2007). Factors affecting vasectomy acceptability in Tanzania. *International Family Planning Perspectives*, 13-21. Retrieved from <http://www.jstor.org/stable/30039188>
- Came, H. (2013). Doing research in Aotearoa: a Pākehā exemplar of applying Te Ara Tika ethical framework. *Kotuitui: New Zealand Journal of Social Sciences Online*, 8(1-2), 64-73. <https://doi.org/10.1080/1177083X.2013.841265>
- Cameron, J. (2010). Focussing on the focus group. In I. Hay (Ed.), *Qualitative Research Methods in Human Geography* (3rd ed., pp. 152-172): Oxford, England; New York, NY: Oxford University Press.
- Campbell, R., & Wasco, S. M. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology*, 28(6), 773-791. Retrieved from <https://search.proquest.com/docview/205349374?accountid=14782>
- Caulson, P. (1993). Social welfare issues. In H. Van Trease (Ed.), *Atoll Politics: The Republic of Kiribati* (pp. 258-265). Christchurch, New Zealand; Fiji: Macmillan Brown Centre for Pacific Studies, University of Canterbury and Institute of Pacific Studies, University of the South Pacific.
- Chacko, E. (2004). Positionality and praxis: Fieldwork experiences in rural India. *Singapore Journal of Tropical Geography*, 25(1), 51-63. <https://doi.org/10.1111/j.0129-7619.2004.00172.x>
- Chant, S. (2000). From 'woman-blind' to 'man-kind': Should men have more space in gender and development? *IDS Bulletin*, 31(2), 7-17. <https://doi.org/10.1111/j.1759-5436.2000.mp31002002.x>
- Chant, S., & Gutmann, M. C. (2002). 'Men-streaming' gender? Questions for gender and development policy in the twenty-first century. *Progress in Development Studies*, 2(4), 269-282. <https://doi.org/10.1191/1464993402ps041ra>
- Chetty, T., & Faleatua, R. (2015). *Keeping it under the mat: The struggle for sexual and reproductive rights in the Pacific Island region*. Retrieved from http://www.dawnnet.org/feminist-resources/sites/default/files/articles/20160131_RATS_Book_TOC_bookmarks.pdf
- Cleary, L. M. (2013). *Cross-cultural research with integrity*. Basingstoke, England: Palgrave Macmillan.
- COP23 Fiji. (2017). Retrieved from <https://cop23.com.fj/kiribati/>

- Cope, M. (2010). Coding Qualitative Data. In I. Hay (Ed.), *Qualitative Research Methods in Human Geography* (3rd ed., pp. 281-294). Oxford, England; New York, NY: Oxford University Press.
- Cornwall, A. (1997). Men, masculinity and 'gender in development'. *Gender and Development*, 5(2), 8-13. <https://doi.org/10.1080/741922358>
- Cornwall, A. (2006). Marginalisation by sexuality: Report of an IDS workshop. *Gender and Development*, 14(2), 273-289. <https://doi.org/10.1080/13552070600747305>
- Cornwall, A. (2016). Women and empowerment: What works? *Journal of International Development*, 28(3), 342-359. <https://doi.org/10.1002/jid.3210>
- Cornwall, A., Corrêa, S., & Jolly, S. (2008). *Development with a body: Sexualities, Development and Human Rights*. London; New York: Zed Books.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches*. (4th ed.). Thousand Oaks, CA: Sage Publications.
- Cronin-Furman, K., Gowrinathan, N., & Zakaria, R. (2017). *Emissaries of empowerment*. New York: Colin Powell School for Civic and Global Leadership at the City College of New York. Retrieved from <http://www.deviarchy.com/emissaries-of-empowerment/>
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, NSW: Allen & Unwin.
- Dahal, G. P., Padmadas, S. S., & Hinde, P. R. A. (2008). Fertility-limiting behavior and contraceptive choice among men in Nepal. *International Family Planning Perspectives*, 34(1), 6-14. Retrieved from <http://www.jstor.org/stable/30039252>
- Daube, J., Chamberman, V., & Raymond, E. (2016). Barriers to contraceptive use in South Tarawa, Kiribati. *Pacific Journal of Reproductive Health*, 1(4). <https://doi.org/10.18313/pjrh.2016.912>
- Davis, K. (2008). Intersectionality as buzzword. A sociology of science perspective on what makes a feminist theory successful. *Feminist Theory*, 9(1), 67-85. <https://doi.org/10.1177/1464700108086364>
- Davis Lewis, N. (1998). Intellectual intersections: gender and health in the Pacific. *Social Science & Medicine*, 46(6), 641-659. [https://doi.org/10.1016/S0277-9536\(97\)00180-9](https://doi.org/10.1016/S0277-9536(97)00180-9)
- De Keijzer, B. (2004). Masculinities: resistance and change. In S. Ruxton & Oxfam (Eds.), *Gender equality and men: Learning from practice* (pp. 28-49). Oxford, England; Herdon, VA: Oxfam.
