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Men’s Reproductive Health Services in the Northern Cape,

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CHAPTER 1

1.1 INTRODUCTION AND BACKGROUND

The 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women in Beijing provided a foundation for expanding family planning and reproductive health services to include men. The ICPD Programme of Action mandates that innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men. A more comprehensive approach to reproductive health care by international agencies creates the opportunity to re-examine programmes and to create new ones that include men, not only as partners, but as clients as well (ICPD, 1994: 4.24).

The ICPD urged that:
"Special efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children (ICPD, 1994: 4.27).

The above challenge calls for more intense efforts to foster partnerships between men and women which help men identify with the magnitude and range of reproductive health illnesses which affect them. The philosophy embodied in the Programme of Action combines a primary health care approach with a human rights dimension.

Reproductive health has been synonymous with women's health. Most reproductive health programmes focused on family planning and in turn most family planning programmes offered their services exclusively to women. Women were viewed as the target group and paid little attention to the roles that men might have with respect to women's reproductive health decision-making and behaviour (RHO, 2000:1).

The clinical practices available in South Africa do not address men's unique reproductive health needs in a holistic manner. There are many maternal, child and women's health centers in both the public and private sectors but there are no equivalents that target men's needs. Services for men are housed in settings where staff lack training in male sexuality and sexual health. Provider's assumptions about men's interest in reproductive health may cause men discomfort and the social environment itself mainly created by the brochures, posters and literature may not reflect men's interests or needs (RHO, 2000:3).

Many men, programme planners and the community in general lack a clear understanding of what men's reproductive health means. In order to define male reproductive health services, programme planners should provide a framework for assessing needs and initiating or enhancing men's services (Shafritz and Hollerbach, 1996:1).

Men are potential partners in and advocate for good reproductive health, rather than bystanders, barriers or adversaries. This new attention contrasts with several decades of neglect that began in the 1960s after the development of modern contraceptive methods for women. Many family planning programmes and other reproductive health care providers were accustomed to paying little attention to men except for the diagnosis and treatment of sexually transmitted diseases. Now reproductive health programmes are seeking better ways to understand men, to communicate with them, to engage them into reproductive health planning and to help them take better care of themselves and their partners (Shafritz and Hollerbach, 1996:1).

Family planning programmes in the past have focused on women instead of men for several reasons-:

- Women bear the risks and burdens of pregnancy and child bearing;
- Most modern contraceptives are for women;
- Many providers have assumed that women have the greatest stake and interest in protecting their own reproductive health.

Reflecting these assumptions, the clinic-based service delivery designed for family planning has made it difficult to include men. Services have been offered in maternal and child health clinics. Many men see maternal, child health clinics and their staff as serving only women and children and feel uncomfortable seeking information or services in the setting (Abdel Tawab, *et al*, 1997:3).

Some men do prevent women from using family planning and they spread STIs to their female partners. It is important that health programmes abandon stereotypes of men and learn more about their concerns and needs, especially when designing programmes for different groups of men (Padian, *et al*, 1997:11).

1.2 PROBLEM STATEMENT

The strong rhetoric at conferences and in policy discussions in South Africa has urged the Department of Health to pay more attention to reproductive health. Largely missing from the discussions, is attention to men's sexual and reproductive health needs. To effectively meet those needs, work must be done to better define the set of medical, educational and counselling services that men require and to determine how and by whom these services should be delivered. The information, counselling and skills-building that men need are just as vital for women but, until recently, they have been overshadowed by women's substantial need for medical reproductive services.

The Northern Cape Department of Health has placed high priority on programmes to promote sexual and reproductive health especially women's health. Only recently has the Department of Health turned their attention to men to solve what are seen as women's problems: unintended pregnancies, sexually transmitted diseases, domestic violence and single parenthood. Despite these efforts, the province has over the years experienced the following problems-:

- Highest level of syphilis rate in South Africa particularly in men. Currently, the rate is 5.4 % ;
- Low condom use and distribution rate which can probably be positively associated with the increase in STIs but cannot be translated into the reduction in HIV prevalence. The Northern Cape has the second lowest HIV and AIDS prevalence rate of 16.1; and
- Very low contraceptive prevalence rate particularly vasectomy. Currently the Northern Cape is at 31.97%.

1.3 THE AIMS OF INVESTIGATING MEN'S REPRODUCTIVE HEALTH

- To identify the core reproductive health services that would constitute basic reproductive health care for men;
- To devise a model that would serve as a framework for programme development and service delivery.

Explicit in this study is the recognition of the influence of multiple determinants on health. These factors influence health policy, men's perceptions towards reproductive health, the utilisation of services and the necessities required from day to day to maintain acceptable levels of men's reproductive health within the primary health care system.

1.4 RESEARCH QUESTIONS

This study addressed the following research questions that arise when men's contribution to reproductive health is considered.

- What progress has been made by the Northern Cape Department of Health since the implementation of the National Health Plan of South Africa, ICPD Program of Action, Beijing Platform of Action and WHO Strategy for Reproductive Health 1997-2007 regarding men's reproductive health?

- What reproductive health related provincial policies and programme plans have been developed by the Northern Cape Department of Health?
- What do men understand about reproductive health services?

1.5 RATIONALE FOR INVESTIGATING MEN'S REPRODUCTIVE HEALTH

In view of the aspects outlined in conceptualising the problem and its accompanying sub-problems, a variety of programme-related purposes were to:

- Assess the availability and quality of men's reproductive health services provided to clients by public facilities;
- Evaluate the extent to which reproductive health facilities are integrated into primary health care;
- Examine the availability and use of information, education and communication materials;
- Assess barriers to access health service;
- Provide data for development of implementation strategy.

1.6 ASSUMPTIONS

Existing studies do not adequately reflect men's reproductive and sexual health needs. Men have concerns of their own such as fears of sexual inadequacy, ignorance about sexual and reproductive functioning, risks of sexually transmitted diseases, and risks of unwanted pregnancies with their partners. Meeting the sexual and reproductive health needs of men in their own right, should inevitably result in lower rates of STDs and unintended pregnancy, better parenting, and healthier and more satisfying personal and family relationships. Ultimately, this will not only benefit men but also benefit women, families, communities and society at large.

1.7 SUMMARY AND SUBSEQUENT CHAPTERS OF THE RESEARCH REPORT

Chapter 1

This chapter deals with the background to the research, the research problem and the rationale for investigating men's reproductive health services in the Northern Cape Department of Health.

Chapter 2

This chapter highlights a series of basic concepts of reproductive health central to the research problem and it also covers the literature review drawn from programmes that outline male attitudes and behaviours, highlighting key factors influencing the use of reproductive health services globally, in Africa and South Africa. It also draws lessons learned from selected male-involvement initiatives and finally suggesting some recommendations for the next steps in engaging men in reproductive health services.

Chapter 3

In this section the researcher discusses the research methodology utilised in this study, and motivates the research design and its application in the study. The section gives an overview of the research design, data collection procedure and it helps the researcher understand the value and limitations of the data collected. The origin of focus groups, definitions, use of focus groups, participants, the interview guide, the moderator collection and analysis of data is discussed in detail. The limitations of the study are also identified.

Chapter 4

This detailed chapter analyses data from chapter three and explores the areas of interest in terms of research findings identifies gaps which are dealt with in chapter five. The broad areas of focus include documentary analysis of strategic plans and annual reports, results from the focus group discussions and interviews with key informants in the Northern Cape Department of Health. Finally, a detailed comparative analysis of all the three data sets is presented.

Chapter 5

Chapter five presents comparative results of all the three data sets in detail. Innovative approaches are discussed and new methodologies are proposed.

Chapter 6

This chapter includes a summary of the research with recommendations that will be pertinent to both the Northern Cape Department of Health programme managers. It is hoped that the findings of the study will positively contribute to future men's reproductive health programme planning and implementation within primary health care services. In conclusion, comprehensive and far reaching strategies to engage men in population programmes are embraced.

References

This section presents a list of the literature that was referred to during the research study.

CHAPTER 2

A REVIEW OF LITERATURE AND SELECTED PROGRAMME INITIATIVES GLOBALLY, IN AFRICA AND SOUTH AFRICA

This literature review defines and highlights a series of concepts that are central to the research problem. It also outlines from programmes and research literature male attitudes and behaviour, highlighting key factors influencing the use of reproductive health services globally, in Africa and South Africa. It also draws lessons learned from selected male-involvement initiatives and finally suggesting some recommendations for the next steps in engaging men in reproductive health issues.

Men's reproductive health means more than increasing the number of men using condoms and having vasectomies. It also includes men who encourage and support their partner and their peers to use health services and who influence the policy environment to become more conducive to developing male-related programmes.

In this context men's reproductive health should be understood in a much broader sense than male contraception, and should refer to all organisational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of reproductive health practice of either sex.

According to Toure (1996:1) in the past, reproductive health programmes have focused attention primarily on women, because of the need to free women from excessive child bearing and to reduce maternal and infant mortality through the use of modern methods of contraception. Most reproductive health programmes are offered within maternal and child health centres and most research and information campaigns focused on women. This focus on women has reinforced the belief that reproductive health is largely a woman's business, with the men playing a very peripheral role (Toure, 1996:1).

Involving men and obtaining their support and commitment to reproductive health is of crucial importance in South Africa, given their elevated position in African societies. Most decisions that affect family life are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through to the national level (International Planned Parenthood Federation, 1994: 6) The involvement of men in reproductive health issues would therefore not only ease the responsibility borne by women in terms of decision-making for reproductive health matters, but would accelerate the understanding and practice of reproductive health matters in general.

A review of literature on male attitudes in Africa and behaviour towards reproductive health, as well as a review of male involvement initiatives revealed that only recently have reproductive health associations recognized the importance of men's role and motivation in fertility decision making, particularly in Africa. Having recognized this, the question is "What can reproductive health programmes do to encourage men's cooperation?" (Population Reports, 1994: 27).

Some programmes have developed information, education and communication campaigns aimed at increasing the awareness and knowledge of men. However, one of the crucial questions now facing these programmes is how to move beyond increasing knowledge to changing attitudes and practice. Another question is how to address the needs of men through different service-delivery strategies (Hawkins, 1992; 7).

A range of service delivery strategies can be provided to meet those needs in a variety of ways. Strategies include special hours for men at maternal and child health clinics, male only clinics, male to male community based organizations, involvement of private agencies and medical practitioners.

2.1 BASIC CONCEPTS THAT GUIDE SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES

Reproductive Health

The World Health Organisation has proposed a definition of reproductive health, derived from the definition of health in general, as: " a condition in which the reproductive process is complemented by a state of physical, mental and social well-being and not just the absence of disease or problems in the reproductive process". This implies that people have the ability to reproduce, regulate their fertility and engage in enjoying their sexual relations and that women should go through the process of pregnancy and childbirth without complications. It further implies that fertility regulation may be achieved without health problems, and that people may feel secure when they have sexual relations.

Implicit are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the rights of access to appropriate health care services. Reproductive health is both rights and health oriented (WHO, 1998:1).

The reproductive health concept agreed to in Cairo and Beijing place men in a very different position from one they have been accustomed to for centuries. The concept gives women and men equal rights in decisions involving reproduction and sexuality and place the responsibility of safe pregnancies, childbirth and the health of offspring on both men and women. The objective is to promote gender equality in all spheres of life, including family life and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles (ICPD, 1994:20).

The ICPD rejects the previous demographic model used to identify factors that affect reproduction, which takes women as the unit of analysis; where men end up is another independent factor; they are seen either as facilitators or obstacles in the decisions women make regarding their fertility (WHO, 1998:1).

Reproductive Rights

These rights are defined as the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. The Platform of Action of the Fourth World Conference on Women (FWCW) strengthens the connection between sexuality, reproduction and gender equality by agreeing that:
"Reproductive rights imply equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, requires mutual respect, consent and shared responsibility for sexual behaviour and its consequences" (FWCW,1995:11).

Sexuality

Sexuality is intricately linked to gender. It is a social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behaviour, and it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality.

According to Villarreal (1998:7) sexuality refers to-:
"The pursuit of pleasure, desire for intimacy, expression of love, definition of self, procreation, domination, violence or any combination of the above. How people relate sexually may be linked

to self esteem, self respect, respect for other, hope, joy and pain. In different contexts, sex is viewed as a commodity, a rights or a biological imperative."

Post-ICPD reproductive health addresses sexuality as a sensitive and intimate aspect of reproduction, beyond an exclusive focus on risks of pregnancy and disease. It also considers questions of sexual enjoyment and confronts ideologies of men's entitlement that threaten women's sexual and reproductive rights and health.

Sexuality is important to male identity in all cultures but it differs from culture to culture. Power relations, in which men have the dominant role, are present in sexuality, since it is an essential arena for where gender relations take place (Villarreal, 1998:7).

According to Health, Empowerment, Rights and Accountability (HERA), sexuality means being able to have an informed, enjoyable and safe sex life, based on self esteem, a positive approach to human sexuality and mutual respect in sexual relations. It enhances life, personal relations and the expression of one's sexual identity. It is positively enriching, includes pleasure and enhances self-determination and communication in relationships. It is also fundamental to the development of ones full human potential, to the enjoyment of human rights and to an overall sense of well-being (HERA, 1998:1).

Sexual Health

Human sexuality and gender relations are closely interrelated and affect the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. The ICPD addresses sexual health as a notion that implies "a positive approach to human sexuality, and the purposes of sexual health care should be the enhancement of life and personal relationships, and not merely the counselling and care related to procreation or sexually transmitted diseases" (ICPD, 1994:7).

WHO defines sexual health as “the integration of the somatic, emotional, intellectual, and social aspects of social being in ways that are positively enriching and that enhance personality, communication, and love” (WHO, 1999:6).

Sexual health also involves satisfaction, an aspect of sexuality that is seen in many societies entitled to men rather than women. A satisfying sexual life and sexual health also imply consensual acts. In fact, pleasure is a central aspect of male sexuality, but it often comes at a price for both men and women. Men’s sexual pleasure is often seen as more important, by men and by women, than women’s concerns about becoming or acquiring an STI. Often performance is another key aspect to men’s sexuality. Many societies reinforce the perception that men’s sexual ability is part of what defines them as “real men”. Besides the obvious issue of safe sex, men’s concerns with performance, commonly referred to as sexual dysfunctions or psycho-sexual problems, provide opportunities for working with men and raising their awareness about the myths that may be contributing to their concerns (Villarreal, 1998:7).

