

Factors influencing men's involvement in reproductive health in Arusha and Arumeru districts, Tanzania

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Keywords:

Men involvement, men's health, women health, reproductive health, MAP, men-engaged, gender inequality, Tanzania, Arumeru, Arusha, gender and reproductive health.

Abstract

Background: In Tanzania as elsewhere, it has been documented that men have a significant impact, directly and indirectly, on women's ability to access Reproductive Health (RH) services. Thus far, however, men have been left out of the mainstream of RH services, a factor responsible for many setbacks including high HIV/AIDS prevalence, high STD rates, high fertility and high maternal mortality rates. Evidently, only a few men (when compared to their female counterparts) in Tanzania seek care from our RH clinics. We need to identify the existing perceptions and needs amongst men which shape their reluctance to participate in RH. This study therefore seeks to identify and describe factors that influence the male involvement in Reproductive Health in Tanzania, as well as the challenges, perceptions and needs which shape their reluctance to participate in RH. These together with identification of the existing opportunities for men involvement in RH will help to address many RH challenges including STDs and HIV/AIDS in Tanzania.

Methods: The study was conducted in Mount Meru Hospital in Arusha and Nkoaranga Hospital in Arumeru district. It is a descriptive study and qualitative methods were used to collect data. FGDs were conducted with men and women of reproductive age. In-depth interviews were conducted with key informants that were purposefully selected among the service providers in the field of RH such as NGO and government workers. The thematic method of data analysis was used in this study.

Findings: The study findings were thematically grouped into three themes including the coordination and partnerships, culture and implementation challenges. Poor coordination and failure of systems in place appeared to characterise the many challenges. Gender inequalities and masculine dominated cultural practices like polygamy and widow inheritance are associated with consequences of ill health among women; including high HIV/AIDS prevalence, early marriage, high teenage pregnancies and high maternal mortality. Although these practices are in favor of men, they hardly protect them from the wrath of poor RH like STDS, HIV/AIDS, stressful big families and vast poverty. Hence, Tanzanian men are also victims of their own behavior.

Conclusion: Setbacks like culture, poor infrastructure, inadequate financing and resource allocation to the RH by the government and other stakeholders are responsible for the failure. More advocacies are required for the men, community and Government to improve their support in RH including financial support, infrastructures, establishment of the policy in favour of RH.

DECLARATION:

I hereby declare that this thesis is my own work and effort and that it has not been submitted anywhere for any award. Where other sources of information have been used, they have been acknowledged

Signature: Z. P. Mmbando



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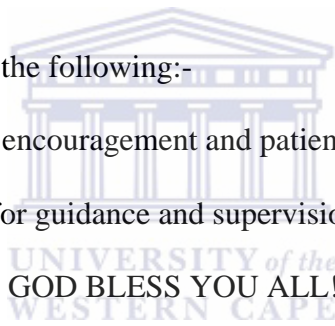
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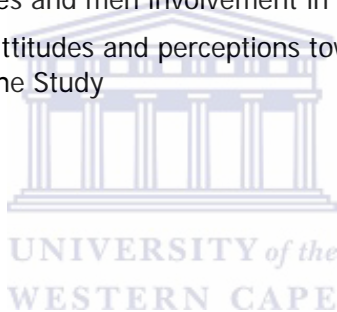
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DEFINITIONS OF KEY TERMS

1. **Adolescent:** is a term used for an individual at a life stage of age from 10 up to 19.
2. **Adolescent Health:** refers to the physical, social and psychological wellbeing of the young people including the interaction related to their reproductive system, gender identity, values or beliefs, emotions, relationships and sexual behavior of young people as social beings.
3. **Family planning:** refers to a program which enables couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and to have informed choice and access to a full range of safe and effective modern methods of preventing pregnancy.
4. **Gender equality:** is defined as the absence of discrimination on the basis of a person's sex, in opportunities, resource allocation, benefits or in access to services.
5. **Gender equity:** refers to fairness and justice in the distribution of benefits and responsibilities between women and men, and often requires women-specific projects and programs to end existing inequalities.
6. **Healthcare Service Provider:** refers to individuals, professionals or institutions which is duly licensed and accredited and devoted primarily to the maintenance, operation and provision of health promotion, prevention, diagnosis, treatment, and care of individuals suffering from illness, disease, injury, disability or deformity, or in need of any medical and nursing care;
7. **Male involvement in RH:** includes all the effort, commitment and joint responsibility of men with women in all areas of sexual and reproductive health, as well as the care of reproductive health concerns specific to men.
8. **Modern Family Planning methods:** refers to safe, effective and legal methods to prevent pregnancy such as the pill, intra-uterine device (IUD), injectables, condom, ligation, vasectomy, and modern natural family planning methods include mucus/billing/ovulation, lactational amenorrhea, basal body temperature and standard days method.
9. **Reproductive Health Care:** refers to the access to a full range of methods, techniques, facilities and **services that contribute** to reproductive health and well being by preventing and solving reproductive health-related problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations.
10. **Sexually transmitted Disease:** includes diseases caused by sexually transmitted infections, and other types of infections affecting the reproductive system.
11. **Reproductive rights:-** the rights of individuals and couples, subject to applicable laws, to decide freely and responsibly the number, spacing and timing of their children; to make other decisions concerning reproduction free of discrimination, coercion and violence; to have the information and means to do so; and to attain the highest standard of sexual and reproductive health.
12. **Skilled Attendant:** refers to accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal or uncomplicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Traditional Birth Attendants or traditional midwives--trained or not--are excluded from this category.
13. **Skilled Birth Attendance:** refers to childbirth managed by a skilled attendant plus the enabling conditions of necessary equipment and support of a functioning health system, including transport and referral facilities for emergency obstetric care.

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LIST OF ABBREVIATIONS

AIDS- Acquired immune deficiency syndrome
BTL – Bilateral Tubal ligation
CBO – community Based Organization
FGD – Focus Group Discussion
FGM – Female Genital mutilation
FP - family planning
HIV - human immunodeficiency virus
ICPD - International Conference on Population and Development
MAP – Men as Partners (in reproductive health)
MCH – Maternal and Child Health
MOHSW – Ministry of Health and Social Works
NACP – National Aids Control Program
NBS – National Bureau of Statistics
NGO – Non Governmental Organization
PLWA – People Living with HIV/AIDS
RH – Reproductive Health
SRH - sexual and reproductive health
STD – Sexually transmitted Disease
STI – Sexually transmitted infection
TBS – Tanzania Bureau of Standards
UMATI – Chama cha Uzazi na Malezi Bora Tanzania
UNFPA - United Nations Population Fund
UNAIDS - Joint United Nations Program on HIV/AIDS
UNICEF – United Nations Children’s fund
USAID -United States Agency for International Development
WHO - World health Organization



Chapter 1

1. Introduction and Background.

Historically women have always been given exclusive focus in international Reproductive health (RH) programmes. On the other hand, the access to RH services among the men is less than their female counterparts despite the efforts to include them as partners and as beneficiaries. In the modern world, however, male involvement in reproductive health has become an important theme among RH programme designers, policy makers, and implementers. However, the meaning of the concept of "male involvement" remains a subject to broad interpretations from various stakeholders.

This study attempts to look critically into the meaning of male involvement, and how it has been interpreted in RH planning and service delivery efforts. In addition, special attention is paid to the RH needs for men, their sexual, marital, parenting, and family decision-making roles in relation to their health seeking behaviors for RH.

1.1 Definition of Reproductive Health

Reproductive health (RH) is a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity in all matters related to RH and its functions (WHO, 1994). The key features of RH include sexually transmitted diseases and HIV, fertility, pregnancy and child birth issues, etc.

On the other hand, the International Conference on Population and Development Program of Action stated that "reproductive health" implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

This implies that people have the right 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 which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. This further implies that women and men attain equal relationships in matters related to sexual relations and reproduction

1.2 Global context of RH

Globally, men are known to be very resourceful in RH matters as caring fathers, supportive spouses, peacekeepers and decision makers from a family to a national level (Stibbard, Robertson & Noormahomed, 2003). It can therefore be argued that; due to multiple psychosocial needs attached to RH, the contribution from male sexual partners remains a vital determinant of a good health system.

In keeping with the above discussion, the concept of male involvement in RH can also be challenging as it raises the many questions about the level and type of male involvement. The examples may range from a simple condoms distribution in the FP clinic to educating men about women's health, gender roles and rights.

In the developed countries, efforts to involve men began as early as the late 1970s, with attempts to make women-oriented family planning clinics more inviting to men. Not much progress has been made over all these years (Porche & Willis, 2004.), though men are in general more welcome than they are in developing countries reproductive health clinics. In developing countries, the tendency has been to exclude men from reproductive health work other than vasectomy or condom distribution. Across all cultures, women, who because of their involvement with children and their position in society, have proved to be more compliant patients and customers to FP clinics and RH at large. (Foreit *et al*, 1992). However, anthropologically, the process of decision making for the birth control, family size and when to seek for health care is not entirely a woman domain, as men and possibly the community has a stake in it

Worldwide, the coming of the HIV/AIDS pandemic has largely played an important role as it literary forced the world to focus their attention to the main stakeholders – the men. With its recent threat to human life and dignity, HIV/AIDS pandemic forced the demographers to address issues pertaining sexuality, fertility, partnerships and gender. Collectively, the meaning of these and their interrelated functions can easily be traced in the causes and prevalence of HIV.