- Dowling, R. (2010). Power, subjectivity, and ethics in qualitative research. In I. Hay (Ed.), *Qualitative Research Methods in Human Geography* (3rd ed., pp. 26-39). Oxford, England; New York, NY: Oxford University Press.

- Drysdale, R. (2015). *A study in increasing vasectomy uptake: Understanding acceptability of vasectomy uptake amongst men in three regions of Papua New Guinea*. Retrieved from <https://www.k4health.org/resources/study-increasing-vasectomy-uptake-understanding-acceptability-vasectomy-uptake-amongst-men>
- Dunn, K. (2010). Interviewing. In I. Hay (Ed.), *Qualitative Research Methods in Human Geography* (3rd ed., pp. 101-138). Oxford, England; New York, NY: Oxford University Press.
- Dworkin, S. L., Colvin, C., Hatcher, A., & Peacock, D. (2012). Men's perceptions of women's rights and changing gender relations in South Africa: Lessons for working with men and boys in HIV and antiviolenence programs. *Gender and Society*, 26(1), 97-120. <https://doi.org/10.1177/0891243211426425>
- England, K. V. (2008). Getting personal: Reflexivity, positionality, and feminist research. In H. Bauder & S. Engel-Di Mauro (Eds.), *Critical Geographies: A Collection of Readings* (pp. 241-256). Retrieved from <http://www.praxispress.org/availablebooks/introcriticalgeog.html>
- Falconer Al-Hindi, K., & Kawabata, H. (2002). Toward a more fully reflexive feminist geography. In P. Moss (Ed.), *Feminist Geography in Practice: Research and Methods*. (pp. 103-116). Oxford, UK; Malden, Mass: Blackwell.
- Family Planning New Zealand. (2016). *Family planning in South Tarawa Kiribati: Usage and barriers*. Retrieved from <http://www.familyplanning.org.nz/media/302832/south-tarawa-kiribati-usage-and-barriers.pdf>
- Family Planning New Zealand. (2016). *Life in Kiribati: A Woman's Perspective*. Retrieved from <http://www.familyplanning.org.nz/news/2016/life-in-kiribati-a-woman%E2%80%99s-perspective>
- Farrelly, T., & Nabobo-Baba, U. (2014). Talanoa as empathic apprenticeship. *Asia Pacific Viewpoint*, 55(3), 319-330. <https://doi.org/10.1111/apv.12060>
- Feyisetan, B. J. (2000). Spousal communication and contraceptive use among the Yoruba of Nigeria. *Population Research and Policy Review*, 19(1), 29-45. Retrieved from <http://www.jstor.org/stable/40230256>
- Flood, M. (2015). Men and Gender Equality. In M. Flood & R. Howson (Eds.), *Engaging men in building gender equality* (pp. 1-31): Newcastle upon Tyne, England: Cambridge Scholars Publishing.