The International Centre for Research on Women has identified four components of sexuality: practices, partners, pleasure/pressure/pain and procreation. The center has also determined that each component of sexuality is closely related to the other, but that the balance of power in a sexual interaction determines its outcome.

Dixon-Mueller (2000: 2) identifies four additional dimensions of sexuality and sexual behaviour; namely, what men do sexually with women or themselves, how they present themselves sexually, how they talk and how they act. She also discusses how gender intersects with and shapes each of these aspects.

Gender

Gender refers to widely shared ideas and expectations about women and men in a given society. These ideas and expectations are learned from families, friends, opinion leaders,

religious and cultural institutions, schools, the workplace and the media. They define typically feminine and masculine characteristics, abilities and behaviours in various situations and they reflect and influence the different roles, health and social status, economic and political roles of women and men in a society (UNAIDS, 1999:8).

The concept of gender argues that the differences between men and women are socially constructed, changeable over time and have variations within and between cultures. Gender is a socio-economic and political variable with which to analyse roles, responsibilities, constraints and opportunities of people. It considers both men and women and their power relations. Men often attain or maintain their position of power by resorting to verbal, emotional or physical violence involving their partners, other men and in extreme cases, themselves. Through the cultural stamp of gender, individuals absorb and reproduce what is permitted and prohibited. Gender marks their perception and their sense of responsibility with respect to all the social facets of life (Matalama, 1998:11).

Neither gender and sex, nor gender and women are synonymous. Gender refers to roles and sex refers to the biological state of being female or male (Laudari, 1998:1). In this context, masculinity is the social construct that identifies males as men. The masculinity equation is defined and discussed in detail in Chapter 3.

“Gender is a fundamental context for work on men as partners – in the way it affects men’s role as clients and in the influence men exert on their partners lives. Gender shapes how partners communicate and how they make decisions, earn and spend money, gain access to formal education and raise their children. All of these are related to health care (AVSC, 1997:5).

Gender Equity

Gender equity considers women’s subordination in most societies and the discrimination against girls and women that is exemplified by low levels of investments in their health, nutrition and education, their suffering of violence and the laws that keep economic resources out of women’s

hands (Greene, 1999:1).

This calls into question gender-based divisions and addresses the discrimination that has risen from these divisions and includes affirmative action. Equal rights and opportunities are its main goal. The concept of gender equity conflicts directly with the conventional male gender models that rely heavily on male power and superiority and its dominance over social relations in the production and reproduction spheres.

Gender equity is supported by the Convention on Elimination of Discrimination against Women (CEDAW), adopted by the United Nations General Assembly in 1979. CEDAW provides the basis for realising equality between women and men through ensuring women equal access to and equal opportunities in health, education and employment, as well as in political and public life (CEDAW, 1979, 1).

Gender relations

Gender relations are not biological givens, but are largely products of social and cultural processes. As such, they are not universal and a-historical. They are dynamic and changeable. Power and dominance are critical elements in gender relations. In the realm of reproductive health, power is about relationships between women and men and the stakes they have in one another's health. It is about who controls whose fertility. It is about who makes decisions about programmes and who manages them and how precious resources are allocated. The role that power play in gender relations has implications for men's role in reproduction and their sexuality. The challenges is to address and redirect men's use of power to improve their and their partner's health and men's relationships with their partners, children and other members of their community (Wouter, 1999:1).

Masculinity

Masculinity is a way to explain men. As a biological destiny, masculinity is used to refer to the innate qualities and properties of men that distinguish men from women. In this view, masculinity is men's nature, and as such helps to explain not only differences but also inequalities between men and women (Greig, *et al*, 2000:6).

Male identity is socially constructed, that is, it is an expression of the social image men have of themselves in relation to women and other men, and a set of characteristics and behaviours that are expected from men in a given culture. An important part of male identity in societies that rely heavily on male dominant status is men's ability to control women. Men feel much pressured to have many feminine conquests to prove their masculinity. Safe sex, which entails a reduction in the number of possible partners, avoiding one night stands and greater selectivity in sexual partnership may therefore be felt as a threat to masculinity (Wouter, 1999.1).

2.2 FINDINGS FROM THE LITERATURE AND RESEARCH ON MEN'S HEALTH

2.2.1 Global studies and macro level programmes on men's health

According to Blaney (1997:22), cultural barriers that prevent men and women from talking about sexuality, lack of training on how to counsel men, health system procedures that discourage men from using services, and men's own attitude towards reproductive health can all block communication and the involvement of men in general.

Riedelberger (1994:37) explores the known behaviour of men, their knowledge of and attitudes towards reproductive health and the societal, cultural and psychological factors that influence them. His focus is on the necessity of including men in reproductive health programmes. Previous exclusion from programmes has also meant exclusion from education and counselling on the prevention of pregnancy and AIDS. This focus is especially urgent due to the fast spread of AIDS. Riedelberger recommends that projects must aim at a

change in behaviour and the cultural reservations which up to now have caused men to take little responsibility.

With increased research and activities focusing on the male role in family planning men are now becoming more involved. Experts believe that the key bottleneck is on the side of the providers, not the men. Two related themes need to be looked at: the use of so called male methods and the role of men as decision-makers. In most developing countries, reproductive health has been led by a concentration on women, but now we can afford to politically and socially concentrate on men (Finger, 1998:4).

The United Nations Population Fund proposition is that, it is lack of useful information and services, rather than lack of interest that has kept men from taking a more active role in reproductive health services. (Finger, 1998:8).

The AIDS pandemic and recent UN conferences have awakened renewed interest in male involvement programmes. Based on the review of male involvement programmes in more than twenty developing countries these review advocates-:

- Changing the social norms that govern male behaviour in sexual relations and parenthood;
- Incorporating male involvement in overall planning of reproductive health programmes, and;
- Adapting service delivery programmes to make them more male friendly (Finger, 1997:8).

Increased access to condoms and vasectomies, involvement of the private-sector and workplace initiatives, targeting the adolescent male audience and promoting communication between partners is recommended (Green and Danforth, 1996:8).

Green, *et al* (1995:104) examined contemporary knowledge of male involvement with reproductive health and looked at the development of public health programmes. The study concluded that men have many avenues where they can be approached including workplace initiatives, and through the media, having generally a higher level of literacy. Despite socio-cultural role resistance to involvement, many men are interested in contraception issues and that to provide male services through the existing systems is cost effective. Private sector initiatives such as condom sales are to be encouraged, as well as supporting initiatives that encourage communication between partners, and integrating HIV preventative measures with reproductive health.

Green and Biddlecom (1997:63) published an article that traced the development of demography's emphasis on women. It describes why men have had a relatively low profile as subjects in demographic research on reproduction and it explains the growing interest in studying men's roles. Green and Biddlecom suggest that the differences between men and women's reproductive experiences and costs and benefits related to parenting will become even more salient for future research.

Hall (1996:12) argues that a gender analysis should look at the socially-constructed differences between men and women and examines how these differences determine differential exposure to risk, access to benefits of technology and health care, rights and responsibilities and control over their lives. The sexual attitudes, perceptions and behaviour of men, protection from sexually transmitted infections and from pregnancy are of great importance for women's reproductive health. Hall (1996:12) recommends the necessity to increase men's involvement without detracting resources from existing programmes and explores these issues and delineates areas for future research and education.

Helzner (1996:146) examined the gender implications of male involvement for the staff and decision makers of service-delivery programmes and the gender dynamics which surround contraceptive use. Given the current gender power imbalances, women's empowerment and male involvement need to be seen and implemented with a critical eye, both from the point of

view of men and women as sexual partners and as part of service provision and policy setting. According to Sherphard (1996:11) many reproductive health programmes are now incorporating a gender perspective in sexual health services, yet are still focused mainly on serving women. These programmes need to expand their focus to deal effectively with a bi-polar gender system that underlies many of the problems they address.

The International Conference on Population and Development served as the international launchpoint for a broadened reproductive health agenda. The ICPD argues that hidden social and health costs that particularly affect women must be included in the assessment and prioritisation of reproductive health interventions. Issues of gender and sexuality cannot be separated from the delivery of appropriate reproductive health care (ICPD, 1994: 20).
The role of gender as a fundamental influence along with decision making power, education and earning power, affects the health choices available for everyone. Hence the need to develop creative strategies to reach men, especially in response to the spread of sexually transmitted diseases. Men need to share the responsibility of disease prevention (Wegner, 1998:38).

Mundigo (1995:32) examined the male role and the potential and actual involvement in reproductive health. Perspectives include biological predisposition, sexuality, sexual networks and male use of contraception. Other male roles such as husband, father, health educator and providers have been examined, and their ability to communicate responsibly. The study concludes that reproductive health is a comprehensive framework which incorporates biological and behavioural dimensions. There is an emphasis on cascading information to assist the development of sexual health in adolescent boys.

PATH (1997:7) has published the findings of their study which explains that men's sexual choices and behaviours can affect their reproductive health as well as that of their partners. The successful experiences of programmes in a number of countries demonstrate that men are willing to take action to protect and promote reproductive health when given access to information and services. A key component of "male involvement programmes" is to also

encourage men to take responsibility of their own health as well as support women in their reproductive health needs and decisions.

EngenderHealth has been working on involving men in reproductive health, including family planning since 1994. The organisation's Men as Partners (MAP) programme has four goals: improving men's awareness and responsibility for disease protection; increasing men's use of contraceptive methods that require their participation and cooperation; and improving men's access to comprehensive reproductive health services. To achieve these objectives, EngenderHealth has worked at multiple levels: internationally, nationally, institutionally, community and with individuals. EngenderHealth's MAP work to date has highlighted several key issues that need to be taken into consideration for future programming in men's reproductive health. One of the key lessons learned is that in order for programmes working with men to be successful, they must incorporate a gender perspective. Additionally, service delivery programmes that seek to involve men need to provide training to service providers to increase their comfort and competency in working with men.

Other programming lessons learned include the fact that men are concerned about and interested in reproductive health; men need to be reached through special communication and marketing strategies; involving men does not have to be a costly effort and men's needs have to be addressed holistically. Finally, programmes with men need to address difficult or troubling issues such as domestic violence (WHO, 2001:42).

Global micro-level activities

The following country level activities highlight the diversity of men's reproductive health activities that has been conducted at the country and community level

Pakistan

Pakistan embarked upon an innovative male involvement project which included the implementation of a diverse but interrelated set of strategies in the areas of research,

advocacy, training, social mobilisation, community education and service delivery. The achievements have been impressive and they demonstrated that when well-planned efforts are made to provide male reproductive health services will actively participate in such activities, thereby improving the health of both men and women.

The greatest contribution has been the establishment of evidence-based best practices fro providing reproductive health services to men. Strategies to promote services and educate men were developed, providers were trained on clinical male reproductive health services, and IEC materials for male clients were developed. These efforts had a major impact on the number of men seeking services (Roy et al, 199:53).

United States of America

The Men's Community Network (MCN) of New York is comprised of 100 organisations in health, employment and other sectors. The goal of MCN is to improve the health of low-income African American and Latino men by increasing their ability to access accurate health information and resources through the internet. Research has found that men would like to receive more information not only on health issues but also on issues such as sexuality fatherhood and domestic violence (WHO, 2001:47).

Turkey

In Turkey institutions have tried to make use of existing opportunities within the health care system to provide targeted information, counselling and services for men. Several institutions have established programmes that use couple counselling or group information for men as a way of increasing couple's access to family planning information and vasectomy services. In another programme in Turkey, service providers initiated a postpartum programme for men in response to research findings that indicated the important role fathers play in decisions and practices affecting maternal and child health (WHO, 2001:46).

The Carribbean

Trinidad and Tobago has forged ahead in its provision of male reproductive services. The response to the service shows that men are interested in accessing a range services and the original service concept had to be expanded beyond dealing with prostate disorders to persistent requests for other genital and urinary problems (Eschen et al, 1999:108).

In Colombia, research findings among men showed that men wanted more than just information about health, but also wanted to know how to communicate with children and partners as well as foster new ideas about being gender sensitive in a changing society. They were also concerned about the relationship between their sexual role and their behaviour (Eschen et al, 1999:108).

Survey findings among men in Jamaica indicate that men are interested in fertility issues and would like to become knowledgeable and involved in reproductive health. The AIDS pandemic has heightened the need for male involvement given that male attitudes about sexuality and their vulnerability put both themselves and their partners at risk. According to WHO, next to sub-Saharan Africa, the Carribbean has the second-highest rate of HIV and AIDS infection (2% of its population). The prevalence of AIDS is in a ratio of two males to one female (2001:109).

2.2.2 Men's reproductive health studies in Africa

Zimbabwe

In 1990, the Zimbabwe National Family Planning Council conducted a national education project targeting men, the first of its kind for sub-Saharan Africa. The programme was designed to increase men's knowledge reproductive health, promote more favourable attitudes towards family planning and promote joint decision making.

An analysis of the 1984 Zimbabwe Reproductive Health survey results found that men who were exposed to the campaign were 1,4 times as likely to use modern contraception methods as were other men, 1,7 times as likely to use condoms, and 1,4 times as likely to believe that both husband and wife should participate in deciding how many children to have. The proportion of men who reported joint decision making in family planning rose from 25 percent to 35 percent (Piotrow, *et al*, 1992:12).

According to Kim, (1996:11) positive lessons from the first campaign were that Zimbabwean men want to learn more about reproductive health issues especially family planning and that communication materials directed at men can change men's attitudes towards family planning, stimulate discussion between husbands and wives and motivate men to support family planning practices.

According to Kumah, *et al* (1993:8) the second male motivation campaign was launched in 1993, drawing heavily on the lessons learned during the first campaign. This campaign focussed on improving the quality of services by developing a video on counselling and interpersonal communication and trained clinic-based health workers and community based distribution agents.

Kumah, *et al* (1993:8) points out that exposure to the campaign was associated with a rise in the use of modern contraceptives. Apparently before the campaign, the demand for contraceptives was declining as a result of increases in contraceptive prices and primary health care fees. With the launch of the campaign, this trend reversed. The demand for contraceptives especially for long term methods began to rise. The findings of the post-campaign evaluation do not indicate by what percentage the figures declined before the campaign and by how much it increased after the campaign.