1.3 Reproductive Health Services in Tanzania

In Tanzania particularly, men with big families and multiple sexual partners earn more respect in their communities because of their perceived strong virility (Haram, 2005). Although the national policies advocate for men involvement in many aspects of RH, not all policies recognize the negative aspects of masculine behavior that impairs the RH for both women and men themselves. As a result, RH services in

Tanzania are poor, with high total fertility rate of 5.24, average growth rate of 1.8%, very high maternal mortality ratio of 1500: making Tanzania among the top five African countries with the worst maternal mortality rates (the others being Sierra Leone 2000, Malawi 1,800, Angola 1,700, and Niger 1,600) (UNFPA, 2006). Despite the high HIV prevalence (7.1% among women compared to 5.8% among the men), the early marriages and teenage pregnancies is another threat in Tanzania as 120 in each 1000 girls aged 15-19 years have children (UNFPA, 2006). Women therefore become victims of masculine behavior and culture.

According to the health policy, various set of objectives including reducing the burden of disease, maternal and infant mortality and increasing life expectancy through the improvement of health services have been established by the Government (National Health Policy of Tanzania, 2003). This policy is reflected in our National Essential Health Package, (2000) with five major components including RH, communicable diseases, non-communicable diseases, common diseases and health promotion. Following this policy, the health sector is one of the priorities in resource allocation, and the Government has progressively improved its allocation from the 1995 figure of US\$ 3.46 per capita on health expenditure to US\$9 per capita expenditure on health 2003/04 and US\$12 in 2004/05. . For example according to the National Bureau of Statistics (NBS), (2005); Between 1999 and 2006, estimated total public expenditures on health rose from \$143.6 million to \$427.5 million, which is a demonstration of the government's commitment to health care (Patykewich, Tien, Mielke & Rosche. 2007). But this allocation which amounts to 10.5%, of the national budget is only a two third of the recommended 15 percent established by the African Union at Abuja in 2001 (Pile & Simbakalia, 2006.). Again the inequitable resource allocation provided the majority of this budget to HIV/AIDS and anti-malarial care, leaving RH and contraceptive supplies with only 10-15 percent (Leahy & Druce, 2009). Although the financial allocation reflects the government's commitment and support to RH issues, this is not enough as the challenges in the resource allocation could be one of the hindrances for access and quality RH services. It can therefore be argued that the government of Tanzania is committed in initiation of RH, but again the poor allocation of resources is possibly reflected by the poor access to the RH services, men inclusive.

Chapter 2

2.0. Literature Review

Male involvement in reproductive health is an approach that addresses men as partners (MAP) or key link between their own reproductive health and that of their female counterparts (Barker, 2005). Ideally, the shift from female focused RH to more gender sensitive one, will engage men in more constructive role of improving sexual and RH, and hence strengthening the fight against STD, HIV/AIDS and gender based violence (Peacock & Levack, 2004). However, since the International Conference on Population and Development (ICPD), the RH programme descriptions are somewhat puzzling especially when a reference is made to the RH services these programmes provide. The problem is that the RH services provided are not comprehensive and may look like they merely replaced FP despite the change of the name. Family planning programmes naturally emphasized family planning methods, while reproductive health programmes are meant to be considerably more comprehensive. By invoking the concept of health, the term RH refers to a much broader idea of well-being than the provision of FP services, (including the psychological, social and physical wellbeing in all RH aspects) and at the same time it is held to a considerably higher standard. Thus an important objective of this work is to look at ways in which RH programmes do something more than provide methods of contraception, and unlike the old FP program, the RH should include both women and men as the recipients of these services.

Although MAP embraces the views that men can improve or impede women's RH as subject to their engagement in RH (Cates, 1996), majority of men are either reluctant or unaware of this fact, and they have been more involved in practices which not only endanger women's RH, but also their own (Report on African men and RH, 1994). While exploring more reasons as to why men should be part of the RH services; we should also appreciate the fact that men in Tanzania are less knowledgeable both on the concept and benefits of fertility control (Coast, 2007). As a result, these men prevent women from contraceptive use while engaging in multiple sexual partnerships at the same time. . Although in different settings these generalizations may be more or less true; the point is that this complex and largely unsupported notions about men's roles in family and sexual life determined the direction and content of RH and its success. (Greene and Biddlecom, 1997)

Again, the 1994 Cairo (ICPD) meeting introduced the International shift to focus on male involvement in RH to promote gender equality, equity and RH (Bustamante-Forest & Giarratano, 2004). In its released

document, the ICPD stated that FP programmes should not be the only means of carrying out a country's population policy and demographic goals. Yet today in developing countries the prevailing scenario is that RH programmes have been built upon former FP programmes that are strongly clinical in orientation and ill-equipped to cope with the broader social goals of RH. Given the history of FP and RH, the placement of RH programmes works against attempts to move away from an exclusive emphasis on FP and to provide broader health services

Globally, the rapid spread of HIV/AIDS is forcing the world to consider both men and women as equal agents in prevention programs (Robey et al, 1998). This emanates from the fact that RH involves the well-being and participation of individuals and their partners: for example in HIV infection, it takes one promiscuous partner to infect the innocent partner and probably their children. In the SRH matters, we can argue that the concept of jointly determined health is more central than in other issues. In invoking men as partners, we are concerned with the concept of shared health and not just shared responsibility. We are also convinced that by involving partners, RH will reflect both social and physical realities including communication, cooperation, comfort, and the state of being free of disease.

There is however lack of dual commitment in RH issues because many African societies for example view pregnancy, childbirth, contraception and associated investigation for infertility, STDs and HIV/AIDS as entirely a woman's responsibility (Mbivzo & Bassett, 1996). It is clear that women bear greater health hazards associated with reproduction than men, even though it is men who are largely responsible for originating them; for example in a situation where an unwanted pregnancy is followed by an unsafe induced abortion. Furthermore, men are often responsible for the sexually transmitted diseases that their partners endure (Mundigo 1995: 5)

This fact remains a challenge for the HIV infection reduction programs. Various International programs were established in a bid to increase male involvement in preventing STDs and HIV/AIDS: a joint WHO, UNAIDS and UNFPA programme on the promotion of condom use for dual protection of STD/HIV and contraception is one example of such joint efforts (UNFPA, 2000). Despite all these efforts, the HIV infections are still increasing (UNFPA, 2006) in Africa. These raises the question on whether men and the larger community were sufficiently involved in these processes, as without them, the success and sustainability of such programs will remain questionable.

Involvement of adolescent boys and men in various aspects of RH is vital to improve the male attitudes and perceptions on HIV/STD prevention. The young Men's Clinic in New York City, USA managed to integrate the treatment of RH cases with other health services like sports, physicals, acute illness, chronic illnesses and psychosocial problems (Armstrong et al. 1999). This clinic was successful because it had both social and medical services of young men's interests. Using South Africa experience, Peacock et al, (2004) also argued that, HIV/AIDS and violence against women are twin epidemics because they are fuelled by social norms, power and gender inequality in favour of men. This has its roots in the cultural issues including the social norms and power relations that are pillars of the gender inequality in African setting and Tanzania is not any difference (Setel, 1999). It is therefore necessary to change the current situation as we need to consider the uniqueness of the Tanzanian culture and the way it affect men's behaviour and how they relate to their female counterparts. To bring a change in people's culture may not be easy, as it will possibly take many years for a significant change to happen. At the same time, the old generation of men may prefer to remain very rigid and conservative to their old behaviours, but probably, by involving the young generation of boys and adolescents, we could after sometime manage to nurture the positive culture and attitude towards better involvement of men in RH. The assumption here is that the government, CBOs and communities will do their part towards enabling the men to access the RH along their female counterparts.

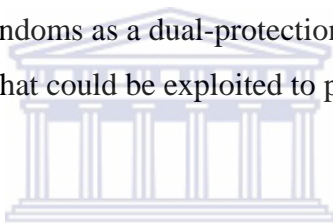
2.1. Opportunities of involving men in RH in Tanzania.

Tanzania is predominantly a patriarchal society, although few tribes like Sandawi, Makonde and Mang'ati practices matrilineal culture. Further more, women in Tanzania earn significant proportion of family income yet men have held their traditional place in society as stronger, more educated and more able to earn an income and hence a greater share of household resources. Men also hold most of the positions of authority in the government and civil service and are managers in both the public and private health sectors. Involving men in RH is therefore essential in order to draw attention to women's rights and improve the health status of both men and women.

Targeting men as beneficiaries of RH care can also address three main RH challenges including poor contraception uptake, high fertility rate (ie.5.24 per woman) and high maternal mortality rate (i.e. 1500 per 100,000 births -(UNFPA, 2006). Contraception uptake will improve if men are involved in RH as it will not only improve women's ability to negotiate for safer sex and FP, but also the number of men users of FP. The high fertility rate will decrease with an increase in contraception use for both women and men. And the

maternal mortality rate will definitely be reduced if men see the advantage of having few manageable children, with a good spacing and also the reason to support their female partners during pregnancy and ensure their labor is attended by a skilled birth attendant.

While targeting men as service providers will improve and expand the services offered by the private and public health services; targeting men as policy makers will facilitate progress towards our Millennium development goals and help mainstream gender equity in legislation and service implementation (Kabeer, 2003). Again, in many cultures, the traditional perceptions of femininity can also make it difficult for women to either talk about sex or negotiate for safer sex with their male partners (Beaufils, 2000). Many RH care organizations that work with women note that their clients want men to be more knowledgeable and receptive to joint decision making especially on contraception (Walston, 2005a.; KHANA, 2000). Moreover, the efforts by many programs to increase condom use outside marriage for prevention of infection, do not consistently promote condoms as a dual-protection method within marriage (Walston, 2005b). All these stand as opportunities that could be exploited to promote men's involvement in RH to achieve better outcomes.