- Frye Helzner, J. (1996). Men's involvement in family planning. *Reproductive Health Matters*, 4(7), 146-154. [https://doi.org/10.1016/S0968-8080\(96\)90018-X](https://doi.org/10.1016/S0968-8080(96)90018-X)

- Government of Kiribati. (2005). *Kiribati Islands. A situation analysis of children, women and youth*. Retrieved from https://www.unicef.org/pacificislands/Kiribati_Sitan.pdf
- Government of Kiribati. (2016). *Kiribati development plan 2016-19*. Retrieved from <http://www.mfed.gov.ki/sites/default/files/Kiribati%20Development%20Plan%202016%20-%202019.pdf>
- Greene, M., & Biddlecom, A. (2000). Absent and problematic men: Demographic accounts of male reproductive roles. *Population and Development Review*, 26(1), 81-115. Retrieved from <http://www.jstor.org/stable/172453>
- Greene, M., Mehta, M., Pulerwitz, J., Wulf, D., Bankole, A., & Singh, S. (2006). *Involving men in reproductive health: Contributions to development*. Retrieved from <https://www.faithtoactionnetwork.org/resources/pdf/Involving%20Men%20in%20Reproductive%20Health-Contributions%20to%20Development.pdf>
- Griffin, G. (2017). A Dictionary of Gender Studies. Retrieved from <http://www.oxfordreference.com/view/10.1093/acref/9780191834837.001.0001/acref-9780191834837-e-137?rskey=fjfmv7&result=134>
- Gutmann, M. (2009). The missing gamete? Ten common mistakes or lies about men's sexual destiny. In M. Inhorn, T. Tjørnhøj-Thomsen, H. Goldberg, & M. La Cour Mosegaard, (Eds.), *Re-Conceiving the Second Sex: Men, Masculinity, and Reproduction* (Vol. 12, pp. 21-44). Retrieved from <https://quod.lib.umich.edu/cgi/t/text/text-idx?c=acls;idno=heb08674.0001.001>
- Hall, S. (2002). The West and the Rest: Discourse and power. In S. Schech & J. Haggis. *Development: A Cultural Studies Reader*. Malden, MA: Blackwell.
- Hammersley, M. (2008). *Questioning qualitative inquiry*. Retrieved from <http://dx.doi.org/10.4135/9780857024565>
- Hancock, D., & Algozzine, R. (2006). *Doing case study research: A practical guide for beginning researchers*. New York: Teachers College Press.
- Hartmann, M., Gilles, K., Shattuck, D., Kerner, B., & Guest, G. (2012). Changes in couples' communication as a result of a male-involvement family planning intervention. *Journal of Health Communication*, 17(7), 802-819. <https://doi.org/10.1080/10810730.2011.650825>
- Hesse-Biber, S. N. (2007). Feminist Research: Exploring the Interconnections of Epistemology, Methodology and Method. In S. N. Hesse-Biber (Ed.), *Handbook of Feminist Research: Theory and Praxis* (pp. 1-28). Thousand Oaks, CA: Sage.
- Hesse-Biber, S. N., & D. Piatelli (2007). From theory to method and back again. The synergistic praxis of theory and method. In S. N. Hesse-Biber (Ed.), *Handbook of Feminist Research: Theory and Praxis* (pp. 143-154). Thousand Oaks, CA: Sage.

- Hodkinson, P., & Hodkinson, H. (2001, December). *The strengths and limitations of case study research*. Paper presented at the Learning and Skills Development Agency Conference, Cambridge, England. Retrieved from education.exeter.ac.uk/tlc/docs/publications/LE_PH_PUB_05.12.01.doc
- Howitt, R., & Stevens, S. (2010). Cross-cultural research: Ethics, methods and relationships. In I. Hay (Ed.), *Qualitative Research Methods in Human Geography* (3rd ed., pp. 40-68). Oxford; New York: Oxford University Press.
- Hubacher, & Trussell. (2015). A definition of modern contraceptive methods. *Contraception*, 92(5), 420-421. <https://doi.org/10.1016/j.contraception.2015.08.008>
- International Center for Research on Women (ICRW). (2010). The Girl Effect: What Do Boys Have to Do with It? *A Briefing Note for an Expert Meeting and Workshop*. Washington DC: Author. Retrieved from <http://www.icrw.org/publications/girl-effect-what-do-boys-have-do-it>
- Itaia, M. (1984). Rebirth: Te Mauri, Te Raoi, ao Te Tabomoa. In A. Talu (Ed.), *Kiribati: Aspects of History*. (pp. 121-128). Suva, Fiji: Tarawa, Kiribati: Suva, Fiji: Institute of Pacific Studies and Extension Services, University of the South Pacific; Tarawa, Kiribati: Ministry of Education, Training and Culture, Kiribati Government.