According to the 1984 Zimbabwe Reproductive Health survey, 42 percent of married women stated that it was the husband's responsibility to decide whether his wife should use family planning methods. Focus groups conducted by the Zimbabwe National Family Planning

Council (ZNFPC) and a private research agency suggested that men were the ultimate decision makers on reproductive health matters, especially family planning. (Piotrow, *et a*l, 1992:12).

Discussions during focus groups conducted by ZNFPC in Zimbabwe revealed that men wanted more information regarding reproductive health issues so that they would be better able to make decisions. Because little has been done to inform men about reproductive health, most of what they knew about the subject came from their wives. As a consequence, many men may have had serious misunderstandings about family planning methods and other reproductive health issues and might have discouraged their partners from making use of the services. Possibly men did not want to discuss a subject about which they felt less informed than their wives (Piotrow, *et al*, 1992: 12).

Ghana

According to Kim, *et al*, (1992:10) the Ministry of Health began a systematic campaign on male involvement to increase knowledge and awareness and to improve attitudes towards family planning. Findings indicated a significant increase in men's family planning knowledge, practice and improvement in attitude. Among those men exposed to the intensive campaign, 47 percent had discussed family planning with their partners and 26 percent stated that they or their partners were using a more modern method.

The Planned Parenthood of Ghana offered a cafeteria style series of lectures on topics of interest and concern to men. The most popular lectures selected were on AIDS, impotence, infertility, the breakdown of relationships and male and female physiology. The programme was successful in terms of the number of men who requested the services. The author does not indicate how many men requested the services (Ellerston, 1992:4).

In Ghana, recent evidence indicates that men have the primary decision-making power in matters of family planning. Further more husbands' attitude to health and fertility goals usually are not influenced by those of their wives (Population report, 1994: 10).

The population report indicates that there is reason to suspect that men comprehend reproductive health messages differently than women do. Men feel that financial considerations were the primary motivations for family planning use, whereas women reported that health and the need for women to rest from childbearing were the primary motivations for use. Ghana is the only country in West Africa where at least three quarters of the men approve of family planning (Ezeh *et al*, 1996: 3).

It is important, however, that this approval of family planning is, in general, conditioned to information. The more accurate and positive the information men receive, the more likely they are to approve family planning for themselves or their spouses (Ezeh *et al*, 1996:3).

Ghana is the only country in West Africa where at least half of the men reported ever using contraception. Elsewhere in this sub-region, proportions ranged form 10 percent of men in Mali to 40 percent in Cameroon. In East Africa the proportion of married men who have ever used contraception ranges from 43 percent in Burundi to 72 percent in Kenya. In North Africa (Egypt and Morocco), about two thirds of men have ever used a contraceptive method (Toure, 1996:9).

Niger

The Directorate of Family Planning in Niger's Ministry of Health initiated a communication project to motivate potential clients to seek reproductive health services. The project was not targeted at men exclusively. However a post project survey found that the project had contributed to positive changes in men's knowledge and attitudes. The survey found a 21 percent improvement in their ability to name one or more contraceptive methods without assistance, an 11 percent increase in approval of the use of contraceptives for birth spacing,

men exposure to television programmes with family planning themes increased by 24 percent and men's reports of hearing a radio programme with a family planning theme increased by 47 percent (Bashin, *et al,* 1989: 24).

Recommendations for the project included among others, targeting men as a primary audience of reproductive health messages, developing messages targeted to men, creating a new role model for men that portrays responsible men as those who communicates with their partners and expanding awareness-raising into organised male networks (Bashin, *et al*,1989: 24).

Nigeria

The Planned Parenthood Federation of Nigeria enhanced male motivation through educational outreach to leaders, family life education for youth and reaching men through existing groups. Government officials, traditional rulers and religious leaders were among those targeted, as were journalists, health educators, teachers, social workers etc (IPPF, 1994:20).

Orubuloye and Oguntimehin (1999:66) conducted a study about men's perspectives on reproductive health in Nigeria. The findings of the study established that men have on average more than one sexual partner than women and men have resisted to changes in sexual behaviour in the presence of AIDS despite knowledge about it. The authors recommended an investigation which will attempt to answer why men resist to change their behaviours.

Family Planning programmes did not respond to the call to recruit men as contraceptive users, nor for the most part did they seek to involve men by directing information, education and communication messages towards men. One of the reasons why fertility remains relatively high in Nigeria stems from the fact that family planning programmes have ignored the key reproductive health decision makers within the family (Kritz, 1999:15).

Kenya

In March 1993, the first Centre for Men opened in Nairobi, Kenya to provide vasectomy services, counselling and other male reproductive services in a confidential environment. In June 1993, the second Centre for Men was opened in Mombasa (Danforth, 1994:17).

The Association for Voluntary and Surgical Contraception (AVSC) provided training to surgeons and conducted information, education and communication (IEC) programmes, largely through mass-media advertising to get basic information about vasectomy out to men. The AVSC found that the number of men who used the Centre for Men rose sharply following each campaign. Through the experiences with the Centres for Men, the AVSC has learned that men are interested in reproductive health issues. The majority of men do not want children for whom they cannot care. Men need good counselling and reproductive health services (Danforth, 1994:17).

Most studies confirm the assumption that no matter how many men want to know about and use of contraception, most reproductive health programmes have not yet given adequate attention to serving them. Moreover, while there exist little information for male consumers, there are even fewer educational materials available for professionals and health care providers who deal with men's reproductive health topics (Rogow, 1990:12).

Most services are located within MCH centres and men do not feel comfortable going to those centres. Most trained providers are female, they are trained to talk to women and may alienate men; the variety of modern methods are generally aimed at women, leading to an emphasis on female contraceptive methods such as the pill, IUDs etc. According to Rogow, men must be reached in other ways. A well-designed and well-focused campaign can have a positive impact on men by increasing their knowledge and improving their attitudes towards reproductive health. Wee-designed campaigns can reach men by using multiple communication channels that appeal to men such as radio dramas and sporting events (Rogow, 1990:12).

Tanzania

According to a 1993 DHS survey, 45 percent of married women in Tanzania either did not know what their husbands thought about family planning or their husbands disapproved of family planning, when in fact many of the husbands approved. Men's lack of access to information and services has been a barrier to family planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them (Toure, 1996:5).

Encouraging men's cooperation can start with understanding their point of view rather than relying on their partners' perception of their views. Contrary, to popular belief, men want information about contraceptive methods for both women and men. Most family planning IEC campaigns have assumed that men are not interested, therefore focused only on women rather than on couples; some campaigns have blamed men and portrayed them as irresponsible, adversaries and a barrier to be overcome in accessing reproductive health services particularly family planning.

These types of IEC programmes may have the very barrier that prevents men from learning more about sexuality and family planning. There is a need for more positive images and messages about the role of men (Toure, 1996:6).

South Africa

According to the South African Demographic and Health Survey (1998:16) the prevalence of sexually-transmitted diseases (STIs) is very high amongst South African men. Twelve percent of all adult men interviewed, reported having recently had symptoms associated with STIs. Ten percent report having had painful urination or a discharge from the penis while five percent have had genital sores in the three months preceding the survey.

The Reproductive Health Research Unit (RHRU) conducted a study on "Male involvement in

Reproductive Health in South Africa" in 1998. The study focused on what men know about contraception and whether they are supportive of women visiting clinics. The study also included questions about women's health. The limitation of the study is that it did not focus on men and their health. However, the findings of the study recommended the development of a male programme by government and non-governmental organisations (RHRU, 1998:2).

The Planned Parenthood of South Africa and EngenderHealth developed a programme called "Men as Partners" which focuses on educating men about both men's health and women's health services. The programme is done nationally with the support of the Department of Health. Training materials have been developed and are being used to educate men. The programme was developed as a result of the recommendation of the National Male Involvement study that was carried out by the Reproductive Health Research Unit.

Sonke Gender Justice Project is a South African NGO focusing on gender equality, human rights, HIV and AIDS. The organisation challenges current gender norms by multifaceted interventions designed to engage men in reducing gender-based violence and to promote men's constructive role in sexual and reproductive health, including HIV and AIDS. The project is carried out through a partnership of civil society organisations collaborating with governmental and academic institutions to transform the behaviours of men and the norms of masculinity (Sonke Gender Justice Project, 2010).

A qualitative evaluation carried out with past participants of the programme by an independent evaluation firm in South Africa indicated that their level of awareness with respect to reproductive health issues has significantly increased and is higher than a control group of men with similar profiles. The evaluation also demonstrated that as one of the very few programmes aimed specifically at men in South Africa, the MAP programme has provided important access for men to reproductive health information and services. The programme has succeeded in getting men to rethink their attitudes towards reproductive health (WHO, 2001:45).

2.3 LIMITATIONS OF PAST APPROACHES

In the past, reproductive health programme planners assumed that men were the barriers to health service acceptance. However, recent studies on reproductive health conducted by the International Planned Parenthood Federation have shown that, contrary to previously held beliefs, men have positive attitudes towards reproductive health issues but cannot communicate them to their partners. Based on the erroneous assumption that men's negative attitudes towards family planning are a barrier, most reproductive health programmes have been designed to serve only women' in that most services are located in Maternal and Child Health Centres (IPPF, 1994:6).

Most trained providers are women and the spectrum of contraceptive methods emphasise female methods. As a result, many clinics do not provide services or information for male clients. Recognising the need to rectify the women-centred programme designed in the past, programme planners in Tunisia are making an effort to understand men's points of view and to conduct more research on men's attitudes towards reproductive health (IPPF, 1994:6).

2.4 THE STATUS QUO ON MEN'S REPRODUCTIVE HEALTH

The rhetoric for involving men in reproductive health programmes has become strong and forceful, but providing integrated or expanded reproductive health services to men in current programmes may not be easy, therefore, certain realities need to be considered. Obstacles to men's involvement are many, both tangible and intangible. Six of the obstacles are discussed below.

Socio cultural environment.

Studies have found that men tend to be more steadfast in holding on to traditional roles and value systems than women (Helzner, 1996:146). Men's roles as fathers and husbands tend and continue to emulate traditional values of a patriarchial system (Mundigo, 1995:18) such

as being economic providers and decision-makers within the family. Hence, in many cultures, men may perceive the practice of discussing and sharing decision-making on family size and contraceptive use with their wives or partners as a personal loss of control (IPPF, 1992:3). They may live in conservative communities that frown upon restricting or reducing family size or letting women decide on fertility and reproduction.

Men's attitudes and beliefs

Fear appears to play a big part in many men's attitudes towards family planning and reproductive health besides traditional beliefs such as women's god-given and society sanctioned roles in bearing and nurturing children. Fears such as loss of power in a relationship; sexual virility, pleasure and potency; their women's fidelity; ridicule by other men or the community are obstacles to men is willingness to taking greater responsibility in family planning and reproductive health (UNFPA, 1995: 28). Men's indifference or aversion to reproductive responsibility is not something that can be overcome easily. One reason why many men targeted initiatives that focus on educational and awareness-raising activities is to gradually change some of these beliefs and attitudes to make men more aware of their personal responsibility and to be more women-supportive.

Male bias in policy-making

Many high-level decision and policy-makers, predominantly men, have not yet committed themselves to initiating or institutionalising male involvement in their programmes. It may be cultural perceptions or a resource availability decision. A display or indication of interest in this area can serve as a motivating force, in many instances, towards changes in attitudes and practices of lower level programme personnel (UNFPA, 1995:28).

Lack of programmes

A number of presumptions exist with respect to men's perceptions, values and attitudes on sexual and reproductive health matters. Presumptions such as disinterest in family planning, lack of concern for their wives or female partner's contraceptive choice and use, unwillingness to use contraceptives themselves and so on. However, studies have indicated men's low contraceptive prevalence or involvement in reproductive health is not due to presumptions such as above, but to the lack of reproductive health programmes and the perception that these services are generally not men-friendly (Hulton and Falkingham, 1996:90).

Provider bias

Family planning and maternal and child health programmes are women oriented and have been so for four decades. Service providers are not likely to be trained or sensitised to men's reproductive needs or goals. Providers are more likely to stereotype men as not interested in taking responsibility for family planning. It will take some time for providers and service outlets to adequately cater for male clients (UNFPA 1995: 30).

2.5 FUTURE STRATEGIES FOR IMPLEMENTING MEN'S REPRODUCTIVE HEALTH SERVICES

Need for focused and integrated interventions

The major weakness of male involvement programmes in the past was the lack of a clear focus on desired outcomes. Traditionally, most male-involvement programmes consisted of broad educational talks to groups of men, with little attempt to elicit their interests and concerns or to provide follow-up services. Because this approach was seldom linked discernible increases in contraceptive use, many programme managers concluded that overtures to men were ineffective and unnecessary (Popoola, 1994:4).

The male involvement programmes that are effective are designed to address specific problems or impediments. Examples of such problems are: restrictions on condom advertising and promotion, female reticence to use contraception due to spousal approval, rising rates of STIs and HIV infection, out of wedlock pregnancy, low usage rates of condoms, underutilisation of vasectomy services, adolescent pregnancy and domestic violence. By specifying the problem and the desired outcome, programme planners can identify key groups of males who are susceptible to change through programme interventions (Poopola, 1994:4).

According to Popoola (1994:3) several generalisations emerge from recent experiences with male-involvement programmes:

- *Structure.* Male-involvement should be seen as an integrated part of the overall reproductive health programmes and not as a separate entity;

- *Situation analysis.* Careful analysis is needed to develop specific interventions to involve men in reproductive health. Reaching programme goals at the country level requires a situation analysis of policies, resources and socio-cultural research for strategic planning. It is essential to understand the actual local situation before designing programmes because the roles of men in families and their individual reproductive behaviour may vary along cultural, religious, kinship or class groups and across the reproductive life-span;

- *Audience segmentation.* Men are not a monolithic audience. Programme planners need to target interventions to specific subgroups of males;

- *Couples as a unit.* Service delivery staff should make a greater effort to relate to couples as a unit while preserving the option of independent actions by individuals;

Recent field experience has shown that well-targetted, focused male involvement programmes can have an impact on both male and female behaviour related to their reproductive health. As with most behaviour-change interventions, the key to success is sound audience research, programme planning and effective implementation (Popoola, 1994:3).