2.2 Challenges of engaging men in RH.

2.2.1 Gender inequalities and RH

The existing masculine superiority that transcends through the generation of men has a close relationship with the failure to engage men in RH programs today (Barker, 2005). For example, among the 500 million children worldwide who start primary school, (United Nations, 1995a); more than 100 million of them, two thirds of them girls, drop out before completing primary school (Mead, 2006). This is more common in developing countries where communities perceive it is right for young girls to be married to older men. According to UN population division, 2000 report, in many countries (including African states like DRC, Niger, Congo, Uganda and Mali; and Asian countries like Afghanistan, Bangladesh and Nepal), over 40 per cent of young women get married before the age of 18; and in contrast, only three of these countries have more than 10 per cent of boys under 19 married. Early marriage is generally more prevalent in Central and West Africa – affecting 40 to 49 percent respectively of girls under 19 – compared to only 27 per cent in East Africa and 20 per cent in North and Southern Africa. Many of these young brides are second or third wives in polygamous households. (UNICEF, 2001). Since education and knowledge is empowerment required to make informed decisions and financial independency, early marriage amounts to denial of

education to girls and therefore depriving them of ability to compete favorably with their male counterparts for both social and economic matters.

Similarly, in Tanzania, even though the government has developed policies that support women empowerment, the National constitution of Tanzania does not prohibit marriage for girls aged 14 years or less (The Marriage Act, 1971). Also the Islamic law in Zanzibar, allows girls to get married before they reach puberty and without their consent (UNHCR, 2004). And when it comes to sex education, Tanzania is largely based on local and tribal customs, and young girls are taught about reproduction in a very informal manner. The poor education on safe sex coupled with little or no access to contraception has resulted in high number of unexpected teenage pregnancies in Tanzania (Media Global, 2010).

On the other hand, the policies do not include punishment for men who impregnate school girls in Tanzania, although the girls involved, not only become victims of high risk sexual behavior (Silberschmidt & Rasch, 2001), but they are also expelled from school. A national law in Tanzania has been in existence for years forbidding young mothers from returning to education once they have given birth. Even with the new constitutional law, the marriage act of Tanzania which was introduced in 2009 and adopted in January 2010, the government has only been successful to force only few schools to accept student mothers back to school (Media Global, 2010). In Zanzibar (a semi-autonomous island of Tanzania) girls who become pregnant before marriage are normally sentenced to 3 months of punishable strenuous community work as a punishment for conceiving outside the wedlock (US Bureau Human Rights, 2007). This is an indication of lack of collective responsibility in Gender and human rights at government and policy level, which leaves a gap on the Government efforts to bridge gender inequalities including RH access.

2.2.2 Cultural/Traditional practices and men involvement in RH:

The existing traditional practices have shaped the attitude and perceptions of men and the way they engage in RH issues. This is obvious in many African cultures as the prevailing norms about manhood encourage men to be aggressive in sexuality and acquire a disproportionately large share of the power and voice in sexual and intimate relationships with women (Barker, 2005). When girls as young as 9 years old are married to disproportionately older men, the men here perceive this as culturally right as long as they can pay the required dowry (Miller, 2006), On the other hand the larger society out there may view this as improper and violation of human rights, a large section of the same society was raised in the same

environment believing in what their culture has defined as “right”. Probably, this clash in the ideology in the same society aroused as a result of the modern education. Modern schools and knowledge are nurturing the young women and men to believe in their freedom of choice of partners and the access to their RH rights, Ideally, this culture is serving to preserve an institution to protect masculine interests that in-turn result in poor RH and low women esteem (UNFPA, 2000).

In some African countries, paying dowry is deemed similar to “buying” a wife, (Wanjohi, 2009). Just few years ago, in the Asian culture women were expected to “buy” the husbands by paying their dowry. Failure to pay all dowries could result in the bride being sacrificed by burning to death (Oldenburg, 1993). In Tanzania, some traditional practices still make it difficult to move towards gender equality and equal responsibility in RH. For example Female Genital Mutilation (FGM), though illegal, it is still highly practiced in Morogoro, Iringa as well as in Arusha, in Tanzania. Men in these communities are not expected to marry uncircumcised girls because they are considered sexually immature and a potential bad omen to their husbands (Snegroff, 1998). Among the Maasai tribe in Arusha, a woman is still an exchangeable commodity as widow inheritance and sharing of women among male friends is still acceptable as a gesture of friendship and unity (Coast, 1999). This Maasai culture is still being practiced and has fueled the spread of HIV and STDs to men and women (Oinyaku, 2002). It suffices to say that the involvement of men in RH could provide the necessary environment to address all these problems including HIV/AIDS infection among the Maasai people in Arusha and Tanzanians at large

2.2.3 Men’s knowledge, needs, attitudes and perceptions towards RH services:

The limited knowledge, needs, attitudes and perception shared by men in all aspects of RH have largely contributed to the negative RH outcome today. Better RH outcomes would have been easy to achieve, if men participated in RH as equal partners, responsible parents and clients at their own right (Pachauri, 2001). Nevertheless, often, men are excluded from accessing the RH care because of their rigid cultural definition of manhood as an epitome of bravery and tolerance, the factors that have contributed to grave consequences to their own RH and that of their loved ones (Barker, 2000). This has negatively affected their health seeking behavior.

Situation may differ depending on the environment of upbringing. For example, in the developing world, boys’ sexual initiation usually takes place outside of marriage, while girls’ first sexual experience usually

takes place within marriage (Singh et al. 2000). This is an important clue, as adolescent RH programs must give close attention to the social context of sexual activity. Efforts to delay sexual initiation and increase sexual safety must take into consideration that boys' first sexual experience is usually self-willed whereas girls' is often involuntary—even in the context of marriage. Reason here is the prevailing social and cultural environment that may allow girls to be married early and possibly to older men whereas the boys may have to wait longer to have their own homes and properties before they finally get married; (although this does not prevent them from having premarital sex)..

Worldwide, studies have indicated that young men often view having sex as a way to prove that they are “real men” and to have status among their male peer group (Marsiglio 1988). The perspectives shared among men and women in the reason to have their first sexual act, also tells the difference between perceptions shared among them. For example, in a study in Argentina, 45 percent of boys in secondary school cited “sexual desire and physical necessity” as their motivation for having sex, whereas 68 percent of girls in the same setting cited the desire for a more intimate relationship as their motivation (Necchi and Schufer 1998). Unlike this search for security and true passion among girls, to the men it is the heterosexual “conquests” which matter the most, and the lack of sexual experience is normally kept hidden. For example, in Guinea, it was reported that young men expressed their fear that if they did not have sex with a girl, they would suffer low reputation and self esteem among their male peers (Gorgen et al. 1998). In various studies, men report that they constantly have to prove their manhood through sexual activity or “risk” having their “manhood or virility” questioned, (Baker, 2005). Although it is true that male's first sexual encounters are more likely to be self-willed unlike their female counterparts, men are not completely safe as they risk diseases, psychological and emotional injuries resulting from the peer pressure in attempts to prove their virility to others (Irvin A, (2000). Men in Tanzania and African at large are particularly more vulnerable as they are living in the era of HIV/AIDS pandemic with our continent hosting the largest percentage of people living with HIV/AIDS (PLWA)

Ignorance of sexual morbidity among men also plays a part. Research findings in India indicate that men know little about maternal or sexual morbidity and they are unlikely to seek for care when they have sexual morbidity (Blom et al. 2000). This mind set may result in men ignoring their pregnant wives or remaining unbothered when they contract an STD and infect their spouses. On the other hand, men are also ignorant of their role and right to safe FP methods (Shelton, 1999). For example, even though vasectomy and condoms

are available and accessible countrywide, the services are seldom used as FP methods, because there is the belief amongst men that vasectomy is castration, and hence the rejection from men (Bunce *et al* 2007). This reasoning is caused by the lack of/limited knowledge on vasectomy and other FP methods by the men.

In Pakistan, they also found that poor knowledge and misconception about various aspects of RH among men affect their spouses (Ali, Rizwan, & Ushijima, 2004). Similarly in Tanzania, men have frequently associated vasectomy with impotence; Maasai men in Tanzania still believe that semen from unprotected sex will speed up the sexual maturity among under age girls, most of who marry before age of 10 years (Coast, 2007). Men have their own sexual health problems like STDs, impotence and infertility, which are associated with stigma, verbal abuse and loss of social status (Dyer, Abrahams, Mokoena & Van der Spuy, 1996). Stigma at the community level as well as negative attitude from the health providers prevents most men from accessing the RH services for their SRH problems. A study done in Tanzania by Mwageni, et al, (1998), showed that men used condoms only with women who were not their spouses or regular sexual partners. In this case, the male involvement in RH could be used to convey the educational messages on the condom use as a dual protection against HIV/AIDS and unwanted pregnancy (Msuya et al, 2004); and also the fact that vasectomy is a long-term FP method to men as bilateral tubal-ligation (BTL) is to women. The involvement of men in RH will empower them to appreciate their role as responsible husbands and fathers to a manageable family. The involvement of the NGOs and civil societies will ensure the creativity and consideration in the RH programs development, by making sure that that their programs will lay down some comprehensive plans to involve the men, by putting some sensitive issues like culture and norms to create programs that are equitable and gender sensitive.

3. Problem Statement and Rationale for the Study

In Tanzania as elsewhere, it has been documented that men have a significant impact, directly and indirectly, on women's ability to access services and implement regimes of care. Thus far, however, men have been left out of the mainstream of reproductive health services, a factor responsible for many RH setbacks including high HIV/AIDS prevalence, high STD rates, high fertility and high maternal mortality rates. Evidently, only a few men (when compared to their female counterparts) in Tanzania seek care from our RH clinics (Danforth & Roberts, (1997). We need to identify the existing perceptions and needs amongst men which shape their reluctance to participate in RH. Also important in unmet needs are the experiences and perceptions of service providers. The experiences and perspectives of different stakeholders and

their ways of reasoning around the use and provision of reproductive health services will give insights into factors that influence men's involvement in RH. This study seeks to understand the experiences about the RH from both men and the health care providers in RH both from the rural and urban setting. The variation in socioeconomic factors among the rural and urban population coupled with poor access and lack of user-friendly services in many health facilities might have an effect on men's utilization of RH services.