- Jackson, C. (2006). Feminism Spoken Here: Epistemologies for Interdisciplinary Development Research. *Development and Change*, 37(3), 525-547. <https://doi.org/10.1111/j.0012-155X.2006.00489.x>
- Jacobstein, R. (2015). *With gender equity comes vasectomy, and vice versa*. Retrieved from <https://www.devex.com/news/with-gender-equity-comes-vasectomy-and-vice-versa-86878>
- Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *The Lancet*, 385(9977), 1580-1589. [https://doi.org/10.1016/S0140-6736\(14\)61683-4](https://doi.org/10.1016/S0140-6736(14)61683-4)
- Jewkes, R., & Morrell, R. (2010). Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. *Journal of the International AIDS Society*, 13(1), 1. <https://doi.org/10.1186/1758-2652-13-6>
- Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. (2008). *Vasectomy: Reaching out to new users* (Number 6 Male Sterilization). Retrieved from <https://www.k4health.org/sites/default/files/Vasectomy-reaching%20out%20to%20new%20usersd6.pdf>
- Jolly, S. (2000). 'Queering' development: Exploring the links between same-sex sexualities, gender, and development. *Gender and Development*, 8(1), 78-88. <https://doi.org/10.1080/741923414>

- Jolly, S. (2011). Why is development work so straight? Heteronormativity in the international development industry. *Development in Practice*, 21(1), 18-28.
<https://doi.org/10.1080/09614524.2011.530233>
- Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J., & Atuyambe, L. (2014). Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda. *Reproductive Health*, 11(1), 1. <https://doi.org/10.1186/1742-4755-11-21>
- Kabeer, N. (1999). Resources, agency, achievements: Reflections on the measurement of women's empowerment. *Development and Change*, 30(3), 435-464.
<https://doi.org/10.1111/1467-7660.00125>
- Kabeer, N. (2003). *Gender mainstreaming in poverty eradication and the millennium development goals: A handbook for policy-makers and other stakeholders*. Retrieved from <https://ebookcentral.proquest.com>
- Kabeer, N. (2005). Gender equality and women's empowerment: A critical analysis of the third millennium development goal 1. *Gender and Development*, 13(1), 13-24.
<https://doi.org/10.1080/13552070512331332273>
- Kapoor, I. (2004). Hyper-self-reflexive development? Spivak on representing the Third World 'Other'. *Third World Quarterly*, 25(4), 627-647.
<https://doi.org/10.1080/01436590410001678898>
- Kaufman, M. (2004). Transforming our interventions for gender equality by addressing and involving men and boys: a framework for analysis and action. In S. Ruxton & Oxfam (Eds.), *Gender Equality and Men: Learning from Practice* (pp. 19-27). Oxford, England; Herdon, VA: Oxfam.
- Kiribati National Statistics Office., Secretariat of the Pacific Community & Macro International Inc. (2010). *Kiribati Demographic and Health Survey 2009*. Retrieved from <http://prism.spc.int/reports/surveys>
- Kiribati National Statistics Office., & Secretariat of the Pacific Community. (2014). *Kiribati 2009 DHS Fact Sheet*. Retrieved from <http://catalog.ihmn.org/index.php/catalog/4131>
- Kitzinger, J. (1995). Introducing Focus Groups. *BMJ: British Medical Journal*, 311(7000), 299-302. Retrieved from <http://www.jstor.org/stable/29728251>
- Kumar, R. (2014). *Research methodology: a step by step guide for beginners* (4th ed.). Los Angeles, LA: Sage.
- Lasee, A., & Becker, S. (1997). Husband-wife communication about family planning and contraceptive use in Kenya. *International Family Planning Perspectives*, 15-33.
<https://doi.org/10.2307/2950781>

- Lemle, R., & Mishkind, M. E. (1989). Alcohol and masculinity. *Journal of Substance Abuse Treatment*, 6(4), 213-222. [https://doi.org/10.1016/0740-5472\(89\)90045-7](https://doi.org/10.1016/0740-5472(89)90045-7)
- Macdonald, B. (2001). *Cinderellas of the Empire: Towards a history of Kiribati and Tuvalu*. Suva, Fiji: Institute of Pacific Studies, University of the South Pacific.
- MacDonald, L., Jones, L., Thomas, P., Thi Thu, L., FitzGerald, S., & Efroymson, D. (2013). Promoting male involvement in family planning in Vietnam and India: HealthBridge experience. *Gender and Development*, 21(1), 31-45. <https://doi.org/10.1080/13552074.2013.767498>
- Mack, N., Woodsong, C., MacQueen, K. M., Guest, G., & Namey, E. (2005). *Qualitative research methods: a data collectors field guide*. Retrieved from <https://www.fhi360.org/resource/qualitative-research-methods-data-collectors-field-guide>
- Mahler, S. J., & Pessar, P. R. (2001). Gendered geographies of power: Analyzing gender across transnational spaces. *Identities*, 7(4), 441-459. <https://doi.org/10.1080/1070289X.2001.9962675>
- Malhotra, A., & Schuler, S. R. (2005). Women's empowerment as a variable in international development. In D. Narayan-Parker (Ed.), *Measuring empowerment: Cross-disciplinary perspectives* (pp. 71-88). Washington, DC: World Bank, & ProQuest.