Policy barriers

Advocacy activities underscore the importance of men's commitment and cooperation in achieving gender empowerment in decision-making. However, myriad policies, regulations and procedures serve to impede men's involvement in reproductive health. Major areas of concern are:

- *Number of spouses.* Having found a positive relationship between polygamy and reproductive preferences and outcomes, a Nigerian researcher proposes that the government take a bold step to discourage polygamy itself (Stephen, *et al,* 1991: 17*);*

- *Condom imports, advertising and sales.* Many countries charge high tariffs for imported condoms and impose sales taxes. These costs raise the price of condoms to consumers. South Africa's customs surcharge and value-added tax, for example, add 33 percent to the cost of imported condoms. Some governments permit only generic condom promotion. Addressing such impediments can have a major impact on reproductive health programmes (Earle, 1994: 27);

- *Service delivery policies.* In some countries, contraceptive use is dependent upon having the consent of one's husband. Some countries prohibit sales of condoms to people under age 21, a serious handicap to STD and AIDS prevention programmes (Lande and Geller, 1994:39).

Vasectomy is appropriate only for couples who have completed child-bearing because it is permanent. Many countries place restrictions on vasectomy services, such as regulating service providers and facilities; defining eligibility criteria, such as the minimum age and parity; and requiring a mandatory waiting period, multiple visits, lab tests and spousal consent (World bank, 1994:56).

Research in programme planning

The most effective male-involvement programmes have evolved over several years after considerable research and some experimentation. Beyond these experimentation, it is difficult to identify interventions that will work in all settings. Programme experience with men is much more limited than that with women. Interventions that have worked well in one setting have failed in a different locale. Some widely promoted programmes have reached small numbers of men and, therefore, raise questions regarding their replicability and cost effectiveness. It is difficult to put a value on educational interventions because behavioural changes are difficult to measure and may occur at a much later time (Coghlan, *et al*, 1994:16).

Research is an integral part of programme planning. Research helps to analyse the local setting, assessing institutional capabilities, providing a baseline of the status quo against which to gauge changes, identifying and segmenting target audiences, determining suitable service outlets and communication channels and testing messages and materials. Collecting such information enables programme planners to fine-tune interventions to ensure that they are focused on the appropriate audiences and promote the desired behavioural changes (Coghlan, *et al*, 1994:16).

Documenting the effects of various strategies and activities will help in the design and implementation of better programmes. According to Piotrow (1994:4) areas of special importance to male-involvement programmes are:

- Effectiveness of various modes of service delivery and promotion in reaching and serving males;
- Acceptability of existing male contraceptive methods and new methods under investigation;
- Cost-effectiveness of alternative strategies to reach male audiences through interpersonal and mass media channels;
- Impact of vertical and integrated services on the clinic caseload, male contraceptive use and client satisfaction and costs;
- Information and motivational appeals that meet men's needs and concerns; and
- Benefits of spousal communication and joint counselling.

Within the context of the broader programme goals and strategies determined at national and regional levels, local staff and community leaders also need to ensure that male –involvement interventions are appropriate to the local setting. To tailor male-involvement interventions to local conditions, field research is needed. Proposed activities should be assessed in the light of their cultural acceptability, appeal and conformity with local practices (Piotrow, 1994:6);

Programme planners should determine where men congregate, where they obtain health care, how they obtain health-related information and how they interact with their sexual partners, peers and authority figures. Such information is critical to identifying appropriate service outlets and information channels (Piotrow, 1994:6).

Ethical issues

Promoting reproductive health entails ensuring equitable access to services and information, protecting individual rights and respecting individual choices regarding reproduction. In bringing men into the reproductive decision-making process, service providers may jeopardize women's autonomy and self determination if their reproductive goals differ from those of their partner. Many women choose to use contraception without their partner's knowledge because they fear hostility, violence and rejection if their partner learns of their actions. Service providers have an

obligation to protect women's privacy, but such actions abridge men's ability to implement their reproductive goals (Haws, *et al*, 1995:85).

Treating those who are infected with STIs and HIV poses many ethical dilemmas. Providers cannot require infected individuals to inform their partners or take steps to prevent them from becoming infected. Yet the lack of information to partners, who may unknowingly be infected and may spread the infection to others. Thus, protecting an individual's privacy has far reaching consequences for others (Haws *et al*, 1995:85).

Other areas of male reproductive health that raise ethical issues include: parental rights and responsibilities; the testing of new male contraceptive methods and drugs to prevent and treat AIDS; and the protection of male workers from workplace conditions that cause infertility. National ethical committees and relevant bodies should be encouraged to review national guidelines for service delivery and monitor the handling of ethical issues as they arise (Haws, et al, 1995:85).

Community Involvement

Male involvement activities should promote increased community involvement in modifying and sustaining behaviours that improve family and sexual health. Existing community networks, facilities and agencies should be used whenever possible. Community involvement in reproductive health programmes can increase their acceptability, improve participation rates and promote self-sufficiency. Involvement can take various forms including:

- The participation of community leaders and members in project design and implementation;
- Service delivery and education activities led by the community groups and conducted by volunteers; and
- Community control over programme activities and contributions of volunteer time, money clinic facilities, supplies and other resources.

Giving local communities major responsibility for reproductive health programmes creates a sense of ownership and ensures that community needs are addressed (GFID, 1994:13).

Family planning and HIV/AIDS prevention programmes are focusing the attention to community involvement. Once relevant community members have been identified, educational programmes can be used to disseminate information and refute rumours. This technique has been shown to be effective in conveying the information and skills needed to change behaviour (Chanuantong and Wienrawee, 1994:10).

Many governments are seeking to decentralise health services and foster community involvement in health promotion. Projects that are oriented towards meeting family health and community development needs, that have flexible objectives and that are implemented by small scale organizations have the greatest likelihood of success (Askew and Khan, 1990:127).

As much as it is important to involve communities in health promotion programmes, it is crucial to gather information on the extent to which men are involved in reproductive health decisions. More information on men vis-à-vis their knowledge and involvement is vital as inputs into the programme planning process. The community can be utilised to gather data that will be used to design programmes that are culturally appropriate and that will identify with the needs of the community.

Programme monitoring and evaluation

Monitoring and evaluation are needed to ensure that male involvement programmes are working. They can also be used to identify the most successful elements that can be adapted to other communities (Anne, *et al*, 1994:18).

One factor impending greater action on male involvement is that, beyond compiling data on condom and vasectomy use, most reproductive health programmes collect little information and male services and activities. The lack of interest in male activities among high level managers

translates into neglect and apathy throughout the various levels of the service-delivery system. Many clinic recorded forms have no space to record male visits for counselling services. Outreach workers receive credit for the number of women they have visited. Discussions with men are not counted. By adding indicators of male involvement activities to the record-keeping system, programme managers send a powerful message to staff members. Such indicators ensure that staff will receive recognition for male-involvement activities and will strive to do more in this area (Coghlan, *et al*, 1994:18).

2.6. CONCLUSION

According to the literature review findings in previous pages it is indicated that a combination of male attitudes and provider bias has resulted in men being both a neglected and a poorly prepared constituency for reproductive health care. There are, however, some examples of various experience and initiatives that illustrate a genuine concern and creative approach towards achieving a greater male involvement globally, in Africa and South Africa.

The findings of the literature review indicate that programmes to encourage men's involvement in reproductive health are expanding, especially through promotional interventions to increase knowledge and interest of men, such as information, education and communication campaigns using mass media and service interventions to increase men's access and use of reproductive health services such as community based distribution, condom sales and promotion, workplace programmes and male clinics and vasectomy services, Some of the field experiences have shown that well-targeted, focused male-involvement programmes can have an impact on both male and female behaviour related to reproductive health.

The findings in this literature review, highlights the need for more extensive research on male reproductive health and on male contraceptive methods since the two major modern male methods are stigmatised. Meaningful reproductive health research should include analysing the local setting, assessing institutional capabilities, providing a baseline of the status quo

against which o gauge changes, identifying and segmenting target audiences, determining suitable service outlets and communication channels and testing messages and materials.

Much of global social science research has provided informative data on the factors which impede enhanced male involvement in reproductive health programmes. However, while the findings of these studies have provided insights into ways of improving and strengthening reproductive health programmes targeted at men, there is a need for more research, especially on the factors perpetuating risky sexual and social practices, because it is the practices that undermine the success of male reproductive health programmes. Programmatic research areas and methodological approaches which can facilitate a better understanding of men's sexual and reproductive health behaviour and enhance programme coverage and quality of services are identified.

Much of the social science research on the male role in reproductive health within sub-Saharan Africa region has tried to examine among others men's sexual and reproductive health behaviour, factors facilitating or inhibiting inter-partner communication and the influence of men on the reproductive health policy environment. The major aim of the research has been to enhance male involvement in reproductive health programmes in the region.

The research has shown that male participation in fertility decision-making is critical to the wider acceptance of family planning and improvement in sexual and reproductive health. Since gender power relations in much of Africa are skewed in favour of men and African men wield a lot of power in the home and within society, they are the key gatekeepers to decisions relating to contraceptive use and fertility control. Involving men in inter-spousal communication has also been found to be critical in the sustained use of family planning methods. Men are also known to take sexual risks which occasionally render them vulnerable to sexually transmitted diseases including HIV and AIDS. This risk taking behaviour certainly impacts directly on the sexual health of their female partners. It is therefore important to address factors underlying male sexual behaviour.

Researchers within the region should, through social research, strive to identify policies and programmes which are culturally sensitive and resonates with local practices. Only through research can programme planners and policy-makers be able to produce socially sensitive, culturally meaningful, male-friendly programmes. In this way, it will be possible to reduce the high incidence of reproductive health problems facing both men and women in the sub-Saharan region and in particular the problem of sexually transmitted diseases including HIV and AIDS, which has reached endemic proportions.

Data to determine the status of male reproductive health is limited and this is the result of focus that has been placed on females. Research studies, principally in the form of reproductive health surveys, should routinely be conducted to determine contraceptive prevalence, provide information on contraceptive knowledge, attitudes and practice and unmet needs among men. Evaluation studies that focus on clinical service delivery in health facilities to determine the best practice for the integration of male services are lacking.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this section the researcher discusses the research methodology utilised for this study, and motivates the research design and its application in the study. The section gives an overview of the research design, data collection procedure and it helps the researcher understand the value and limitations of the data collected. The limitations of the study are also identified.

This research report takes on a qualitative research orientation in order to understand the phenomena. It will also employ documentary analysis, key informant interviews which are linked to documentary analysis. Focus group discussions with men will also be conducted in order to understand the phenomena. This will give triangulation. Below, the sections deal with both the details of methods and with intricate aspects of the application of this methodology.

3. 2 RESEARCH DESIGN

The qualitative research paradigm is based on induction, holism and subjectivism. An exploratory descriptive research strategy is inductive in that the researcher attempts to understand a situation without imposing pre existing expectations on the setting. Holism is the assumption that the whole is greater than the sum of the parts and that context is essential for understanding (Mouton, 1992:204).

The qualitative approach therefore aims to gather data on numerous aspects of a situation and to construct a complete picture of the social dynamic of the particular or setting. An important assumption of the qualitative paradigm understands a situation from the perspective of participants in the situation. The qualitative approach is subjective in that the focus is on the experiential states of actors and their perceptions of a situation. In short, the qualitative method

advocates an approach to examining the empirical world which requires the researcher to interpret the real world from the perspective of the participants (Mouton, 1992:205).

The commitment to get close and to be factual, descriptive and quotive, is thus a commitment of the qualitative researcher to represent participants in their own terms and to give a living sense of day to day talk, activities, concerns and problems in such a way that the audience is at least partially able to project itself into the point of view of the people depicted. A combination of data collection methods used in this study allowed the researcher to get close to the data and to obtain first hand knowledge. This study has been conducted in three phases:

Phase 1. Documentary analysis to review various policy and planning documents at National, Provincial and District levels.

Phase 2. In-depth key informant interviews with the following:

- National Deputy Director - Reproductive Health;
- Northern Cape Provincial Coordinator - Reproductive Health;
- Northern Cape Deputy Director - Information Management;
- Northern Cape Provincial District Coordinator;

Phase 3. Focus group discussions with men to discuss their reproductive health concerns namely, attitudes, feelings, beliefs, experiences and reactions.

3.3 DOCUMENTARY ANALYSIS

Documentary analysis that involves primary sources has been used widely in the field of health policy research, particularly in the analysis of health care policy implementation (Abbott *et al*., 2004: 264). Documentary analysis can provide a useful supplement to data collected from human subjects by other means. Despite this, documentary analysis has some flaws, including partial or superficial official documents, which sometimes represent aspirations rather than realities (Abbott *et al*., 2004: 265).

The primary documents that were analysed in this research project are -:

- National ten point plan 2004 – 2009;
- National ten point plan 2009 – 2014;
- National strategic plan 2006 – 2009;
- National Mother, Child and Women's Health (MCWH) operational plans 2006 - 2009;
- Provincial strategic plan 2004 – 2009;
- Provincial strategic plan 2009 – 2014;
- Provincial annual performance plans 2006/2007; 2007/2008; 2008/2009;
- Provincial MCWH annual plan2006/2007; 2007/2008; 2008/2009;
- Provincial annual report 2006/2007; 2007/2008; 2008/2009;
- Reproductive health policy;
- National policy guidelines for contraceptive services;
- National population policy;
- State of the province address 2007 and 2008;
- Provincial growth and development strategy implementation plans;
- Northern Cape Programme of Action 2006/2007; 2007/2008; 2008/2009;
- District health information management;
- Information, education and communication material;
- District health plans of the five districts in the Northern Cape 2006/2007; 2007/2008; 2008/2009.

3.4 KEY INFORMANT INTERVIEWS

Face to face interviews with the above-mentioned key informants were conducted at the Department of Health. The purpose was to find out the extend in which reproductive health services are delivered at the public health facilities, the availability of information, education and communication strategy and the general progress made since 1994 transformation of reproductive health services. The following key informants' were interviewed:

- National Deputy Director for reproductive health who provided information about the national strategic framework, policies and plans;
- Northern Cape Provincial Coordinator for reproductive health who provided provincial plans, strategies and reproductive health information in detail;
- Information Manager in the Northern Cape Provincial Office who provided information on the status of information management on Reproductive health; and
- Provincial District Coordinator who provided information on the districts health services.