The assumption that family planning could yield benefits by targeting only women ignored the complex realities and contexts of women's lives, including gender power dynamics (Chikovore, 2002). As indicated earlier, studies increasingly suggest not only the importance of gender power in sexual relationships, but also the key role men play in childbearing, including inhibiting contraceptive use by women (Waltson, 2005a; Khana 2000). With the Global shift toward a more comprehensive RH strategy, we need to identify the factors impeding the Tanzanian men from actively participating in all ranges of RH services. Men have been neglected until recently in RH policy and research, little is known about their perspectives regarding RH, or factors that influence their utilization of RH services in Tanzania. The extensive levels of gender inequality coupled with low utilization of RH services by men, is an area that needs to be explored. These together with identification of the existing opportunities for men involvement in RH will help to address many RH challenges including STDs and HIV in Tanzania. The answers to these questions will help us develop recommendations for interventions aimed at increasing men's participation in RH to a level that is acceptable to men, their partners, and service providers.

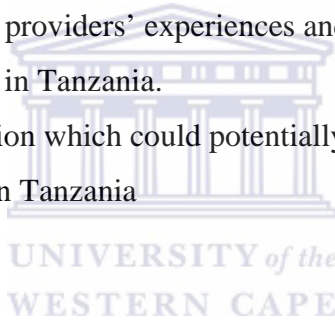
4. Study Aims and Objectives

4.1. Aim

To identify and describe factors that influence male involvement in Reproductive Health in Tanzania, including the challenges, the experiences, perceptions and needs which shape their reluctance to participate in RH as individual clients, husbands, spouses or fathers.

4.2. Objectives

- 1 To investigate the experiences and perspectives of men and their ways of reasoning around reproductive health in order to gain insights into factors that influence their participation in reproductive health
- 2 To describe the patterns of utilization of reproductive Health services by men, including family planning, HIV and STD screening.
- 3 To investigate the health care providers' experiences and challenges of engaging men in reproductive health programs in Tanzania.
- 4 To elicit the useful information which could potentially improve men's involvement in reproductive health services in Tanzania



Chapter 3

5. Methodology

5.1 Study design:

Qualitative research is the study of contextual principles, such as the roles of the participants, the physical setting, and a set of situational events that guide the interpretation of discourse (Ting-Toomey, 1984). It shares the theoretical assumptions of the interpretative paradigm, based on the notion that social reality is created and sustained through the subjective experience of people involved in communication (Morgan, 1980). Qualitative researchers are concerned in their research with attempting to accurately describe, decode, and interpret the meanings of phenomena occurring in their normal social contexts (Fryer, 1991). The researchers operating within the framework of the interpretative paradigm are focused on investigating the complexity, authenticity, contextualization, shared subjectivity of the researcher and the researched, and minimization of illusion (Fryer, 1991).

In this study, the researcher used qualitative study because of its uniqueness and opportunities it provides in obtaining a more realistic feeling from the respondents that cannot be experienced in the numerical data and statistical analysis. The FGD and KI interviews used provided a flexible way to perform data collection, analysis, and interpretation simultaneously and get clarification on the issues that could have been misunderstood. The design also enabled the researcher to interact with the research subjects in their own language and on their own terms (Kirk & Miller, 1986). Through this design, I was therefore able to explore the primary and unstructured data using the descriptive capability provided by this study design.

5.2 Study Area

The study was conducted in two sites. Mount Meru Hospital in Arusha district and Nkoaranga Hospital in Arumeru districts. While Arusha district is one of the most cosmopolitan towns in Tanzania, Arumeru district is more than 95 percent rural (National census, 2002). Thus, the study was able to compare experiences and perspectives of men in RH in both urban and rural settings in Tanzania. These experiences from both urban and rural areas enabled the researcher to determine whether living in rural or urban setting can have any significant influence on the way men behave towards RH.

Mount Meru hospital is the regional referral hospital for Arusha region in Northern Province in Tanzania. It offers a comprehensive health services including a RH unit with an average of 25 deliveries daily. It is well staffed with both professional and non-professional staff. About 600 clients visits the RH clinic per week, of which only 75 of them are men who are either RH clients or are accompanying their spouses/children (MCH clients' records –Mount Meru Hospital). Nkoaranga serves as a district hospital for Arumeru district. Its RH unit conducts 20 deliveries daily. Nkoaranga is the district referral hospital for all health facilities in Arumeru district. It is a rural district hospital in terms of services provided, infrastructure, and staffing. About 450 clients visit their RH clinic every week, but only 24 of them are men. Overall, Arumeru District does not differ greatly from other districts in Tanzania with regard to women's Health status. Thus it offers the perspective of a rural and more traditional setting for this study.

5.3 Study Population:

In this study, the study population includes mainly the men (and women) aged between 15 to 49 years old.. . Women were involved in order to include their vital contribution and understanding especially on aspects like culture where we thought men could be too biased. The fact that most of the men do not attend the RH, the involvement of the women was strategic in exploring the nature and the quality of the RH services provided to the clients. Women were also useful in the follow up of the male respondents. The second part of the study population consists of the key informants, who were purposefully selected from people working in the RH area in the two study sites (Arusha and Arumeru districts) and have some expert knowledge in the field of RH. These include health workers who work with RH patients and NGO, District and regional reproductive health officials. The RH providers should have worked with RH clients for more than two years. In the era of HIV/AIDS in Tanzania, there are many NGOs that came in to supplement the Government's efforts to reduce high rates of mortality from RH and HIV/AIDS, and their participation in the study is therefore valuable.

5.4 Sampling:

The selection of these health workers was purposefully done. Skinner (2007) noted that purposive sampling ensures that the researcher chooses respondents or settings so as to accommodate a full range of possible features of interest. Purposive sampling gathers information relevant to the study by obtaining rich based data from cases that have an in-depth understanding of all aspects of a certain phenomenon. It therefore allows the researcher to select study participants that are conversant with the study areas. The key

informants' interviews was purposefully selected from agencies that are involved in RH interventions and these included RH managers, coordinators, and other RH providers from the two districts. All districts maintain an inventory of names and titles of staff from agencies that deal with RH interventions. Through this list, I was able to choose the 'Key Informants' for the study. The criteria used was based on identification of the managers or supervisor of the programs who are directly involved in working with RH providing facilities in Arusha, Arumeru or both. Five key informants participated in the study after obtaining their consent for the interview. Written consent was obtained and interviews were conducted in Kiswahili, which is a national language in Tanzania, and is understood by all participants.

Eight FGDs were conducted and each group consisted of 6-10 men/women, four groups from Arumeru (rural) and four from Arusha (urban). The first two FGDs were held in an urban setting of Mount Meru Hospital each comprising of men who have attended and used RH services; while the third group included men who are residents of Arusha and have not used the RH services at all. In addition, the fourth group included the female clients identified from the RH clinics. The male service users were selected systematically by identifying every third man in the register of the men who attended a RH clinic at Mount Meru hospital in Arusha on their own or while accompanying their spouses as a next of kin. Where as the men in the third group was identified by following up the partners of women who confirms the non-involvement of their partners/husbands in RH services to the researchers. The researcher wrote an introductory letters to their partners/husbands and invited them to a meeting where they were approached for consent to participate in the FGDs which took place in their neighboring meeting areas e.g. local community halls and church premises. Snowballing was also used to identify other men who do not use RH services in their community. For women participants, they were all identified from the RH clinics and form a group of 10 women of which half of them have partners/spouses who participate to the RH services and half of them have partners who do not participate. They were chosen systematically by recruiting every second woman who tuned up at the RH clinic with a spouse and every third woman who turned up without her spouse. The researcher purposely included the participants with some homogeneous characters or those who share some things in common about RH (e.g. same age groups, those who attend RH clinics Vs the ones who do not). The convenient venues easily accessible by all participants on foot were used for the FGDs.

Again, the other four FGDs were held in a rural setting of Nkoaranga Hospital. All men in this category were residents of Arumeru district. The selection criteria used for the urban group also applied for the rural group. The date, time and venue for the FGDs were set between the moderator and the respondents in all categories mentioned above. The participants of all the FGDs were served with refreshments during the session. The sponsor of the researcher met all the costs.

5.5 Data Collection

Data was collected through interviews and FGDs. The researcher used the two methods to get rich information from the respondents. The advantage of using focus groups is that they are a quick, convenient and therefore a cheaper way of gathering data from a number of people at the same time (Coreil, 1995; Kitzinger, 1995). Group processes helped exploring and clarifying people's views through stimulation of conversations and reactions in ways that would be less accessible in individual interviews (Kitzinger, 1995; Mack *et al.*, 2005). Data collection was done by the Researcher with help of a research assistant and we are both fluent in Kiswahili, which is the National language in Tanzania. Eight FGDs were conducted, of which 4 took place in Arusha (two FGD took place at Mount Meru hospital's CME hall and the remaining two at Lutheran church hall in the city centre) and the remaining 4 in Arumeru (the first two FGD took place at Nkoaranga hospital chapel and the remaining two took place at Oldadai secondary school student hall. Planning was carefully done to ensure that all FGDs were free from any interruptions). So in total I had 6 FGDs with Men (3 from each district) and 2 FGDs with women. Many groups for men than women were meant to have a larger sample space of men and basing on their perceived understanding and involvement in RH. An FGD guide that among other things included questions on their needs, perceptions, attitude, knowledge, beliefs, involvement and sensitivity to RH was used to guide the discussions. Information about each group will be kept safe by keeping the findings in a password controlled computer.