- Mansfield, H. (2013). *Discourses of vulnerability: Kiribati, I-Kiribati women and forced migration due to climate change*. (MA thesis, Victoria University of Wellington, Wellington, New Zealand). Retrieved from <http://researcharchive.vuw.ac.nz/handle/10063/2847>
- Marván, M. L., Ehrenzweig, Y., & Hernández-Aguilera, D. (2017). Mexican men's view of vasectomy. *American Journal of Men's Health*, 11(3), 610-617. <https://doi.org/10.1177/1557988316655743>
- Maneaba-ni-Maungatabu, Parliament of Kiribati. (2015). *Parliamentary Select Committee on Population Management and Development Report*, Ambo, Tarawa, Kiribati: Author.
- McEwan, C. (2001). Postcolonialism, feminism and development: intersections and dilemmas. *Progress in Development Studies*, 1(2), 93-111. <https://doi/pdf/10.1177/146499340100100201>
- McMillan, K., & Worth, H. (2014). Development, dependency and HIV risk in Kiribati. *World Journal of AIDS*, 2014. <http://dx.doi.org/10.4236/wja.2014.42028>
- Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. Retrieved from https://doi.org/http://helicon.vuw.ac.nz/login?url=http://www.VUW.eblib.com/EBLWeb/patron/?target=patron&extendedid=P_1662771_0

- Mehta, M., Peacock, D., & Bernal, L. (2004). In S. Ruxton & Oxfam (Eds.), *Gender equality and men: learning from practice*. (pp. 89-100). Oxford: Herdon, VA: Oxfam.
- Mohanty, C. T. (1991). Under Western eyes: Feminist scholarship and colonial discourses. In Chandra Talpade Mohanty, Ann Russo, & L. Torres (Eds.), *Third World Women and the Politics of Feminism* (pp. 51-80). Bloomington: Indiana University Press.
- Momsen, J. (2004). *Gender and development*. London; New York: Routledge.
- Momsen, J. (2010). *Gender and development*. (2nd ed). London; New York: Routledge.
- Mosedale, S. (2005). Assessing women's empowerment: towards a conceptual framework. *Journal of International Development*, 17(2), 243-257.
<https://doi.org/https://search.proquest.com/docview/214895289?accountid=14782>
- Moser, C. O. N. (1989). Gender planning in the third world: Meeting practical and strategic gender needs. *World Development*, 17(11), 1799-1825.
[https://doi.org/10.1016/0305-750X\(89\)90201-5](https://doi.org/10.1016/0305-750X(89)90201-5)
- Moser, C. O. N. (1993). *Gender planning and development: theory, practice, and training*. London, New York: London: Routledge.
- Mullen, K., Watson, J., Swift, J., & Black, D. (2007). Young men, masculinity and alcohol. *Drugs: Education, Prevention and Policy*, 14(2), 151-165.
<https://doi.org/10.1080/09687630600997816>
- Mullings, B. (1999). Insider or outsider, both or neither: some dilemmas of interviewing in a cross-cultural setting. *Geoforum*, 30(4), 337-350.
[https://doi.org/10.1016/S0016-7185\(99\)00025-1](https://doi.org/10.1016/S0016-7185(99)00025-1)
- Nanda, G., Schuler, S. R., & Lenzi, R. (2013). The influence of gender attitudes on contraceptive use in Tanzania: New evidence using husbands' and wives' survey data. *Journal of Biosocial Science*, 45(03), 331-344.
<https://doi.org/10.1017/S0021932012000855>
- National Statistics Office. (2016). *2015 Population and Housing Census*. Retrieved from <http://www.mfed.gov.ki/sites/default/files/Revised%20Census%20Preliminary%20Report%202%20020516%20update%20%5B1306646%5D.pdf>
- Nawyn, S. J. (2010). Gender and Migration: Integrating Feminist Theory into Migration Studies. *Sociology Compass*, 4(9), 749-765.
<https://doi.org/10.1111/j.1751-9020.2010.00318.x>
- Nelson, N., & Wright, S. (1995). *Power and participatory development: theory and practice*. London: Intermediate Technology.