The main advantage of in-depth interviews over structured interviews is its ability to provide insights into and understanding of the context in which behaviour occurs and the broader structural determinants of behaviour. Other advantages include:

- Respondents determination of the salience of topics and themes
- Greater depth and detail of information
- Greater opportunity to share and understand the viewpoints of respondents and how beliefs and experiences and vocabulary relate to wider issues; and
- The possibility of discovering the unexpected, which is precluded in a highly structured approach (Lundgren, 2000:13).

Repeat interviews were held with the same respondents to elicit as much narrative as possible. The emphasis was getting peoples' own perspective on events, and on gaining a rich description of the context and situations in which these events and actions are taking place. It also allowed a deeper understanding of underlying motive of behaviours since the researcher had ample time to probe for explanations, resolve apparent contradictions and obtain additional example of events or actions. Since the objective of this research is the understanding of processes, representativeness was not a primary issue in the choice of informants.

3.5 FOCUS GROUP DISCUSSIONS

There are many definitions of focus groups, but features like organised discussion (Kitzinger, 1994:299), collective activity (Powell, et al, 1996:499), social events (Goss and Leinbach, 1996:115) and interaction (Morgan, 1997:12) identify the contribution that focus groups make to social research.

Powell *et al* (1996:499) define a focus group as a group of individual selected and assembled by researchers to discuss about the topic that is the subject of research.

Focus groups are a form of group interviewing that relies on interaction within a group based on topics that are supplied by the researcher (Morgan, 1997:12). The key characteristic which distinguishes focus groups is the insight and data produced by the interaction between participants.

The role of focus groups

Focus groups can be used at the preliminary or exploratory stages of the study (Kreuger, 1988: 28); during a study, perhaps to evaluate or develop a particular programme of activities (Race *et al*, 1994:730); or after a programme has been completed, to assess its impact or to generate further avenues of research. They can be used either as a method in their own right or as a complement to other methods, especially for triangulation and validity checking.

Focus groups can help to explore or generate hypotheses and develop questions or concepts for questionnaires and interview guides. They are however limited in terms of their ability to generalise findings to the whole population, mainly because of the small numbers of people participating and the likelihood that the participants will not be a representative sample (Hoppe *et al* , 1995:102).

Rationale for focus groups in this study

The main purpose of focus group research is to draw upon respondents, attitudes, feelings, beliefs, experiences and reactions in a way in which would not be feasible using other methods, for example observations, one to one interviewing or questionnaire surveys. These attitudes, feelings and beliefs may be partially independent of a group or its social setting but are more likely to be revealed via the social gathering and the interaction which a focus group entails. Compared to individual interviews which aim to obtain individual attitudes, beliefs and feelings, focus groups elicit a multiplicity of views and emotional processes within a group context. Compared to observation, a focus group enables the researcher to gain a larger amount of information in a shorter period of time in these sense, focus group are not natural but organised events (Morgan and Kreuger, 1993:23).

Focus groups are particularly useful when there are power differences between the participants and decision-makers or professionals, when the everyday use of language and culture of particular groups is of interest and when one wants to explore the degree of consensus on a given topic (Powell *et al,* 1996:193*)*.

Potentials and limitations of focus groups

Kitzinger (1995:299) argues that interaction is the crucial feature of focus groups because the interaction between participants highlights their view of the world, the language they use about an issue and their values and beliefs about a situation. Interaction also enables participants to ask questions of each other, as well as to re-evaluate and reconsider their own understandings of their specific experiences.

Another benefit is that focus groups elicit information in a way which allows researchers to find out why an issue is salient, as well as what is salient about it. As a result, the gap between what people say and what they do can be better understood. If multiple understandings and meanings

are revealed by participants, multiple explanations of their behaviour and attitudes will be more readily articulated (Morgan, 1988: 98).

The benefits to participants of focus group research should not be underestimated. The opportunity to be involved in decision-making processes, to be valued as experts and to be given the chance to work collaboratively with researchers can be empowering for many participants. If a group works well, trust develops and the group may explore solutions to a particular problem as a unit rather than as individuals. If participants are actively involved in something which they feel will make a difference and focus group research is often of an applied nature, empowerment can realistically be achieved. Another advantage of focus groups to clients, users or participants is that they can become a forum for change during the focus group meeting itself and afterwards (Race *et al,* 1994:740).

3.6 SAMPLE DESIGN AND SAMPLING METHODS

Sample design, techniques and criteria used in selecting sample

To pursue this study, the researcher opted for a qualitative, exploratory and descriptive design based on the nature of the study problem as outlined in Chapter one. A qualitative, exploratory and descriptive design was chosen by the researcher because it enabled the researcher to obtain informative rich data from the men. Use of this design further allowed the researcher to explore and describe the reproductive health concerns of men.

Focus group participants are typically selected for their special expertise or experience and it is desirable to seek out a wide range of views to defend the study against charges of selection bias. The group setting of focus groups means that the participants must feel comfortable talking openly and honestly with each other, which requires that each group be somewhat homogeneous in background and experience. Therefore diversity should generally be achieved by running a diverse set of relatively homogenous groups rather than trying to achieve diversity within a group.

The sample population was delimited to men between the age of 26 and 38. The participants in each group were purposely recruited by the facilitator from the provincial men's forum in Kimberley. Men in all the provinces in South Africa have formed forums to address issues that affect men as well as women and children such as gender violence. During the recruitment, the potential participants were invited by the researcher to come to a venue arranged and on the day set to discuss the reproductive health views. During the selection period, the researcher ensured that full information about the purpose and uses of participants' contribution is given. The researcher was honest and kept participants informed about the expectations of the group and topic and not pressurising participants to become part of the discussion group.

Size of the group and number of groups

It is generally accepted that an ideal number of participants in a focus group discussion should be not fewer than six and not bigger than twelve, to allow for a range of viewpoints and to keep the discussion manageable.

Merton *et al* suggests that the size of the group should manifestly be governed by two considerations. It should not be as large as to be unwieldy or to preclude adequate participation by most members nor should it be so small that it fails to provide substantially greater coverage than that of an interview with one individual (1990:137).

Three focus group discussions with ten participants in each group were conducted in Kimberley. Biographical information was obtained from the participants during the selection of participants. The socio-demographic profile of the sample in all the groups consisted of the following characteristics, age group, level of education, marital status, number of living children, place of residence and religion. All the participants were married with at least one child. The level of education ranged from grade ten to post graduate degrees.

3.7 DATA COLLECTION METHODS AND FIELDWORK

Measuring instrument

The researcher compiled a list of questions which was tested in a pilot focus group discussion in the exact same population as the final focus group discussion. The format of the questions was clear, flowing and easy for participants to answer. Responses to the pilot focus group discussion were analysed and the results were incorporated in the final list of questions. The purpose of the pilot focus discussion was to evaluate the clarity, comprehensiveness and format of the questions.

The pilot focus group discussion yielded the following information. Some participants voiced a strong urge to discuss the questions outside and away from the other participants. It was an opportunity for some of the participants to discuss their personal sexual issues with the researcher. This to some extent confirmed the sensitive nature of the discussion and the fact that it is not culturally appropriate for men to discuss sexual and reproductive health issues amongst themselves and with women. The list of questions discussed (presented in Appendix 1) were derived from the literature.

Gaining access to participants

The primary means of data collection to these research types is focus group discussions. Due to the sensitive nature of the research topic, accessibility to participants was established by means of verbal requests to a men's forum in the Northern Cape. In an effort to enhance access to potential participants and ensure their voluntary participation, the following criteria were adhered to during data collection.

- All participants were clearly informed of the purpose of the research and emphasis was placed on their voluntary participation.
- Each participant was assured of the confidentiality of his answers and the protection of their identities.

- The researcher stated clearly that the discussion does not have correct or incorrect answers. The participants were requested to engage actively in the discussion and were encouraged to answer questions honestly.

Data collection process

The researcher's job is not to interview but to act as a moderator and to facilitate the discussion of others without being an active participant. The technique of moderating a focus group is a skill in itself where the moderator may have to wear many hats and assume different roles throughout the course of the discussion.

Kreuger (1988:90) states that moderators have the difficult task of dealing with dynamics that constantly evolve. They must handle the problems by constantly checking behaviour against attitudes, challenging and drawing out respondents with opposite views and looking for the emotional component of the responses.

According to Kreuger (1988:85) moderators must be mentally alert and free from distraction, anxieties and pressures, should practice the discipline of listening to others in group situations, should memorise the questioning route and should be able to listen and think at the same time.

Glesne and Peshkin (1992:79) indicate that a good interviewer is anticipatory; alert to establish rapport; naïve; analytic; paradoxically bilateral (dominant but also submissive); non-reactive; non-directive and probes patiently.

The discussions were facilitated by the researcher. Prior to the interviews, the researcher orientated herself in the research area and trained herself in moderating skills. The discussions were conducted in both English and Setswana and the participants were invited to use the language of their choice. The facilitator led the discussions according to prepared guidelines. First, the researcher explained to the participants that the discussions would last about an hour and half and that their views would be co-ordinated and the information used for research

purposes. The information which they provided would be kept confidential and only their first name would be used during the discussion.

The researcher introduced the procedure to the participants, clarified the concepts to be discussed and established ground rules which included a request that only one person speak at a time and that participants do not engage in side conversations. The role of the researcher was clarified as learning from the participants and requesting everyone to participate. Participants introduced themselves and described their background to break the ice. This was the researcher's attempt to build rapport with the group. The researcher then introduced the first open-ended question to the group to get the discussion underway, guided the discussions to keep them on track and probed the participants' views and statements where more information was required. The discussions were audio recorded with the permission of the participants.

Some of the men found it difficult to actively participate in the discussion but were soon able to participate. It is not clear whether it was because the interviewer was a woman or the subject was sensitive. The researcher's view is that the discussion dealt with highly sensitive issues of sexual behaviour which make the some of the participants ill at ease, particularly if the responses can be heard by others.

The researcher attempted to maintain a non-judgemental neutral and objective stance. This was done by asking open–ended questions to facilitate the expression of the respondent's perception. Throughout the interview, the researcher reflected on statements made by respondents to eliminate the researcher prematurely ascribing meaning to the respondent's answers. The researcher did not make use of a formal structure when questioning the respondents. Frequently, the respondents dictated the sequence and form of the interview. This approach allowed the respondents to describe their own perceptions and experiences without being confined to a formal interview schedule and this consequently elicited rich complex data.

The researcher's use of open-ended questions, clarification and focusing assisted in eliciting the subjective viewpoint of the respondents. Summarising primarily took place towards the end of the discussions. This avoided the temptation for the respondents to agree with the summary, rather than continue to describe their experiences.

3.8 DATA CODING AND ANALYSIS

The audiotaped interviews were transcribed verbatim. This included all hesitation, repetition and any incorrect use of the language. The transcribed interviews were then analysed individually for content. Emergent themes were identified which included and organised into broad categories. During this analysis, additional themes or categories were added where necessary and other were collapsed where appropriate. Transcripts were further cross-analysed for similarities and differences regarding the emerging themes and categories. Again some themes were expanded if this was deemed necessary and others collapsed to achieve homogeneity.

Qualitative data is the integral part of data analysis. It is guided by the research questions and leads to more questions. It frees a researcher from entanglement in the details of the raw data and encourages higher-level thinking about them.

The researcher has used all three qualitative data coding namely open coding, axial coding and selective coding. The process will be discussed in detail in Chapter four.

Data analysis means a search for patterns in data, recurrent behaviours, objects or a body of knowledge. Once a pattern is identified, it is interpreted in terms of the setting in which it occurred. The researcher moves from the description of a social setting to a more general interpretation of its meaning.

According to Neuman (2000:426) data analysis involves examining, sorting, categorising, evaluating, comparing, synthesising and contemplating the coded data as well as reviewing the raw and recorded data.

The researcher used both successive approximation and domain analysis in this study. Successive Approximation as a method of analysis involves repeated iterations or cycling through steps moving towards a final analysis. After several iterations, a researcher moves from vague ideas and concrete details in the data towards a comprehensive analysis with generalisations (Neuman, 2000:426).

Domains are defined as the basic unit in a cultural setting or an organising idea or concept. Domains are later combined into taxonomies and broader themes to provide an overall interpretation of a cultural scene or social setting. The researcher has followed all the steps of domain analysis. The process has assisted the researcher to build up from specifics in the notes to an overall set of logical relationships (Neuman, 2000:431).

Qualitative research designs begin with specific observations and build towards general patterns. Categories or dimensions of analysis emerge as a researcher comes to make sense of and organise patterns that exist in the empirical world which is studied. The researcher began to focus on testing and eliciting what appears to be emerging. The researcher then develops analytical, conceptual and categorical components of explanations from the data itself.

3.9 VALIDITY AND RELIABILITY

The validity of the study was ensured through a wide representation and participation of the relevant officials dealing with reproductive health matters from National, Provincial and District health levels.

The reliability of the research was ensured by relevant official documents of the Department of Health and activities. Information provided by the key informant interviewees was similar to what was documented or not documented by the Department of Health plans.

3.10 LIMITATION OF THE STUDY

One major limitation is that the research is not focusing on general health related policy and programme matters but tackles issues around men and reproductive health matters only. This narrow angle attempts to identify why men's health reproductive health has failed to be prioritised by the Department of Health and the implications thereof.

Document analysis may be biased in the way documents are written. They also provide an incomplete account to the researcher who has had no prior experience with or no knowledge of the events. In many cases, the information was never recorded.

3.11 CONCLUSION

In this chapter a description and explanation was provided of the chosen methodological approach followed in this study which further determined the research methods discussed. Both the methodology and research design were chosen for their functionality in attempts to answer research questions presented in section one, and to assess the whole variety or preliminary answers provided in Chapter two.

The section has outlined three elements which are necessary in undertaking a qualitative study, namely, intensive immersion in a sector of social life to gain intimate familiarity with what is going on; focusing on interactional strategies and tactics of participants to understand the situation and assembling and analysing an abundance of qualitative data of situations, events, strategies, action, people and activities to convey the reality of the place represented in its mundane aspects.

CHAPTER 4

RESULTS AND ANALYSIS

4.1 INTRODUCTION

The findings of this study contribute to the debate of focusing on the relatively understudied issue of men and reproductive health matters. Male involvement in reproductive health is mentioned in most of the forums addressing the issues of reproductive health, gender equity and empowerment of women. Very little however, is known about how to enhance male involvement. Against this backdrop, it is interesting to take a look at how the Northern Cape Department of Health which is committed to implementing ICPD Programme of Action is addressing this issue. What efforts have been made by the government to provide and involve men in reproductive health and what results have been achieved? Are innovative and replicable models to enhance male involvement available?