In-depth interviews were conducted with 5 key informants from each district with the aim of eliciting responses on a range of questions concerning the participants' experiences and views about providing RH services. Their working environment, encounters with men using RH services, the challenges and facilitators for the health workers to provide RH service and how the service provision is monitored and documented at community level was explored. The two data collection methods complement each other in a view that the respondents from both categories are knowledgeable in the subject matter. (I.e. the FGD respondents are the recipients of the services whereas the KI are RH services providers and managers).

5.6 Data Analysis:

The analysis of data was a continuous process that started during data collection process. The rationale behind this was to ensure that emerging themes could be followed up in order to verify them. Before the final data analysis took place, all the recorded data were transcribed. To help capture the important non-verbal expressions, notes taken during the interview process were inserted into the interview transcriptions. The thematic method of data analysis as described by Miles & Hurbeman, (1994) was used in this study. The first stage was data familiarization stage, which was accomplished by reading and re-reading the data sets. A process of coding and categorizing the contents of these data was done by seeing trends on which words are mostly repeated and what meaning they hold to various participants in relation to research objectives and questions. These assisted the researcher to establish the meaning of various responses from the respondents. The recurring themes related to the men involvement in RH, their needs, perceptions and attitudes towards the RH services as well as the existing opportunities and challenges of male involvement in RH were identified through this process.

By starting the data analysis immediately in the field, the completeness and the appropriateness of the responses was ensured. As this is a qualitative study there is more categorical than numerical data that was manually analysed by grouping the FGD responses into specific themes. This allowed an analysis of the content by seeing trends, which words are mostly repeated and what meaning they hold to various participants in relation to research objectives and questions. Different responses from key informants allowed testing of the research questions, while cross checking findings with grey material information. This helped to eliminate any bias or distortion of data.

5.7 Rigor:

Two data collection methods were used. These include FGD and individual In-depth interviews. The researcher summarized key points at the end of each FGD to verify that his understanding and interpretation of participants' perceptions/opinions were accurate. The key issues raised were followed up in the subsequent FGDs and in-depth interviews with key informants. A diary of personal thoughts and feelings was maintained throughout the research process for personal monitoring.. Data collection was conducted in different premises convenient to the study participants. In order to prevent interruptions and ensure confidentiality, the researcher identified quite venues (like church premises on weekdays) and work within closed doors.

Rigor was also ensured by paying particular attention to the four criteria proposed by Guba & Lincoln (1990): credibility, fittingness, auditability and conformability. To ensure credibility in this study, the respondents were identified and described carefully. Peer debriefing in the form of constant communication and contact with my supervisor throughout the study was another way of ensuring that this study will be credible. Fittingness, also called transferability, was ensured by providing a dense description of the study settings (Arusha and Arumeru), themes and participants so as to allow the audience to judge for themselves this study's applicability to other settings or similar contexts (Creswell & Miller, 2000). In addition, the researcher endeavored to demonstrate that the findings are well grounded in the life experiences of the people interviewed and reflect their typical and atypical elements.

Auditability is assessed by the ease in which another researcher can follow the "decision trail" used by the investigator in the study (Guba & Lincoln 1990). In this study an "audit trail" was ensured by a thick description of the research's methodology (Creswell & Miller, 2000:128). Holloway and Wheeler (1996) argue that the decision trail provides a way of establishing rigor in qualitative research and auditing the entire study. The decision trail has been provided through a clear and detailed description of the data collection and analysis process. Furthermore, the chosen methodology and data analysis has been well presented, clarified and justified by demonstrating all the actions of the research, the influences on them and events that occurred during the course of the study (Holloway and Wheeler, 1996). Confirmability is a criterion for neutrality in qualitative research. Confirmability is ensured when the reader is able to assess the adequacy of the research process (Holloway and Wheeler, 1996). In this study, confirmability was achieved by ensuring auditability, credibility and fittingness of the study as described above (Sandelowski, 1986).

5.8 Ethical considerations:

The vital ethical principles including autonomy, informed consent and confidentiality were considered in this study. To ensure the participants' autonomy, participation in this study (either in FGD or Key informant interviews) was on a voluntary basis and a written informed consent was sought in advance (Annex 2) from each respondent. Further explanations of my study have been provided to each respondent who would like to know the reason for conducting this research. Permission to participate in the study was sought from all the participants. Participants were also given an information letter explaining the research process, purpose and benefits of the study. All participants knew that they were free to withdraw their participation from the

study at any time. Participants were assured that whatever they said in the interview shall be kept confidential and FGDs participants were constantly reminded not to share any information from FGDs with anyone outside the group.

Every effort was made to ensure that the participant's identities could not be revealed or easily deduced by the readers of the research outcomes (See Annex A). To ensure the promised confidentiality, no names are mentioned in this thesis and information have been aggregated. After the interview, the information on RH (including guidelines on available RH services in each district) and how to access them were distributed to the respondents. The findings of the FGD and KI interviews will be stored in the code-controlled computer. Given the nature of the research, it is mostly unlikely that the informants perceived the research as threatening or invasive, so it was anticipated that the research caused no harm to the participants.

The District committee for health and management team (a Tanzanian National institution that supervises and coordinates the health services from both public and private sector in each district) approved our ethical application for this study. The National institute for medical research in Tanzania allows the technical team within the health management team in districts to review and provide clearance for the studies which do not involve biological specimen (e.g. blood, tissues, sputum etc) and those which clinically non invasive. This study falls under the same category. Ethical clearance was also sought from the University of Western Cape Higher degrees Committee

5.9 Study Limitations

In some parts of Tanzania, it is considered taboo for adults to discuss sex issues in public. Most of the participants were grouped in similar age groups to eliminate this. Despite careful planning, my schedule and logistics could have been constrained due to poor roads and unpredictable weather. Heavy workload related to my role as a fulltime employee for ELCT and a Masters student at the same time made the time management a challenge. Some of the male respondents declined to participate in the study for personal reasons. Nevertheless, the study was successfully conducted and various key findings established gave the response to the study questions

Chapter 4

6. FINDINGS:

In this study, the respondents from both FGD and KI interviews discussed the study questions at length and came up with various responses. The responses were thematically grouped into two major themes which include coordination and partnerships and culture. In coordination and partnership, the participation levels, approaches and health promotion strategies are extensively discussed. On the other hand, culture is broadly discussed with main focus on masculinity, gender roles, modernity and human right issues.

6.1. COORDINATION AND PARTNERSHIPS:

The respondents pointed out that coordination and partnerships between the RH service providers and the recipient's are wanting in various aspects. These aspects including the stakeholders' coordination and their levels of involvement, partnerships and their approaches, policy issues versus the practice, scale up strategies and HIV/AIDS are believed to have impact on the level of the male involvement in RH .

According to the FGD respondents, there is a weak linkage between the government coordination mechanisms and service providers to their recipients – the men. This is reflected in many aspects of RH which have proved to be a setback in MAP. For example, the government expected that the MAP process will simply draw the men (along with their partners) to the RH service, but the men expected better RH services provided in conducive environment including their own consultation rooms and privacy from women. This shift in goal posts/expectations from the service providers and the recipients is a result of poor planning and coordination of the good intentions in the MAP process. This means the service providers want men to attend RH services, but to the contrary, the men are not satisfied by the service offered.

Basing on these findings, it doesn't mean that the policy makers and other stakeholders have not done much towards making the implementation of MAP a success. But rather, they (policy makers) did not think carefully about the practical issues when they formulated the policy on the male involvement in RH. Actually, the unforeseen obstacles like infrastructures, social and economic issues- were not given a significant emphasis by the policy makers and yet in reality, they can easily compromise the access of these particular RH services as this quote indicates:

I think the government, NGOs and FBOs are trying so hard to get the men onboard, however, the social-economic and infrastructures in our facilities are not encouraging the men to participate extensively in the RH services. [KI 04]

6.1.1 The challenge of participation levels and approach

From the study findings, it is pertinent that men understood the meaning of MAP, but they have not translated this knowledge into reality. For example, the respondents from both KI interviews and some from FGD referred to MAP as an act of getting the men to participate actively in all matters concerning the RH for men, their wives and children. This reasoning however, is not reflected in the implementation of the RH as only few men attend the service provision facilities.

On the other hand, the study also identified the fact that men need to be acknowledged as partners in RH. According to the FGD respondents, men are not participating in RH services because of poor communication and relationship between them and the service providers, and hence the reasoning among men that the services are not male user friendly. Possibly, their partnership with the health facilities in their communities could be better if the services were more welcoming to men including seeking their opinion about the best way to serve them.

Coordination was defined differently by our participants, and depending on their level of understanding – with KI respondents being highly knowledgeable and most of the FGD respondents who are lay people – being fairly knowledgeable. They defined coordination as providing leadership and support, bringing things together, organising people and mobilising resources. In addition, they (mainly KI respondents) acknowledged the District Reproductive Health coordinators (DRCHCOs), District Medical officer - (DMOs) and Maternal and Child Health care Units (MHC) of each health facilities as responsible coordinating bodies in the districts. The respondents identified district stakeholders as including community-based organisations (CBO), Non-Government organisation (NGO), Private Health units, international organisations and the Public, all of which are supporting RH services from different perspectives.

However, despite the presence of all these important organisations with a stake in RH, the Government has assigned NGOs to work in certain regions/provinces while leaving other regions unsupported e.g. NGOs like Engender-health and FHI which was initially supporting RH throughout Tanzania was forced to work in only 5 regions out of 25 Regions. Some of the KI respondents reported that as demoralizing as it frustrated their initial strategic planning and target goals. Again, some of these NGOs (e.g. Pathfinder International working in Arumeru and Arusha) were providing more than one category of RH services (e.g. FP and

HIV/AIDS support), and their re-allocation was based mainly on one service provided and only in some of the wards in each districts. As a result, the service provision was uncoordinated as NGOs supporting the same RH are located in the same district while others remain unsupported. The implication of this is poor access to the potential clients and failure to meet the goals by the NGOs. To some KI respondents, this is a result of the government managing the coordination process single-handedly and without seeking the views of the recipient and other stakeholders like NGO, so the failure is not a surprise. According to the KI respondents, the Government is smoothly coordinating other Non-health NGO work, but the RH and other health related NGO work was frustrated with the coming of many heavily funded NGO to carry out HIV/AIDS activities in only certain regions. The Government took the decision to re-distribute them across the country. Otherwise, the coordination is mainly done by quarterly meetings where they mostly discuss issues to do with the reporting. Although the reports are sent to the Government and the donors, the feedback from their main coordinating partner is little or none existent.