- Ngaebi, T., Russell, T., & Tamuera, F. (1993). The status of women. In H. Van Trease (Ed.), *Atoll Politics: The Republic of Kiribati* (pp. 266-269). Christchurch, N.Z. Fiji: Macmillan Brown Centre for Pacific Studies, University of Canterbury and Institute of Pacific Studies, University of the South Pacific.
- Nicholls, R. (2009). Research and Indigenous participation: critical reflexive methods. *International Journal of Social Research Methodology*, 12(2), 117-126.
<https://doi.org/10.1080/13645570902727698>
- O'Leary, Z. (2017). *The essential guide to doing your research project*. (3rd ed.). Los Angeles, London: Sage.
- Onyango, M. A., Owoko, S., & Oguttu, M. (2010). Factors that influence male involvement in sexual and reproductive health in Western Kenya: a qualitative study. *African Journal of Reproductive Health*, 14(4). Retrieved from <http://www.jstor.org/stable/41329752>
- Pacific Community. (2017). *Women's Economic Empowerment in the Pacific Regional Overview*. Retrieved from <http://www.spc.int/wp-content/uploads/2017/09/Overview-Pacific-Womens-Economic-Empowerment-SPC2.pdf>
- Pacific Periscope. (n. d.). *Australia's Microstate Visa brings in Kiribati workers*. Retrieved from <https://pacificperiscope.wordpress.com/2017/01/16/australias-microstate-visa-brings-in-kiribati-workers/>
- Perry, B., Packer, C., Chin Quee, D., Zan, T., Dulli, L., & Shattuck, D. (2016). *Recent experience and lessons learned in vasectomy programming in low-resource settings: a document review*. Retrieved from <https://www.fhi360.org/sites/default/files/media/documents/resource-vasectomy-lit-review-final.pdf>
- Pillow, W. S., & Mayo, C. (2007). Toward understandings of feminist ethnography. In S. N. Hesse-Biber (Ed.), *Handbook of Feminist Research: Theory and Praxis*. Thousand Oaks, CA: Sage.
- Pulerwitz, J., & Barker, G. (2008). Measuring attitudes toward gender norms among young men in Brazil development and psychometric evaluation of the GEM scale. *Men and Masculinities*, 10(3), 322-338.
<https://doi.org/10.1177/1097184X06298778>
- Ratele, K. (2015). Working through resistance in engaging boys and men towards gender equality and progressive masculinities. *Culture, Health and Sexuality*, 17(sup2), 144-158.
<https://doi.org/10.1080/13691058.2015.1048527>
- Reeves, H., & Baden, S. (2000). *Gender and development: Concepts and definitions*. Retrieved from: <http://www.bridge.ids.ac.uk/sites/bridge.ids.ac.uk/files/reports/re55.pdf>

- Rose, G. (1997). Situating knowledges: positionality, reflexivities and other tactics. *Progress in Human Geography*, 21(3), 305-320.
<https://doi.org/10.1191/030913297673302122>
- Rose, S. (2014). *Waves for change: the role of the South Tarawa-based women's interests program in the decolonisation process of the Gilbert Islands*. (Doctoral dissertation, Queensland University of Technology, Brisbane, Australia). Retrieved from <http://eprints.qut.edu.au/66735/>
- Rowlands, J. (1998). A word of our times but what does it meant? Empowerment in the Discourse and Practice of Development. In H. Afshar. (Ed). *Women and Empowerment: Illustrations from the Third World*. Houndmills, Basingstoke: New York: MacMillan Press Ltd ; St. Martin's Press.
- Ruxton, S. & Oxfam (Eds.), (2004). *Gender equality and men: learning from practice*. Oxford: Herdon, VA: Oxfam.
- Saunders, K. (2002). *Feminist post-development thought: Rethinking modernity, post-colonialism and representation*. London: Zed Books.