The findings reflect the complexity and ambivalence of reproductive innovations and of gender dynamics in our society and play an important role in the formation of men's attitudes towards reproduction in general which in turn greatly affect reproductive health decisions and practices.

4.2 DATA AND METHODOLOGY

To answer these questions, three sets of data have been used. These include:

- Review of various policy and planning documents;
- In-depth interviews with key informants at National, Provincial and District Level; and
- Focus group discussions with men in the Northern Cape.

4.3 FINDINGS OF CONTENT ANALYSIS OF POLICY AND PLANNING DOCUMENTS

All relevant documents produced since 1996 including policy statements, strategic and annual plans, programme objectives and annual reports were reviewed to identify the Northern Cape Department of Health commitment to men and reproductive health programmes. Table 1 summarises the findings of this review.

Table 1: Content analysis of various programme documents regarding male reproductive health.

Name of document	Year	Content with respect to men and reproductive health
National strategic plan	2007/2008 2008/2009	No reference is made regarding men and reproductive health.
National ten point plan	2004 – 2009	No reference is made regarding men and reproductive health.
National ten point plan	2009 – 2014	No reference is made regarding men and reproductive health.
National strategic plan	2006 – 2009	Reference is made regarding male involvement in reproductive health activities.
National strategic plan for HIV and AIDS and STIs	2007 – 2011	Reference is made regarding male involvement in reproductive health activities.
National Mother, Child and Women's Health (MCWH) operational plans	2006 – 2009	Reference is made regarding men and reproductive health activities.
Provincial strategic plan	2004 – 2009	No reference is made regarding men and reproductive health.
Provincial strategic plan	2009 – 2014	No reference is made regarding men and reproductive health.

Name of document	Year	Content with respect to men and reproductive health
Provincial strategic plan for HIV and AIDS and STIs	2009 – 2011	Reference is made regarding male involvement in reproductive health activities.
Provincial annual performance plans	2006/2007 2007/2008 2008/2009	No reference is made regarding men and reproductive health.
Provincial MCWH annual plan	2006/2007 2007/2008 2008/2009	There are no activities documented regarding men's reproductive health
Provincial annual report	2006/2007 2007/2008 2008/2009	No reference is made regarding men and reproductive health.
Reproductive health policy		The policy is not available.
National policy guidelines for contraceptive services	2002	The policy guidelines make reference to contraceptive services for men.
National population policy	1998	Reference is made about involving men in all the issues that are affecting women.
State of the province address	2007 2008	No reference is made regarding men and reproductive health.
Provincial growth and development strategy implementation plans	2004 – 2014	Detailed implementation plans about HIV and AIDS makes no reference about male reproductive health except the distribution of male and female condoms. Implementation plan regarding the

Name of document	Year	Content with respect to men and reproductive health
		reduction of maternal mortality makes no reference with regard to male involvement.
Northern Cape Programme of Action	2006/2007 2007/2008 2008/2009	It gives priorities about HIV and AIDS and strategies to reduce prevalence rate.
District health information management	2008/2009	Information Management Unit does not have data with regard to men and reproductive health.
Information, education and communication (IEC) material	2006 – 2009	There is no IEC material both at National and Provincial level.
District health plans of the five districts in the Northern Cape	2006/2007 2007/2008 2008/2009	There is no reference on reproductive health and men.

Some of the policies reviewed provide general statements of good intentions without necessarily committing to concrete actions. Reference to men is notably absent from most documents that refer to reproductive health and even to gender inequality. The absence of clear policy directives, plans and a monitoring system with built in indicators to measure achievements of the programme in enhancing men's reproductive health programmes will make it difficult to address this issue and plan for it.

4.4 FINDINGS FROM IN-DEPTH INTERVIEWS WITH KEY INFORMANTS BOTH AT NATIONAL AND PROVINCIAL LEVEL

Interview 1.

National Department of Health Deputy Director for Reproductive Health.

In-depth interviews with key informants illustrate their knowledge of what men's reproductive health entails. They appreciate and agree that male participation in the provision of reproductive health services is critical for the success of the programme although it is currently an afterthought. Despite the recognition that men can and do play an important role in reproductive health, this research has shown that there are certain bottlenecks to male participation in reproductive health programmes.

The interviewee indicated that men's reproductive health is on the agenda of the Department of Health. The National Department of Health is taking International Conference on Population and Development, the National Health Plan and the South African population Policy seriously. She highlighted that the departments' strategic plan do not make reference of men annually but their operational plans include men's reproductive health activities and they do hold men's meeting on an annual basis to discuss reproductive health matters extensively. All the provinces are invited to share information and to develop strategies. There is also a strong collaboration with non-governmental organisations and international organisations that provide funding for the programme. She indicated that National office has not been monitoring progress regarding men's health issues.

Women's health issues such as maternal mortality, prevention of mother to child transmission of HIV and AIDS, choice on termination of pregnancy and youth and adolescent health have been highly prioritised. She indicated that the departments' quarterly reporting system monitored by the directorate health information management do not have the indicators monitoring reproductive health services for men. She mentioned that men have got serious reproductive health problems but national office has not kept record of how bad the problem is. She highlighted that what men face cannot be compared with what women go through during their reproductive health years but that does not mean that they should be ignored. She agreed that national has done a disservice to men. There are no IEC materials that were developed to provide men with reproductive health services.

"The main responsibility of national department is to develop policies and guide provinces with regard to programme development. Implementation happens at the provincial level and national should support what provinces do. Provinces are independent and they are expected to design and implement programmes based on the level of priority and the available resources, financial and human. National cannot force provinces to implement programmes but it supports their strategies."

The National Deputy Director agreed that the pillars of male reproductive health services should include the following:

- Targeting male needs according to their age, marital status, sexual orientation, health and family life, education and socio-cultural orientation to reproductive health;
- Promotion of condom use to provide dual protection against sexually transmitted infections and pregnancy;
- Promotion of communication skills to improve cooperation between partners on sexual and reproductive matters;
- Provision of comprehensive reproductive education and information;
- Clinical services to address a range of services that include contraception, infertility, STIs and AIDS, sexual dysfunction, screening of prostate cancer, etc;
- Counselling services for individual men and couples;
- Promotion of lifestyle changes to prevent and protect against risks of reproductive health diseases and compromising sexual behaviour;
- Promotion of male sterilization;
- Condom social marketing to improve variety and access.

She further indicated that services are being provided but the information is not documented. "*As a result, I cannot tell you what the prevalence rate of testicular and prostate cancers is per province. National will have to give reproductive health services for men an equal status as women's reproductive health. IEC will be a priority activity for our 2010 strategic plan".*

Interview 2.

Northern Cape Department of Health Provincial Office – Reproductive Health Coordinator.

According to the Provincial Coordinator almost all the services are provided in most of the facilities. Those that are not available in clinics such as the treatment of cancers are referred to the hospitals. The Deputy Director indicated that information, education and communication (IEC) material has not been given priority due to budget constraints. She mentioned that lack of access to print and electronic media coupled with high illiteracy levels means that few men have access to quality reproductive health information.

The Provincial Coordinator has however, highlighted that the Department of Health in the Northern Cape is faced with the following challenges-:

- Unavailability of funds to implement a holistic reproductive health programme;
- Lack of staff both at the facility level especially rural areas and provincial office;
- Lack of reproductive health district coordinators;
- Poor data collection at the district level.

As a result, it is difficult for the province to plan for the programme when there are budgetary constraints. She indicated that there is no capacity to develop IEC material for men. There is only one official responsible for reproductive health in the provincial office which means that focus is more on women's reproductive health as a priority programme especially maternal mortality and HIV and AIDS. "We are one of the provinces with the highest maternal mortality. Every year, our maternal mortality rate goes up. *Currently we are at 300 per 100 000 women. This is bad. The cause is a whole range of issues ranging from lack of staff to HIV and AIDS. The department is prioritising HIV and AIDS as well as prevention of mother to child transmission of HIV. How can we begin to talk about men when we are failing women in this province? We cannot ignore men's health. It is important but the situation is bad here. How are we expected to function without reproductive health coordinators in each of the districts? It is impossible to monitor programmes in such a vast province with such distances. We are always reminded that there are financial constraints".*

Some of the gaps were highlighted in the Key Informants knowledge of reproductive health issues which involve men namely, less experience and information on programmatic issues and how that can influence and improve programme design, implementation and service delivery.

Location, quality of service and service delivery

Research findings in Kenya show that men are concerned with the location of a facility, the quality of service and the calibre of the service provider (Nzioka, 2000: 134). The Provincial Coordinator indicated that if a service is offered where privacy cannot be assured, men shy away from that service. For instance, if men are to seek vasectomy, it is most likely that they will seek the service from the clinic which is physically located in the open or where a clinic is stigmatized as offering a particular service. The Coordinator indicated that men are always pressed for time and they are not keen on spending lots of time in the clinics. Most of the clinics have long queues that is why they opt for private services. When they cannot afford such care, they opt for self-medication.

Acceptability of contraceptive methods

The Northern Cape has a syphilis prevalence rate of 5.4 % which is the highest in South Africa (Department of Health: 2006/2007). According to the Facility Manager, men are very reluctant to go for condoms or STI treatment especially where the service providers are females for fear that the provider might disclose the problem to other women. It has also been observed that they have a limited knowledge of certain methods of contraception. They are against vasectomy and they see it as a way of ending their sexual desire and performance.

The Provincial Coordinator indicated that the range of contraceptive methods for men at present is limited. More research is needed to develop newer methods. There is also a need

to conduct more research to establish which of these methods are more acceptable or not and what strategies could be used to promote acceptability of methods which are not very popular. She indicated that she does not see how men will not use the services if they have been provided with information. She indicated that there has not been a vigorous advocacy programme to encourage men to take care of their sexual and reproductive health.

Research should explore how promotional messages on men's reproductive health can be better designed and packaged to earn greater acceptance among men. This will also assist providers to understand what needs to be done to increase male compliance.

Impact of vertical and integrated male service

The Provincial Coordinator indicated that data of clinic attendance is collected in all the facilities but it is not properly analysed. The districts do not have qualified information management personnel who are skilled in data analysis. Each of the five district offices has one information management officer at the Administrative Officer level. This means that data at the facility level is collected by nurses and managed by one official at the district level. Currently, the provincial office has two qualified information management officers, a Deputy Director and a Senior Administrative Officer. She highlighted that more effort is needed to establish the level of acceptability of vertical as well as integrated reproductive services. Focus should be on the impact of vertical and integrated services on clinic caseloads, attendance, level of male contraceptive use and client satisfaction. Such information can provide insights into ways of improving reproductive health service delivery systems for men. Only through research can programme planners and policy makers be able to produce socially, culturally meaningful male-friendly programmes.

In this way it will be possible to reduce the high incidence of reproductive health problems facing both men and women and in particular the problem of sexually transmitted diseases including HIV and AIDS which has reached endemic proportions.

Interview 3

Northern Cape Provincial Manager for Information Management.

The interviewee mentioned that the province is experiencing lack of information management skills in the province. Currently, the structure has a Deputy Director and Senior Information Officer. There is only one information officer per district. The nurses collect information and forward it the information officer at the district level for analysis and then it is send to the provincial office through a district health information system.

He further mentioned that most of the departmental indicators are developed by the directorate. It is the responsibility of the provincial coordinator for reproductive health services to provide the indicators that should be monitored by information management office. Currently, the directorate is not collecting information on men's reproductive health. He indicated that there are forty young officials on information management internship programme. As soon as they complete, they will be placed in all the districts and will reduce the backlog that is been experienced in the districts. Hopefully, more appropriate information will be collected.

Interview 4

Northern Cape Provincial District Coordinator.

The Interviewee indicated that reproductive health is one of the priority programmes within primary health care services. Unfortunately, focus has been on women, young people and children and has completely ignored men's reproductive health. She further indicated that services are available for all in the health facilities. Unfortunately, men do not attend to their reproductive health until it is too late. Men do come to the health facilities to consult for other illnesses other than reproductive health illnesses. Men consult traditional healers for problems such as erectile dysfunctions. There are health promotion and awareness days to inform people about different kinds of illnesses in all the districts and on a regular basis. Women always come to these sessions and not men. There are cases of reproductive health

cancers that have been picked up in the districts and have been referred to the tertiary hospital for further treatment. Information in terms of what illnesses were presented at the clinic is documented but it is never analysed. The information is only available when you request it.

Regarding IEC materials, the coordinator indicated that there are no pamphlets on erectile dysfunctions, reproductive health cancers for men. There is plenty of information on HIV and AIDS and sexually transmitted diseases. There is a lot of information encouraging communities to take care of their health and it is men's responsibility to go the facilities to get checked, ask questions and get treated.

When asked why the district health plans do not have men's reproductive health activities, she indicated that the plan is generic but she agreed that focus has been mostly on women particularly maternal health and HIV and AIDS for all the groups. She said that if the plan does not have some of the information, this does not mean that the services are not offered. The stressed the fact that all the services are available and accessible for all in all the facilities. She indicated that the province will have to focus more on reproductive health for men.

4.5 FINDINGS OF THE FOCUS GROUP DISCUSSION WITH MEN IN THE NORTHERN CAPE

The focus group discussions covered a wide range of issues pertaining to knowledge on male sexuality and reproductive health, preferred and actual sources of knowledge and advice about reproductive health issues, men's sexual health behaviour and men's utilisation of public health services. The participants were encouraged to discuss the services available to them, their likes and dislikes of the services and to describe the services they need.

Knowledge of male sexual and reproductive health

When asked if they know of any sexual and reproductive health diseases that affect mostly men, most of the participants said that they know of gonorrhoea. None of the participants could think further than sexually transmitted infections. However, when probed for more specific problems, most of the men admitted to having heard of other problems such as erectile dysfunction/impotence, infertility, herpes etc. Participants indicated that they have never experienced any sex related problem.

Participants indicated that they overhear conversations about men's reproductive health matters but choose not to directly participate in such conversations. One participant said that learning basic information about men's reproductive health through interaction with other men was relatively rare unless at the bar or shebeen.

This one participant said "men talk about sexual issues when they are drunk". The discussion is about women and sexual intercourse. Participants indicated that alcohol stimulates talking. Wait for men to get drunk and you will get useful information.