From these findings it seems that the health care professionals understood what coordination is and who was supposed to be involved. But the policy makers' approach to the coordination of RH is poor and various reasons have contributed including lack of good leadership, the regionalisation of NGO work and lack of participatory approach in reallocation of rather heavily funded NGOs supporting HIV/AIDS activities among other.

Government and its stakeholders in RH should be able to see in reality that NGOs, CBOs and other similar organizations are complimenting the Government's efforts by means of sharing power through coordination and managing the RH services. This is not the case now. In addition, the respondents reported the planning between the Government and NGOs is done separately, although the implementation is again supervised by the Government. In this context, respondents argued that the NGOs have not been accorded with significant participation in the coordination as they are all observed as the reporting points but not necessarily involved in planning for coordination process. This lack of consultation between the government and the NGOs is a reflection of poor communication and lack of shared vision among the stakeholder. As a result, the respondents from the NGOs and CBOs felt to have been left out. The quotes from these stakeholders illustrate more:-

The Government makes all decisions, allocate sites for stakeholders, conducts monitoring and supervision and is responsible for joint meetings [KI 01],... but they don't ask us to be part of the planning [KI 03]

6.1.2. Specialization Vs Comprehensive approach

It is important that coordination be strategically organised to reflect the public policy and interest. The public policies emerge through a process of interaction between many sources and interests and can either influence specialization or comprehensiveness of the service. The conflicting interests observed as men who accompany their partners to RH clinics argue that many of the services offered are mainly for women yet there is little or no support available for men. For example, the pregnant women with Hypertension can be seen by gynecologist but male spouses with the same condition will have to consult a physician from a different department. This challenges the current debates of specialization vs. comprehensive approach in medical care. Contrary to the western and developed countries where specialization is been emphasized, In Tanzania, the limited resources and infrastructure are in favor of comprehensive approach than the specialization approach and hence the need to adopt a system feasible to our contest

It was also suggested that the facilities providing RH should plan and facilitate the men users of the RH facilities to hold meeting for peer support and encouragement to promote demand for RH seeking amongst couples. These meetings should use the services of the respectable men who are also regular users and supporters of MAP to be the hosts and main speakers. The respondents in this case were in view that men can play a big part in creating a positive change amongst their fellow men and hence contribute to the comprehensiveness of the RH services.

6.1.3. The Paradox of policy versus practice

Although men's attitude here are viewed as rigid (by some women and service providers) to the RH issues, the male respondents argued that the RH providers are part of the problem as their own attitudes towards the male clients are very negative and hence discouraging the greater male involvement in RH. While the male respondents are holding the service providers responsible, the KI respondents reasoned differently as they argued that it is all because of the structural challenges like of lack of space.

In addition to the structural challenges, respondents felt that it was unfortunately that during the process of developing comprehensive RH services–MAP inclusive, the main stakeholders were not consulted. As a result today, both the service providers and the RH clients still find the services and the naming of RH services confusing. For example the name Maternal and child health (MCH) - which technically stands for

RH in Tanzania), is still broadly used and yet many (especially the men) think it is not gender sensitive and possibly a reason for poor attendance by men. This RH nurse from Mount Meru Hospitals confirms:

It is apparent that most men in our district feel out of place when they come to the so called “maternal and child clinics”...obviously, men are not part of that name! The Government should ensure that the information about the proper naming of our services are shared promptly as this could promote MAP

The privacy issues were also discussed by some women and also the service providers as some of the reason why men involvement in RH is still dragging behind. They argue that men are not allowed into the labor wards as part of efforts to improve privacy for women. However, this is frustrating to the men who responded positively to the Government’s efforts to engage the men in RH. The paradox therefore arises when the government policy encourages male involvement in RH and the practice discourages them from being involved in the same services. This male RH service had the same views:-

Men have constantly been reminded of their role to support their partners and be there in those very special moments like pregnancy and childbirth, however, the nurses at our hospitals will not allow us to enter the labor wards to be with our expectant wives...this is contrary to what the government advocate for and is very disappointing (Man from Nkoaranga)

Apart from the staff attitude, other institutional factors have also contributed to the paradox of policy versus the practice. For example, the respondents reported that men’s participation in RH has been lagging behind because of the RH facilities were built specifically for women and children and any efforts to involve the men will again compromise women’s privacy especially those in labour and during delivery. Most of the labour rooms here are constituted of one large room with more than twenty beds for women in various stages of labour. Female respondents’ reports that they would love their husbands to be with them while in labour. However, this is not possible as most of the Public health facilities do not provide single rooms for couples and hence their argument that the presence of men will compromise their privacy.

In the labour room, honestly its all women affair; as all women in labour are practically naked; I will not appreciate any man (apart from Doctors) let alone my husband to watch naked women in labour ward...it will affect them sexually and psychologically (woman from Arusha FGD)

Still on the paradox of policy versus practice in our health system issues, the respondents also argued that the RH facilities are not user friendly. Mainly this is due to the failure on the government side to integrate RH services in the lower health facilities like dispensaries and health centers leaving the comprehensive RH at major hospitals only. Again this is another evidence of failure on the Government's side to plan well and ahead of time. This leave the fact that most of the men in rural and urban setting will easily access the lower health facilities where not only the specialist care is unavailable, but also the RH services like ordinary maternal and child care are not provided.

K 04: Overall, the government has done its best to include all RH in some of its facilities; however more is required to house all RH needs under all health facilities - including lower health units, to promote the demand and access for service among the men especially in the rural setting.

In addition, the respondents argued that the traditional healers (who are extensively used by men in my study area) are taking the advantage of the system failures in the modern medical practice to win the male clients. For example, the FGD male respondents (and also some women respondents) suggested that in case of very sensitive issues, where men will prefer to be seen alone (or doctors will prefer to first see the men alone), then separate rooms where men can consult the doctors for very sensitive masculine issues like erectile dysfunction, impotence, premature ejaculation and infertility should be available. Married men with these conditions should be counseled for the involvement of their wives as a part of the process and management. The provision for this space will improve on the male's participation in RH and avoid the current practice where men with these conditions will prefer to seek for the services of traditional healers.

6.1.4. Health promotion strategies for RH and Male Participation

The respondents discussed various strategies to be employed in order to promote Male involvement in RH. This included the stakeholders' efforts to promote RH and male participation using the RH promotion and educational programs which already exist in Tanzania.

(I). Information and educational communication materials (IEC):

Various stakeholders including the MOHSW (through district RH services) and NGO like the Champion Project from Engender-Health project are using various forms of IEC materials (posters, stickers, brochures, and audiovisual messages) to promote the RH and male involvement issues. The champion Project for

example is entirely working to change the male attitude against RH issues. Through their radio and TV messages, the project has been promoting good practices among the male gender; however the limited coverage to the target population is a setback due to language and type of type of IEC~ material used. Most of the messages are aired in TV – (media accessible by only few urban residents who already have better access to RH) - and using English language – (which again is spoken by the elite population), and in some cases the themes could be too abstract or foreign for local men to grasp the shared ideas or concept. Male FGD respondents suggested that the radio being the media with the largest coverage especially in the rural settings could be preferred over the TV

The FGD respondents were in view that (IEC) materials like posters, fliers, brochures be used in the villages and towns to communicate the right and accessible messages to the men and their partners. Again, the use of visual aids and right messages in the local language (i.e. Kiswahili and vernacular) about availability and the importance of RH services could improve the male participation.

In addition to the IEC materials, the education provided to certain target groups should be goal-oriented. The general assumption by health care providers is that information given to women during health education is passed on to men, but they forget about the other social and cultural barriers. For example the female FGD respondents reported that the government and the Health facilities normally organize some teaching (during the RH clinics sessions) on the role of the men involvement in RH. However, most of these good messages are not goal oriented as they go to women only (because men are not regular clients in these clinics), and again they (women) find many difficulties conveying the same messages to their male partners to bring some significant change. For these education sessions to be useful, forums with good attendance of men should be primary target. Examples of such forums includes meetings where men meet regularly for a common cause like church, mosques and related public gatherings.

Finally, the respondents were in view that the Government could utilize the community health programs and professionals to further visit and educate the men and their partners about RH and the need for the masculine involvement. This was observed as an easy way to reach all the men with their wives and provide a meaningful RH education at home setting - where privacy and other factors like peer pressure will be ruled out.

6.1.5. HIV scale up program and their effects on RH

In Tanzania, Some positive changes have been observed in HIV programs. From their description, the KI respondents argue that they recognized the fact that the process of male involvement in all RH issues have definitely achieved to bring some significant changes in the way men behaved towards RH issues. The changes have been specifically noted in the HIV treatment scale up programs where men are invited for couple counseling and testing (VCT) of HIV. The respondents acknowledge that the program has managed to attract men into RH clinics not only for VCT but also education for various health issues including good nutrition for their pregnant and breastfeeding wives. In addition, other benefits like health education, distribution of free condoms, a lot of funding from international community and local stakeholders are available. In general, men more knowledgeable on HIV issues than they were before and the management of HIV/AIDS programs are better coordinated and accessible in most parts of Tanzania.