- Scott, B., Alam, D., & Raman, S. (2011). *Factors affecting acceptance of vasectomy in Uttar Pradesh: Insights from community-based, participatory qualitative research*. Retrieved from http://www.respond-project.org/pages/files/6_pubs/research-reports/Study3-PEER-NSV-Report-May2011-FINAL.pdf
- Secretariat of the Pacific Community. (2010). *Kiribati Family Health and Support Study: A study on violence against women and children*. Retrieved from Noumea, New Caledonia: <http://countryoffice.unfpa.org/pacific/drive/KiribatiFamilyHealthandSafetyStudy.pdf>
- Secretariat of the Pacific Community. (2015). *Stocktake of the gender mainstreaming capacity of Pacific Island governments Kiribati*. Retrieved from Noumea, New Caledonia: <http://www.pacificwomen.org/wp-content/uploads/Kiribati-gender-stocktake.pdf>
- Sharma, J. (2009). Reflections on the Construction of Heteronormativity. *Development*, 52(1), 52-55. <https://doi.org/10.1057/dev.2008.72>
- Sharan, Mona & Ahmed, Saifuddin & May, John & Soucat, Agnes. (2011). *Family Planning Trends in Sub-Saharan Africa: Progress, Prospects, and Lessons Learned. Success Stories from A Dynamic Continent*. Retrieved from https://www.researchgate.net/profile/Saifuddin_Ahmed4/publication/265076721_Family_Planning_Trends_in_SubSaharan_Africa_Progress_Prospects_and_Lessons_Learned/

- Shattuck, D., Wesson, J., Nsengiyumva, T., Kagabo, L., Bristow, H., Zan, T., & Ngabo, F. (2014). Who chooses vasectomy in Rwanda? Survey data from couples who chose vasectomy, 2010-2012. *Contraception*, 89(6), 564-571. <https://doi.org/10.1016/j.contraception.2014.02.003>
- Siddle, J. (2014). *Kiribati: Tiny island's struggle with overpopulation*. Retrieved from <http://www.bbc.com/news/science-environment-26017336>
- Smith, L. (2012). *Decolonizing methodologies: Research and indigenous peoples*. (2nd ed.). London; New York: Zed Books.
- Smithson, J. (2000). Using and analysing focus groups: limitations and possibilities. *International Journal of Social Research Methodology*, 3(2), 103-119. <https://doi.org/10.1080/136455700405172>
- Sonke Gender Justice Network. (2013). *Policy Report: Engaging men in GBV and HIV prevention, SRHR promotion, parenting and LGBTI rights*. Retrieved from: <http://menengage.org/wp-content/uploads/2014/07/Engaging-Men-in-HIV-and-GBV-Prevention.pdf>
- Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME: An International E-Journal for Critical Geographies*, 6(3), 374-385. Retrieved from on at: <https://www.researchgate.net/publication/228497658>
- Sweetman, C. (2013). Introduction: Working with men on gender equality. *Gender and Development*, 21(1), 1-13. <https://doi.org/10.1080/13552074.2013.779445>
- Tabokai, N. (1993). The maneaba system. In H. Van Trease (Ed.), *Atoll politics: the Republic of Kiribati* (pp. pp. 23-29). Christchurch, N.Z. Fiji: Macmillan Brown Centre for Pacific Studies, University of Canterbury and Institute of Pacific Studies, University of the South Pacific.
- Talu, A., & Tekonnang, F. (1984). Tradition: Ancient Gilbertese Society. In A. Talu, S. (Ed.), *Kiribati: Aspects of History*. Suva, Fiji: Tarawa, Kiribati: Institute of Pacific Studies and Extension Services, University of the South Pacific.
- Teaiwa, T. (2005). Articulated cultures: Militarism and masculinities in Fiji during the Mid 1990s. *Fijian Studies: A Journal of Contemporary Fiji*, 3(2), 201-222. Retrieved from <https://search.informit.com.au/documentSummary;dn=424776827387206;res=IELIND>
- Terry, G., & Braun, V. (2011a). 'I'm committed to her and the family': positive accounts of vasectomy among New Zealand men. *Journal of Reproductive and Infant Psychology*, 29(3), 276-291. <https://doi.org/10.1080/02646838.2011.592976>

- Terry, G., & Braun, V. (2011b). It's kind of me taking responsibility for these things': Men, vasectomy and 'contraceptive economies'. *Feminism and Psychology*, 21(4), 477-495. <https://doi.org/10.1177/0959353511419814>
- Tito, K., Tiata, T., Teanako, B., Uentabo, F., & Arobati, T. (1984). Tradition: Ancient Gilbertese Society. In A. Talu, S. (Ed.), *Kiribati: Aspects of History*. Suva, Fiji: Tarawa, Kiribati: Institute of Pacific Studies and Extension Services, University of the South Pacific.
- Tusitala Marsh, S. (2000). Ancient Banyans, Flying Foxes and White Ginger. In A. Jones, P. Herda, & T. Sua'ali'i-Sauni (Eds.), *Bitter Sweet: Indigenous Women in the Pacific* (pp. 137-159). Dunedin, N.Z.: University of Otago Press.