When asked about who do they choose to talk to when they have sexual health problems. Participants responded that men are most likely to manifest their concerns or curiosity with

those whom they trust most but they will still get slightly drunk to talk about a sexual issue. One participant said "*You must go to the bar. You will find the barman selling muthi in a gin bottle. It works more like Viagra. When a man has an erectile dysfunction, he takes it five minutes before having sex and it works wonders. It gives energy and a man can have any woman he wants. It also cures STDs like no other medicine. If men have problems, they use a bar as a venue for advices."*

One participant said that he believes that a bar is where all men get wrong advices. All the participants were confident to say that they do not use muti to give them energy. They indicated that they are still going strong and that they are taking care of themselves. All the information that they are providing is from what they overhear from their colleagues.

Culture

Culture was discussed as an issue that hinders communication amongst men. Men are brought up to see themselves as strong, both physically and emotionally. Participants indicated that men think of themselves as independent, not needing to be nurtured by others. Men are unlikely to ask others for help. Men would face danger fearlessly, take risks frequently and have little concern for their own safety including their health and well-being in general. Men talk about anything but feel uneasy and find the discussion about sexual problems quite embarrassing.

The influence of culture and religion on sexual behaviour is complex at both individual and societal levels. Participants discussed at length how men publicly endorse the strict moral norms of their culture while at the same time, privately behaving quite differently. Sex is said to be the area of human experience most lied about. Sex is something to do and not to talk about. The view is that sex is for male pleasure.

Most participants still value culture, tradition, beliefs and values. They indicated that culture changes over time. Sensitive approaches are required that promote discussion and

involvement, not top-down instructions from outside the culture and that are based on socio-cultural research in the field to determine what really are the risk factors, what sustains practices, traditions and behaviours and what is required to transform them. This does not mean abolishing a particular practice or custom. Instead of change being threatened to them, men can share in the benefit of change and help promote it.

Age

Age differences constitute another effective barrier to men's communication because of the traditional age-based social hierarchy and partly due to generational differences in education and aspirations. Older men rarely interact on reproductive health issues.

Actual and preferred sources of knowledge about reproductive health

Most men reported that they learned about reproductive health issues from their social networks, friends and colleagues and from the mass media such as magazines. The participants indicated that IEC materials encourage men to take care of other people close to them than taking care of themselves. The media messages therefore do not necessarily cultivate an interest in sexual and reproductive health issues. They indicated that they would like to get information from the health sector.

Men's sexual health behaviour

The global HIV AIDS epidemic is driven by men. Men have more opportunity to contract and transmit HIV. Men usually determine the circumstances of intercourse and men often refuse to protect themselves and their partners. Men endanger themselves and their female partners and it appears from the discussion that they regularly act without thought for their partners. The participants indicated that they do talk a lot about HIV/AIDS in very general terms focusing more on the selection of uninfected sexual partner than on practicing safer sex.

In the context of gender inequality, male attitudes and behaviours are currently the crux of the HIV/AIDS problem. As the dominant partner in most sexual interactions and the main initiators of sexual activity, many men put personal pleasure first and responsibility, respect and restrained a poor second.

Stereotypes of masculinity and what it means to be a “real man” encourage male dominance over women, risk taking and promiscuous sex (a “real man is not satisfied by one woman).

In many South African cultures, ideals of manhood include strength, courage and dominance and critically accept men as having an uncontrollable sex drive that lets them off the hook of responsibility.

Participants insist that alcohol is a major contributing factor reducing their sense of responsibility further. Little blame or stigma is attributed when a man says he had sex when he was drunk and in many male circles he will be applauded for his manliness. Knowledge about HIV/AIDS may not be a sufficient deterrent to casual sex even if they think they should remain monogamous.

Recognising the role that men play in the spread of HIV is not the same as simply blaming men. Participants indicated that men are as trapped in social expectations of gender roles and behaviour as females are, even if those stereotypes often benefit males far more than they do females.

Participants argued that although men are not empowered about sexual and reproductive health matters, not all men are irresponsible and fit the stereotypes depicted about men but rise above it. They remain faithful to their partners, they are deeply concerned about avoiding infection and they respond to their partner’s sexual needs as well as their own.

Participants pointed out the importance of turning around sexual and gender stereotypes that promote high-risk behaviours. Participants raised the concern that there are no initiatives to

help challenge existing stereotypes and ideas around masculinity and male-female relationship. They advised that they would like to see initiatives providing South African role models of men who do take a different approach to gender and who have not lost their stature as males as a result.

As one participant put it *"Men are often afraid that letting go of their dominant position and rights will mean losing their self-esteem and the respect of their colleagues, friends and relatives."*

"Change is needed not just for men but through out society and among women as well."

Utilization of clinics

Since health is an important resource, men provided useful information and this helped the researcher to identify the perceptions men have of services as well as constraints affecting utilization. There appeared considerable dissatisfaction with the services and several of the problems have their roots in the attitudes of health workers. Men feel that an in-depth discussion between men and health workers need to occur. The purpose of these would provide the health sector with feedback on how the services can be made more user-friendly and culturally acceptable.

One man said "I'd rather go to the private doctor because there are always problems with public clinics. There is no enough staff to attend to all the patients. Few nurses attend to an excessive load of patients. There are too many patients and too little time for the nurses. This result in problems of overcrowded stuffy and noisy waiting rooms and passages as well as long processing times."

The consultation with a nurse is usually the most time consuming activity. The nurse sees patients as rapidly as possible and there appears to be little time for individuals to raise their problems and the questions with her.

One participant said, “There is no way that men will have the opportunity to learn any sexually related information from the nurse. If a man consults about a sexual problem at the clinic it means that he is desperate and does not have money to consult a private doctor. The clinic is no place to discuss your sexual life. That is why you don’t see many men in clinics. Clinics have been designed to provide services to women.”

The nurses are perceived to lack good communication skills. The men indicated that the nurses approach patients harshly. “They do not care that you are a man or not. If you have an STD, you will see from their facial expression that does not communicate well with you. You feel like you have made the biggest mistake in the world. It is very rare that they care about your feelings or at least listen to you. You are made to feel irresponsible.”

Confidentiality and trust are the two main issues that are lacking in a clinic. Most nurses are from the local area and they know everybody in the community. Your secrets will be known everywhere. Women are good gossipers and we cannot exclude nurses.

Clinics are designed for women. The atmosphere is so unfriendly for men unless you have flu. There is no information giving about men’s health in the clinics. One participant said that he has heard about erectile dysfunctions, prostate cancers and other problems but he does not have information about what causes these diseases. He indicated that he understands women’s issues more than men’s issues.

4.6 COMPARATIVE ANALYSIS OF THE THREE DATA SETS

This section contains a comparison of the three sets of results that were obtained from the documentary analysis, the key informant interview results and focus group discussions.

The success of policies and programmes relies heavily on the implementation by the health facilities at the district level. This task has been made difficult by both National and Provincial level managers who do not have the drive to plan and monitor reproductive health programmes progress at the district level. There are no plans for the provision of reproductive health for men from a provincial office to the district level. The district managers develop a district health plan on an annual basis which has a specific format developed by District Health Services directorate at the national level. The district managers do not bother to include services for men in the plan since it is not a priority. Most of the programmes at the district level have a coordinator to supervise and monitor the implementation of programmes except reproductive health. The programme is managed by one official from the provincial office. HIV and AIDS is receiving more focus than other programmes. The focus is only on condom distribution, testing and treatment.

Men's programmes will be most effective and well received if they are implemented in response to rational, strategic decisions based on the needs of a programme. This type of strategic analysis can best be carried out when policy makers and programme managers are cognisant of the possible benefits and limitations of the approach and the current situation in the province regarding men and reproductive health. Monitoring and evaluation systems are lacking.

Instead of trying to gain the cooperation of men, however, programme managers have largely ignored men's roles in reproductive health or portrayed men as adversaries and irresponsible. By tacitly accepting or emphasising these stereotypes, reproductive health programmes both at provincial and district levels have unwittingly been doing a disservice to large segments of the male audience. Advocacy and IEC for men has not been given any priority in all the programmes that deal with men's issues.

Implicit in this approach is the belief that the main reason why men do not alter their sexual behaviour is that they are uncaring. The findings of the focus group discussions indicate that

the macho stereotype of men is the very barrier that prevents them from learning more or accessing reproductive health services. They complained that false stereotypes of machismo limited their opportunity to obtain information about sexuality and contraception.

4.7 CONCLUSION

The study thus reveals that serious effort to involve men in reproductive health has yet to be made in the Northern Cape. While the National Department of Health has taken some initiative and could provide some leads as to possible interventions, ultimately it is focused policy and programmes on the part of the Northern Cape Department of Health which will make a difference. At present, the Department has not crystallised any definitive policy or programme which could help in the involvement of men. Currently men's reproductive health remains a remote goal.

The overall assessment of men's needs in terms of attitudes, reproductive and sexual practices and communication behaviour has provided some indication of where future programme priorities would be. More efforts are needed in changing the prevailing men's attitudes, risk-taking behaviour and opportunities for safer sex negotiation especially where disinterest in sexual and reproductive health seems more myth than reality. As men are generally excluded from reproductive health services, this is another niche to be filled to improve men's understanding of sexuality, their role and how to act in their procreation decisions.

CHAPTER 5

INTERPRETATION OF FINDINGS

5.1 INTRODUCTION

This chapter will analyse and interpret the results obtained in the preceding chapter. Chapter four gave the results of the three sections and used thematic analysis to organise different areas. This chapter will analyse all the results in a combined manner. The intention of this study is to describe programme and organisational impediments constraining the acquisition of preventive and curative exercises in state health facilities. This analysis will inform the policy makers and programme managers at national, provincial and district level of the gaps identified in the design and implementation of reproductive health programmes.

5.2 ANALYSIS AND INTERPRETATION

Globally, health programmes focused on women because they assumed that women are responsible for reproduction; women make decisions on their own or in perfect agreement with their male partners and dealing with women only is therefore adequate. It is much simpler to focus on women only in programmes.

The Northern Cape Department of Health has followed a similar pattern and has misinterpreted the ICPD call. Programmes now involving men tend to reflect and reinforce several specific assumptions about them, which include the following; men are uninformed and irresponsible and act as barriers to women's control of their own fertility; women's sexuality is more important than men's; men can't and won't change and it is not in their interest to do so.

This study has shown that there are certain bottlenecks to male participation in reproductive health programmes. The range of services available to men in health facilities at present are limited and this inhibits men's capacity to participate in reproductive health. Studies in Kenya and Zimbabwe show that lack of information and services on male methods such as vasectomy is a major hindrance to their use of family planning services.

There are pragmatic obstacles to men's participation as both clients and supportive partners in reproductive health programmes. These obstacles include long-cherished traditional practices. This study has shown that men hold certain traditional beliefs or misconceptions regarding men's sexual matters. Men who contract STIs often have to contend with concoctions or other traditional forms of treatment whose efficacy is highly doubtful. These limitations inhibit men from taking appropriate reproductive health decisions even when the risks are apparent. The absence of inter-spousal communication and discussions inhibit men from using reproductive health services. Men value quietness and see silence and sexual passivity as good attributes for women. The need to devise more appropriate and acceptable communication strategies can therefore not be over-emphasized.

Lack of health promotion and advocacy strategies coupled with access to print and electronic media means that few men have access to quality reproductive health information. Health facilities exist and are accessible in the Northern Cape but problems such as lack of privacy, comfort, convenience, confidentiality and poor provider behaviour adversely affect men's capacity to use reproductive health services.

Effective gender-sensitive programmes should seize the opportunity to empower men to improve their health and their partner's health and consider the needs of the individual and the couple, while protecting men's reproductive health and rights. Men's reproductive health concerns are not met although there is no consensus on the extent to which population programmes and primary health care setting should satisfy the unmet sexual and reproductive health needs of men. These include family planning, prevention and treatment of STIs, sexuality and sexual dysfunction, psychosexual problems, infertility, prostate and

testicular cancers and urologic conditions. Other reproductive health concerns that men often express range from size of penis, impotence, early ejaculation, masturbation, AIDS and other STDs.

The findings of this study show that men have been left out of the reproductive services but have tried to be involved without the benefit of the education and information that women are privy to. Men's interest in and lack of knowledge about sex and reproduction, their sexual dysfunctions especially impotence and infertility, has been ignored in primary health care settings. Men know little about their own or women's sexuality and they communicate very little about sexuality in their relationships and often believe myths.

Men require sexual and reproductive health services that are flexible and respond to their sexual behaviours and changing needs throughout their lives. However, the services provided and their delivery may vary significantly due to local needs, cultural values and available resources. Referrals for services that are beyond the scope of a basic reproductive health clinic may be a more efficient way of operating.

Acknowledging that men need sexual and reproductive services for themselves has been a factor in building partnerships with men in sexual and reproductive health. The findings of this study indicate that men's positive attitudes about reproductive health issues, access to education and information about women's and men's reproductive systems and access to specific services may increase their participation in reproductive health.

It is critical that the health providers working with men are learning about the complexity and far-reaching implications of involving men in sexual and reproductive health. Men have their own issues, sometimes independent of those of their partners. Men's health programmes face the challenge of responding to men's wide-ranging and fluid reproductive and sexual health needs. A sexuality-based approach to men's services would require considering not only changes throughout a man's life cycle, but also how needs differ according to sexual relations patterns.

Reproductive health programmes and family planning providers play a key role in helping individuals realise their reproductive intentions. Service providers may assume that vasectomy is unacceptable to their male clients or a certain family size should be achieved before recommending sterilisation. They are also more likely to recommend procedures that they perform.

Service providers make decisions for patients without involving them, under the assumption that they know best. Successful partnerships are non-hierarchical and the partners share decision-making and responsibility. Service providers should respect patients as equals, capable of and responsible for making life decisions. They should provide patients with the medical information they need to make informed decisions.

A national and provincial strategy on men's reproductive health was never drawn except the national and provincial strategic plan on HIV and AIDS and STIs. HIV and AIDS has been given more attention and treated separately from reproductive health matters. The plan has set aside the gender issue and has not tackled men's sexual issues in detail. The concept of gender equality and equity has been highlighted in the annual performance plans of the Northern Cape but has not been integrated into reproductive health programmes. As a result, monitoring access to health care faced by men has not been done.