On the other hand however, the shift of attention to HIV/AIDS at the expense of other RH programs has managed to pull all resources (both human and financial) towards HIV/AIDS support. In that process many important RH programs including FP, adolescent health, communicable and non-communicable diseases have been given little consideration both from Government and NGOs in Tanzania. The distribution of NGO support services was for the past few years based mainly their (NGOs) involvement in HIV/AIDS support work and this has disrupted many other health services including many aspects RH. Nevertheless, the achievements in this regard can be credited to the strategies applied by the Government, FBOs, NGOs and the communities at large towards improving the RH. Although this was not an experience for all respondents, some service providers and KI respondents held this as a success as per the quote below.

(KI 02, 04, 05): The advocacy has definitely seen a number of men in our RH clinics increasing. Some men have come to RH to test for HIV with their wives during pregnancy. Counseling sessions to expecting couples gave women a better bargaining chance for family planning and condom use.

6.2 CULTURE:

6.2.1. Culture and perception of gender roles

Culturally defined social behaviors and relations were mentioned as one of the issues linking the culture to the poor RH outcomes (for both men and women). For example, the male respondents from the Maasai tribe (Arumeru) argued that polygamy defines the wealth of a man in-terms of numbers of wives and children

“owned”. Therefore; in other words, the numbers have a different meaning to them, as a man you carry a certain status if you have more. The unwanted RH outcomes like maternal and infant mortality is one of the problems encountered. It is therefore important for the policy makers and health care providers to acknowledge and respect these cultural values and work on them in order to change the risky behaviors.

The findings also established that, some KI respondents blamed the men and their cultural values for RH problems whereas the men in FGDs argue that the health providers are not sensitive to the important issues in their culture. This is a reflection of misunderstanding and lack of collaboration between these stakeholders. And on the other side, of these findings, one could argue that it is difficult to change men’s behaviors without changing the cultural institutions and behaviors that shape their manhood. However, it is also possible that men are not difficult if you work with them and allow them to take the lead

But when it comes to changing the culture, unfortunately, it is not easily done over a short period of time and a lot of resources may be required to achieve that. It is unfortunate that although our MAP program implementers acknowledge cultural barriers to the RH implementation, they have not invested much in these time consuming yet very important processes. And therefore, instead of spending too much time and resources trying to change the culture of the men, we should instead partner with them and find out the best ways to address the culturally driven behaviors that can help in improving the RH outcomes. The quote from this KI respondent illustrates that:-

(KI 01, 05): Our culture shaped men to show their virility strength in form of many sexual partners and children... this culturally fuelled behavior is largely responsible for some major RH challenges we are facing today including HIV/AIDS, STDs and high maternal and infant mortality.

On the other hand, male respondents defended their reluctance to participate in the RH citing the division of labor and gender responsibilities as an excuse. This is rooted into the way the various communities have trained their sons and daughters to be men and women of tomorrow. The new generation also learns from their very conservative and closed cultures, for example, the youth from the closed societies like the Maasai people who rarely travel outside their area of domicile and they can hardly take up foreign cultures exposed to them through media or travel. Despite that, some men from the urban setting (Arusha) seem to be flexible

in the issue of culture and men involvement, unlike their rural counterparts who seem to use gender roles as an excuse for non participation in RH programs

According to the respondents, there is always an expressed need for men to show their male peers that they are in control. As part of that, men will also choose to participate only in those roles only defined as masculine roles and shy away from roles defined as feminine including assisting with housework (even when a wife is sick) and also taking children or wife to the RH clinics. According to the respondents, some of these acts may be perceived as masculine behaviors of bravery as this quote suggest.

Our cultures have clearly defined the roles for men and women as far as sex, marriage and RH is concerned. If Pregnancy and child bearing are for women, then why should we appear in their clinics? (Man from Arumeru).

Unlike the attitude nurtured by social status and education levels in women, the men seem to attach a lot of meaning to RH as a response to the way they were socialized in their communities. This defines the sensitivity attached to RH matters and especially from the masculine gender, but also it reflects the way of upbringing and socialization of men in Tanzania. For example the men will not take an offence to queue for others services like for diabetes clinic, hypertension and other diseases but they do for RH because women (seen as inferior) will most likely be the clients here. This quote the male non RH service user illustrates more:

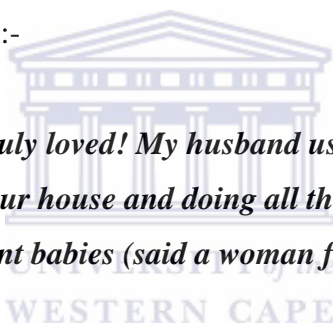
The RH services can hardly complement men's needs... the facilities not only that they lack a room and staff for men, but also they are not culturally sensitive (its abomination to keep a grown up man behind women on a queue) (said a Man from Nkoaranga FGD)

Marriage and the meaning attached to it have influence on the gender roles. The findings from the respondents indicate that marriage have various meaning and serves different purposes. For example, respondents reported that there are many reasons as why people enter into sexual relationships and marriage including economic support, sexual satisfaction, love, companionship, procreation and emotional support. While majority of the male spouses pointed out that their major expectation from their female partners was sex and raising the family of their own (which in turn will help them to keep their family name); the

women's major expectation from their male partners was mainly on a security basis (financial and protection). Suffice to say, for any man or woman joining a partner into the marital institution, there is always an expectation of benefit from each party involved, of which good health and mutual support during the illness is expected.

However tedious pregnancy and child birth can be; men in our setting expect their wives to give birth at least in the first year of marriage. Again as parents they give a special value to their first-born child as it comes with the unique experience of being a father (or mother) for the first time. For men, their first-born is a connotation of being a real man- (in terms of expression of sexual prowess and fertility), a father and a man who should earn more respect from younger generation. Women also acknowledge some special moments when men can go an extra mile in caring for their spouses (e.g. men become very compliant when a woman delivers their first babies, -though this is only short lived-, it is well appreciated). This quote from a second time pregnant mother illustrates:-

When I had our first-born baby, I felt truly loved! My husband used to cook for me, gave me hot bath and massaged my body daily plus cleaning our house and doing all the laundry; I'm not sure though whether this trend will continue in our subsequent babies (said a woman from Arusha")



6.2.2. Masculinity

From both the FGD and KII respondents, being a man or woman has many attachments to the cultural definition of the group of people. The definition of the masculine and feminine gender issues rely mostly on the local understanding of roles assigned to each gender. For example being a man in many African cultures means having more freedom and power than a woman. Men are also free to go anywhere and at any time they want without mercenarily asking permission from their wives, they make decisions at any time for themselves and others but at the same time men have to shoulder most of the responsibility in the family. Men as head of family, gives them higher levels of authority and control over how things are done at home. For some female participants, physical and financial security is not enough; they argued that men must also provide emotional support for their wives and family at large. All these cultural practices has an effect on the utilization of health services including RH.

In this study, culture appears to cut across all major areas of male involvement in RH. The respondents discussed issues from various angles which seem to contribute significantly to the way men use culture to gainfully monopolize power and authority over women, and at the same time contribute to the negative outcomes in RH for both women and men. The FGD respondents reasoned that the government's efforts through the health facilities, their staff and RH units should consider the important aspects of the community like culture, social life and health systems factors like equipments, skilled staff and hospital infrastructures - as prerequisite for success.

(a). Culture and human right conflict:

The participants responded differently to the relationship between culture and RH concerning the involvement of men in the service provision. Though the reasoning and experiences differ from one tribe to the other, both men and women respondents suggested that culture in many tribes in Tanzania helped the men to nurture their attitude toward RH. Women in particular, argue that men's failure to attend RH with their partners is an issue of "status" rather than behaviors, and once again, the culture that favors the men is here to be blamed.

In this context, women believe that a conflict exist between the cultural definition of the gender and their roles versus the human rights. To some respondents, possibly it seems like men are taking advantage of culture. This is because culture is dynamic and it does change over time, (e.g. one of the KI respondents argued that; *in the past men helped their families to earn living as hunters and gatherers but today life depends on small-scale farming, animal grazing and waged labor. So if the life style has glossily changed over a period, why not the male attitude?*) The female respondents acknowledge the fact men were raised in cultures favoring the masculine superiority, but when it comes to the illness and being supportive to wives and children, the whole concept of men being superior should be brought to rest and necessary support both morally and materially should be provided to women and children as their basic human right. According to some female respondents, the support to female partners and male participation in RH should be perceived as a basic human right and not a favor to female partners.

Our culture has taught men to be superior from women, so attending RH clinics with women will definitely make men feel inferior, but in reality, this should be their duty and it's our right (woman from Nkoaranga RH clinic).

(b). Cultural dynamics – modernity in urban versus rural

Men engagement in RH issues was perceived differently by urban men, they however reasoned that it is an act of bravery and modernity. This category of urban men argued that not all cultural connotations for masculinity should be acceptable and nurtured by modern men even when they utterly disrespect women and children. True men are not defined by their way of sticking to old cultures but rather by being very responsible to their families' issues including illness and social wellbeing. From cultural diversity, men who attend the RH are modern and of higher class while those who stick to their cultural definition of masculinity, are perceived by their counterparts as uneducated and possibly of lower social status

As a modern man, I feel very responsible when I express my love to my wife (and children) by being there when she need me the most; I have been there when she is sick and attended clinics with her...I feel very unique and my wife like me for that! (Said a man from FGD in Arusha)

In the modernity theories, some social values, like economic status, wealth, social class and the level of education has a direct effect on the perception of health care. This has been displayed in this study in which some men in Arusha– representing the modern, urban, well educated and working class - attaches some value onto male participation in RH. The story is completely different in the rural settings like Arumeru where most of the men are peasants and less educated, and hence they attach a lot of meaning to their cultural definition of manhood. Caring and loving your wife is associated with modernity in Arusha, but it's despised and condemned in rural Tanzania. The implication of this is that the gender inequality is more prominent in the rural setting of the country where people are less educated and their way of living is only predetermined by their culture. From these findings, it seems like the rural-urban disparity in the role of men in RH is a very important, yet the policy makers have given it a little consideration and attention when it comes to formulating the important programs like Men involvement in RH.