- UN Women Training Centre. (n.d.). *Gender Equality Glossary*. Retrieved from <https://trainingcentre.unwomen.org/mod/glossary/view.php?id=36&mode=cat>
- Underhill-Sem, Y. (2011). *Gender, culture and the Pacific Asia-Pacific Human Development Report Background Papers Series 2010/05*. Retrieved from https://www.researchgate.net/publication/264786458_Gender_culture_and_the_Pacific_AsiaPacific_Human_Development_Report_Background_Papers_Series_201005
- UNFPA United Nations Population Fund. (n.d.). *Family Planning*. Retrieved from www.unfpa.org/family-planning
- UNFPA United Nations Population Fund. (1994). *ICPD Programme of Action*. Retrieved from https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf
- United Nations, (2011). *World Contraceptive Use Wall Chart*. Retrieved from <http://www.un.org/en/development/desa/population/publications/family/contraceptive-wallchart-2011.shtml>
- United Nations. (2015). *Trends in Contraceptive Use Worldwide 2015*. Retrieved from <http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf>
- Vaiolleti, T. (2006). Talanoa research methodology: a developing position on Pacific research. *Waikato Journal of Education*, 12(1). Retrieved from <http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=0&sid=726c6012-8a9b-4388-9790-9e0bb5413c40%40sessionmgr4010>
- Vaiolleti, T. (2013). Talanoa: Differentiating the Talanoa Research Methodology from phenomenology, narrative, Kaupapa Maori and feminist methodologies. *Te Reo*, 56, 191. Retrieved from <https://search.informit.com.au/documentSummary;dn=674853083445219;res=IELIND> ISSN: 0494-8440
- Van Trease, H. (1993). (Ed.), *Atoll Politics: The Republic of Kiribati*. (pp. xvii – xviii; 23-29). Christchurch, N.Z. Fiji: Macmillan Brown Centre for Pacific Studies, University of Canterbury and Institute of Pacific Studies, University of the South Pacific.

- Vu, L., Pulerwitz, J., Burnett-Zieman, B., Banura, C., Okal, J., & Yam, E. (2017). Inequitable Gender Norms From Early Adolescence to Young Adulthood in Uganda: Tool Validation and Differences Across Age Groups. *Journal of Adolescent Health, 60*(2), S15-S21. <https://doi.org/10.1016/j.jadohealth.2016.09.027>
- Walcott, M. M., Ehiri, J., Kempf, M. C., Funkhouser, E., Bakhoya, M., Aung, M., . . . Jolly, P. E. (2014). Gender norms and family planning practices among men in Western Jamaica. *American Journal of Men's Health*. <https://doi.org/10.1177/1557988314543792>
- Wanner, T., & Wadham, B. (2015). Men and Masculinities in International Development: 'Men-streaming' Gender and Development? *Development Policy Review, 33*(1), 15-32. <https://doi.org/10.1111/dpr.12090>
- White, V., Greene, M., & Murphy, E. (2003). *Men and reproductive health programs: Influencing gender norms*. Retrieved from http://pdf.usaid.gov/pdf_docs/Pnacu969.pdf
- Wesley-Smith, T. (2016). Rethinking Pacific Studies Twenty Years On. *The Contemporary Pacific, 28*(1), 153-169. doi 10.1353/cp.2016.0003
- Willis, K. (2005). *Theories and practices of development*. London; New York, NY: Routledge.
- Wetherell, M., & Edley, N. (1999). Negotiating Hegemonic Masculinity: Imaginary Positions and Psycho-Discursive Practices. *Feminism & Psychology, 9*(3), 335-356. <https://doi.org/10.1177/0959353599009003012>
- Yin, R. (1994). *Case study research: Design and methods*. (2nd ed.). Thousand Oaks: Sage Publications.
- Yin, R. (2014). *Case study research: Design and methods*. (Fifth ed.). Los Angeles: Sage.
- Zakaria, R. (2017). The Myth of Women's 'Empowerment', Opinion. *The New York Times*. Retrieved from https://www.nytimes.com/2017/10/05/opinion/the-myth-of-womens-empowerment.html?rref=collection%2Fsectioncollection%2Fopinion-contributors&action=click&contentCollection=contributors®ion=stream&module=stream_unit&version=latest&contentPlacement=2&pgtype=sectionfront