The population policy of South Africa has challenged the Department of Health to incorporate gender and reproductive health into their core activities. However, effective structures and systems needed to coordinate reproductive health activities of the Northern Cape do not exist. Furthermore, responsibilities and accountabilities from provincial level to the level of districts and facilities are unlinked. Both the national and the provincial level have failed to give direction to the districts and facility level. This primarily includes planning, monitoring, evaluating and ensuring well-defined operational plans with detailed specific objectives, activities, timelines and responsibilities at district and facility level.

The Northern Cape has not achieved the objective of reducing HIV and syphilis incidence and one factor that has contributed to this has been a lack of human and financial resources which has become chronic. The implementation of reproductive health by poorly trained staff in men's health complicates the problem and compromises health standards.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The research has analysed a wide range of literature, policy documents, conducted focus group discussions with men and interviewed key informants in the Department of Health in an effort to summarize what is happening about men's sexual and reproductive health.

A great deal has been done about the conditions of men's lives and about the focus on gender equity that frames the discussion of men's reproductive health at the policy level. An important impetus was the realization that existing reproductive health programmes were missing opportunities to engage men. Guided by these insights, innovative programme models should emerge to involve men on a broad range of issues such as HIV and STI prevention, male reproductive health needs, fatherhood etc. The obstacles to involving men in reproductive health centre around a limited vision of both reproductive health and the steps needed to achieve gender equity. People's sexual and reproductive lives are not just about the health sector, nor are the reproductive health and gender equity only women's issues.

6.2 Programming for Men's Reproductive Health

Practical and obstacles impede efforts to field effective gender-sensitive programmes in the Northern Cape. Uncertainty about how best to involve men lingers, budgetary constraints loom large and cultural obstacles to a more transformative agenda persist and logistical challenges pose the main obstacles to involving men. There has been very little effort to identify and implement practical ways of helping men understand that safer sex is in their own best interest and that of their families.

Addressing gender inequities requires more than working with women and involving women.

Every programme should begin its work by identifying the gender issues to be addressed in improving people's sexual and reproductive health. Addressing gender inequities requires focusing on how services are provided rather than specifying which reproductive health services should be provided and to whom. True gender-equitable male involvement programmes will address gender dynamics and the negative consequences of the unequal balance of power between men and women.

Most men want to care for their own health and that of their sexual partners

When they are encouraged and provided with opportunities, many men will seek out reproductive health care. A distinct male reluctance to seek out medical care has been explained variously by low quality of care and poor service promotion and by the need to protect their reputations as strong and uncomplaining. Having realised the importance of constructive male involvement in reproductive health, health facilities should provide facilities focusing on men. This will make men feel more comfortable and encourage them to seek help. With a little support, many men are eager to challenge customs and practices that endanger women's health and are willing to participate in supportive reproductive health decision-making.

Men should be encouraged to share their experiences of masculinity with each other.

Given that men are socialised in groups, it is important and valuable to offer men alternative group experiences that challenge their traditional notions of manhood. According to WHO, experiences such as these allow men opportunities to build connections with other men and to explore more positive dimensions of their masculine identities (1998:5). Safe and comfortable settings also allow men to express their dissatisfaction with dysfunctional

prevailing norms. Improving men's understanding of their own motivations, fears and desires, their ability to broach topics relating to sexuality and their respect for their partners wishes is central to improving reproductive health.

Design a holistic reproductive health program

As add-ons to existing reproductive health and development programmes, male involvement programme are generally vertical in their design and implementation. Instead, constructive male involvement should be viewed as a paradigm that needs to be integrated into the planning and development stage of any reproductive health project.

Expand programme content beyond traditional issues

Most current reproductive health programmes cover a limited number of traditional reproductive health issues, such as family planning, maternal health and HIV prevention and more recently HIV testing and treatment. Creative attempts must be made to involve men in other critical areas such as the gender-based violence, reproductive cancers etc.

Consistent monitoring and evaluation

Male involvement efforts of all types must be monitored and evaluated more consistently. Failure to do this results in lack of clarity about objectives or an imprecise definition of constructive male involvement. In other situations, it is due to the difficulties of measuring the effects of normative change takes so long. Furthermore, very few programmes have been successful in devising appropriate tools and these could serve as models for others.

Strategic multi-sectoral, multi-stakeholder partnerships are key to effective programming

Sectors beyond health such as education, law and employment are increasingly addressing gender inequities, creating opportunities for linkages between these sectors and the reproductive health field. These multi-sectoral, multi-stakeholder partnerships are critical to ensuring that male involvement is addressed and integrated on a large scale into health care delivery and other development activities. When programmes build on an existing social capital and relationships with communities they gain access to men where they congregate and interact with one another. Challenging the status quo requires the forging of strategic alliances at the community level.

Training

Appropriate staff training in gender analysis and working with men greatly increases the effectiveness of outreach efforts and programme activities. A study examining the possibility of offering services to men in Bolivia, Colombia and Paraguay found that in all the three countries, providers acknowledged the importance of these services, but felt unable to provide them because of their scant technical capacity and knowledge about the emotional and cultural aspects of male sexual behaviour (Bliesner et al, 2001: 3).

The confidence and effectiveness of staff can be greatly increased through appropriate experiences and training. Providers comfort with their own sexuality and understanding of gender directly condition how they interact with male clients. To ensure that key decision makers and managers support constructive male involvement and understand the linkages between gender equity and reproductive health, programmes need to include focused time with senior management and key staff within partner institutions. Eventually, concern with gender equity should permeate all aspects of organizational culture, influencing recruitment of appropriate staff and contributing to the establishment of a gender balance within an organisation, especially in positions of decision-making.

Assess needs

It is more important to study situations and test designed. Some programmes have demonstrated that a clinic can be successful in reaching males (WHO, 1998:5). Resources to establish a separate facility to serve men may not be available. It is necessary to change the clinic environment so that men feel at home. Other programmatic barriers such as provider's lack of knowledge and biases regarding men's reproductive health should be identified and removed by conducting a knowledge, attitudes and practice (KAP) survey with service providers to understand their thoughts about and attitudes towards men's and adolescent boys in reproductive health. Service providers require special training, particularly in counselling, to successfully serve a male clientele.

Close the Knowledge-practice gap

There is a gap between knowledge and practice, between what people know and what they actually do. Different approaches have been used to increase men's share in their reproductive responsibility such as campaigns, IEC activities, print media, workplace programmes and sporting events. Condom social marketing has been used but it has not lead to increased use mostly for STI/AIDS prevention. This strategy has generated high levels of awareness of condoms; however, acceptance rates have remained relatively low. Therefore, addressing this gap should be the next step in future programmes.

Develop appropriate service delivery strategies

It is important to design programmes that give men accurate information about reproductive health as well as enable men to communicate with their partners about these issues which encourage shared decision making. Current knowledge affirms that men do seem to value privacy, convenience, information, caring providers and attention to reproductive health needs beyond contraception. It is advisable for male services to integrate male reproductive

health care services, including contraception, impotence, STIs, infertility and other conditions. This broader definition of male health would make it easier for men to walk into a clinic.

Include evaluation in programme design

Better programme design includes evaluation. It is important to measure the targets outputs of the programme, monitor the quality of services provided, measure the impact achieved by a programme compared to its goals and the use of lessons for adjusting or changing future programmes.

Target messages to men

Special messages should be targeted to men, to foster responsible and caring attitudes and to encourage men to discuss reproductive health issues with their partners. Reproductive health messages that portray responsible men as those who discuss contraception with their partners should be designed for male audience. Campaigns should emphasise the need for the husband and wife to share decisions.

Develop education and services for young people

Introducing reproductive health knowledge into secondary schools and university prepares young people for future responsible parenthood. Programmes should view sexuality education as a life-long process, beginning with programmes to help parents teach their children, male and female alike throughout their developmental years. Such programmes will ensure ongoing dialogue and the most meaningful behavioural change.

Advocate for men's reproductive health services

Programme managers, service providers, teachers and male opinion leaders need strong advocacy training to enable them to advocate for and propagate reproductive health issues in

their own communities. Advocacy strategies should target multidisciplinary groups to raise their awareness about the importance of male involvement in reproductive health.

Changing men's behaviour

Men need to change their sexual behaviour. However, it will not be easy for individual men to change. Men are more likely to protect themselves and their partners when they are encouraged to do so by their peers. This means that society as a whole must change. Political and community leaders should recognise the role of men in the epidemic, change their own behaviour and encourage policies that support change. Religious leaders must recognise and respond to all different factors influencing men's behaviour and the media can raise awareness of the role of men and the need for men to change.

Many other approaches can be used, depending on the target group and their environment. Traditional healers are an important influence on men's lives and have been involved in HIV and AIDS education for many years. Many organisations both governmental and non-governmental organisations have considerable experience in working with men and can help to plan and implement such programmes.

Sex and reproductive health education

Traditionally, men have not talked openly about sexual matters. The result is that many men do not understand their own bodies, the bodies of their partners or the implications of the sexual acts that bring them together. Many myths pervade, such as it is impossible for a girl to fall pregnant the first time she has sex or the fear that a condom can get lost inside a woman's body. By refusing to talk about sex openly and by allowing ignorance and myths to dictate men's behaviour, HIV has entered and almost destroyed our society.

Communication

Information by itself does not change behaviour. Men give an impression that they know everything and do not need to learn, but in fact they are afraid to be seen as ignorant and weak. Providing a safe environment for men to talk seriously about sexual issues is the first step in encouraging them to understand and eventually change their own behaviour.

Issues can be discussed in innovative and non-threatening ways. Clinics can hold men only sessions. Choosing a name that is fun, although the questions and answers will be serious and honest. Sessions should provide a forum for open and free talk, where men can learn from each other. Visiting bars in the early evening, when men are relaxed but not drunk, provides opportunities for them to talk and learn about sex and HIV. Such programmes have been very successful in Zimbabwe.

6.3 Challenges and recommendations

The research recommends that:

- The Northern Cape must make an effort to remove barriers that hamper men's access to reproductive health services, including contraception;
- Men's responsibility in caring for their own health should be stressed;
- Integrate full men's reproductive health;
- Continue to promote responsible, healthy reproductive lifestyles and behaviour;
- Whilst it is recommended that men's reproductive health services be developed and expanded to ensure that they are accessible to men, these developments should be accompanied by educational drives to inform communities and especially men of the area of the facility and services offered. These campaigns should be geared towards reducing stigma and anxiety in visiting these facilities;
- Men must continue to be given high priority in developing HIV prevention interventions, as this will have a significant impact on the future course of the epidemic

in the country;

- Strengthening commitment to and enhancing national capacities and mechanisms for the collection, analysis, interpretation and dissemination of reproductive health data, and the use of such data and information to inform policy making and development planning;
- Intensifying programmes, coordination and multi-sectoral approach to enhance development planning and integrating responses to HIV and AIDS and men's reproductive health into all its sectoral and multi-sectoral development programming;
- Enhancing capacity to establish mechanisms to monitor and evaluate progress of interventions on reproductive health service delivery;
- Strengthening cooperation and partnership in advocacy and IEC programmes related to reproductive health particularly HIV and AIDS at all levels.

6.4 Concluding comments

The critical perspective that has led to calls for greater male involvement in sexual and reproductive health has often described men in rather negative terms. Policies designed to encourage male involvement and responsibility would probably be more successful if they were conceived of as rights. Clarifying the negative effects of gender norms on men's health and well being and not just women's could facilitate the development and implementation of more visionary policies and more innovative implementation.

It is time that we recognise that gender roles interfere with men's health as well as women's and that dominant masculinity poses risks to men's health.

The main objective of this research has been to communicate that all policies and programmes, information and services need to reflect the social realities of men and how this affects their health. It is a simple message, but it is one of the major contributions of the Cairo Programme of Action. This thinking shifts the focus of our analysis of health away from simply biomedical, clinical or technical responses to the social relationships that shape health

outcomes. Increasingly, the common denominator of successful programs is that they pay attention to the relational components of sexual and reproductive health.

Currently, men's behaviour is contributing to the spread and impact of HIV/AIDS rather than to its prevention. Men can choose to change. As the call to action reaches more and more men of all ages and lifestyles and cultural backgrounds, increasing numbers will do everything in their power to protect themselves, their partners and their families.

Society and health services do not make it easy for men to expand their roles to include more responsibility for their sexual and reproductive lives, subjecting them to ridicule. Men in their many roles, personal and professional can help construct positive role model and encourage one another to respect their families and themselves. Men can take responsibility of their own bodies and help other men to understand the forces that push them to take risks and the benefits that can be gained by accepting responsibility.

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APPENDIX A

DATA COLLECTION TOOL: FOCUS GROUP DISCUSSION QUESTIONS

Do you ever visit a clinic?

How often do you go to the health service?

What illnesses make you visit the clinic?

Do you know what men's sexual and reproductive health diseases are? Please name them?

What men's reproductive health services should be available at the clinic?

Have you ever heard of someone who has had a reproductive health problem for which they couldn't help for? Can you tell the group more about that situation?

Coming to your experiences, have you ever had a reproductive health problem that you found you could not get help for?

Can you think back to the last time you used the health service and can you tell the group what you liked and what you did not like about the service you received?

If you could receive whatever you wanted at the clinic what would you like to have on offer especially about men's reproductive health?

Are there any difficulties in this area which prevent men from going to the health service? If so explain what these are?

At the health service, if you have a question, can you ask the health worker at the clinic?

APPENDIX B

DATA COLLECTION TOOL: KEY INFORMANT INTERVIEW

Identification of the interviewee

Job title : _____

Date : _____

Can you begin by explaining to me what your responsibilities are?

Nowadays, people are talking about reproductive health as a new comprehensive concept. What do you think are the most important interventions to achieve good health for men?

In an ideal situation, what services would you chose to be included in a health service that provides comprehensive men's reproductive health care?

What services are currently provided by your health service for men's health?

What services are missing that you would like to see offered?

Explain how existing services are organized (by this I mean if they are available everyday or not or if they are provided by separate providers)?

Many people are talking about changes in men's health services. In your opinion, are changes needed and if so, what are they?

How again is the ideal situation? Do you think these should be organised from the point of view of the health care provider?

You have said what your ideal service would be. What do you think could actually be implemented in the next year? In other words, what do you think is feasible?

People talk about rights a lot nowadays. They also talk of patients rights. What do you think the patient has a right to?

What do you think should be done to make it possible for clients to exercise their rights within the health services in your area?