Some of the male respondents felt that it is right to accompany their female partners to the hospital, however; the nature of the employment has an effect on their participation in RH. For example, men who are working as casual labor or far from their families may have little freedom to be with their wives when the need arises. Instead, all they could do is to provide the money for transportation and medical bills and the women can go to RH clinics alone; unless when they are seriously ill.

6.2.3. Societal division roles and RH:

(a). Gender inequality:

Majority of the female respondents argued that culture in each society has taught their subject to behave like men or women and these are translated on the way they relate to each other. However, it's from that same mentality that they felt that the roles and responsibilities accorded to the masculine gender can be damaging because they not only divide the community in classes of people, but also have deluded the men into feeling superhuman born to rule the fairer gender. Various factors of "being a man" like courage to face their sexual problems alone and avoiding practices categorized for weak and henpecked men like being too supportive to their female partners are largely responsible here. The societal values and expectations make it difficult for men to participate in RH programs. In general, the role played by men including peer pressure from non-service users, superstitions and belief among men that they are superior, could challenge their participation in all aspects of RH.

Gender inequality and cultural practices in Tanzania that held men as superiors are largely responsible for their poor involvement in RH! (KI 03)

Apart from this inequality driven by gender divisions of roles, the respondents also added that the economic production also influence the way each society defines its roles for each gender in relation to RH. For example, the male respondents asserted that women attend to the sick children and members of family because men remain mainly the breadwinners for the family. They may only come to the hospital to pay for the medical bills or sign for the surgical consent; otherwise raising money is part of their responsibility as men

Men must work hard to raise money required to pay for food and medical bills...then our women should take the remaining role of caring for the child - Said the man from Nkoaranga)".

The implication of this perception/attitude is poor involvement of men in RH as they seem to believe that the only thing they owe their families is financial support. To the contrary, the society views them as the controller of all family welfare issues – including the RH. Since it takes two (man and woman) to conceive and raise a child, one will therefore find it an irony that the men who are considered the heads of families would remain comfortable to see women partaking the role of caring for the pregnancy and sick children single handedly. On the other hand, some men felt that since pregnancy and childbirth is naturally a

woman's responsibility, then most of the macho men perceive the calling for the men to attend the RH clinics practically reduce them to a female status or softy men. Actually, this question the level of their understanding of RH as there is more than just pregnancy and childbirth in RH.

And on the feminist aspect, some women - mainly the urban well educated and financially independent argued that they need their autonomy and privacy from men in this sensitive medical procedure and examination respected. However, some few of the same class of women also argued that they can manage to pay for the costs of the medical care in private hospitals and hence men involvement in maternal care is not for the sake of paying the bills, but rather for their love and company during difficult times. This quote illustrates more:

I can afford a good medical care for me and my family...All I need is my husband to be there for us when we need him the most (said a woman from Arusha)

(b). Labor Migration and multiple partners:

According to the respondents, men from the many areas of Tanzania are either working far from their families or married to more than one wife (either because their culture or religions allows that). For example the Maasai tribe from this study area, men are pastoralists who live a nomadic life searching for pastures. Their culture also demands for men to marry many wives (some have up to more than 10 wives) who mainly remain behind while men are away. Unfortunately, this behavior contributes to STI including HIV infection and it creates problems in contact tracing. Polygamous men and men with mistresses are often unavailable to their wives and children, even when they need them during illness or just for company.

On the other hand, jealousy among the women and their co-wives (incase of polygamy marriage) was reported to be one of the reason for poor male involvement in RH. Some male respondents reported that sometimes they are forced to side with one of the wives while abandoning the jealous co-wife. As a result, some of the female partners will remain a mere victims of circumstance as their male partners will not be available for their support (like in illness including poor RH) when they need them the most. At times, some men choose to stay with one wife where they work and have a second wife at their home village, who is usually neglected.

Chapter 5

7.0 DISCUSSION:

In this study, conducted to establish the factors influencing the of male involvement in the RH in Arusha and Arumeru districts in Northern Tanzania, the provision and utilization of RH services in a rural and urban area in Tanzania was explored..

Using the experiences and perspectives of different stakeholders and their ways of reasoning around the use and provision of RH services, it was established that poor progress of MAP is related to the men, the service providers and issues surrounding their respective communities. Factors like culture, socioeconomic issues, access to information and available infrastructure which are held responsible for poor involvement of men in RH are also affected or interrelated in various angles to the level of education, residence (rural or urban) and also the employment status. Overall, a slightly positive trend exists among the urban based educated men when compared to their rural counterparts and the cause can be traced back on these factors. Possibly the flexibility and the likelihood to change among these men are related to one or more of the factors mentioned above and hence their better response.

Among other findings, the study established that only few male partners were involved in the RH services including FP, antenatal care, postnatal care, couple testing and treatment of STDs and HIV/AIDS. The reasons for poor male involvement as they appear in the findings (e.g. culture, coordination issues etc) have a direct impact in RH and health services at large and this has to be addressed. The low levels of male involvement have also been reported from other studies from Eastern Africa (Byomire, 2003). For example one study from Mulago Hospital in Kampala, Uganda, showed that male participation in the prevention of mothers to child transmission of HIV program (PMTCT) program was as low as sixteen percent when compared to their female counterparts (Farquhar *et al*, 2004). Similarly, the findings for the study conducted in the antenatal care clinic at a Nairobi based hospital in Kenya, established that the male partners who turned up for voluntary counseling and testing (VCT) of HIV along with their female partners was also as low as fifteen percent (Farquhar *et al*, 2004). Despite the differences in the study methodologies used among these studies, the findings seems to suggest a close similarity on the level of involvement of the men in RH services in Tanzania and her neighboring countries of Kenya and Uganda.

The findings around Culture suggest that it is largely responsible for the study outcomes for both women and men. Since culture is a learned phenomenon, the men have been nurtured by their respective cultures to see women and children as inferior members of their community and hence the reluctance to be involved in the RH service mainly established for the same inferior lot. Again, some cultural practices like polygamy, division of labor and other gender roles (e.g. nomadic pastoralist among men) have played a big part as barriers for male involvement in RH because they withdrew the men away from their female partners. To the policy makers, MAP was developed on an assumption that culture and people's way of living is subject to change. However, the findings in this study highlights that changing the peoples' culture may not be a simple process as a lot of investment in education to the target communities, health personnel, service providers as well as the infrastructures is a must. The fact that the policy makers did not invest much in the cultural change is largely responsible to poor progress of MAP, and it calls for intervention to address the shortfalls.

Among the RH service providers, the failure to acknowledge the importance of culture and its implication on RH outcomes is a setback. Several cultural factors found to be preventing an equitable male involvement in the RH. The uniqueness of cultural roles related to the masculine gender and the sensitivity of the respect and recognition expected among the men needed some more consideration from the service providers. For example, in this study, both antenatal and postnatal care was culturally perceived as women's affair, yet MAP process expected the men to also accompany their wives or bring the children for postnatal care with little or no education to enlighten them about the need for this change. This was simply perceived as feminization of the masculine gender –which is not acceptable by the men. Elsewhere, various similar studies have been conducted in the similar field of MAP. For example, the study done among other tribes in Tanzania indicated that culturally, the attitude towards pregnancy and child birth is also perceived in the similar context as my study area, as men regard all pregnancy consultations as entirely women's affair (McIvor & Bassett, 1996). Similarly, in the neighboring country of Kenya, another study concluded that culturally, it is not acceptable for men accompany their partners to antenatal and postnatal care (Mullick, Kunene & Wanjiru, 2005). This perception might have influenced both by their culture as well as limited knowledge of RH, including the risks on pregnancy, STDs and HIV/AIDS. Across all cultures, it has been also established that men fear to loose control over their spouses and home as it is culturally and socially it is unacceptable for a man to be “too submissive” to a woman's demands. In addition, the communities do not hold in high esteem men who accompany their partners unnecessarily; they are perceived as weaklings,

lazy or plainly proud (Mullick, Kunene & Wanjiru, 2005). Unless these negative sentiments are addressed, their influence to the way they behave towards RH issues will not be tackled.

Socio-economic factors is yet another obstacle to the smooth involvement of men in RH and it stands out as a cross cutting factor. Factors like employment status, education level, lack money, time and infrastructures were discussed separately by the respondents as hindrances yet they are all ascend from the larger socio-economic aspect of life. For example, the role of men as bread winners and family financier is a socio-economic role, which makes them keep chasing the funds and in so doing, they missed the opportunity to support their spouses in seeking the RH care. Here in Tanzania, the evidence from other similar studies confirms the similar findings. The example is the study conducted in Dodoma, where social economic factors like education level, employment status and family income was established to be some of the factors which affected the male participation in RH (Lyatuu, Msamanga & Kalinga, 2008). Further still, the evidence from elsewhere, a study done in Uganda seem to comply with our study findings as the importance of education level and its influence to the male participation in RH has was found to be crucial among the respondents for the similar study (Bajunirwe & Muzoora, 2005).

Increased **access to information**, knowledge and awareness facilitates good choices. In our study men who had more knowledge about RH issues (mainly the urban, educated and working class) were more likely to get involved in RH services and in support to their female partners than their rural and uneducated counterparts who had not. The evidence from a similar study done in Mambwe district in Zambia further confirm that indeed the access to information and knowledge about the need and advantages of male involvement in RH (Tshibumbu, 2006).

The **structural set up** of the RH clinics was a source of frustration to men. To the respondents, the RH facilities and their RH service providers were not user-friendly for the male clients. The fact that some hospital staff are reported to be uncooperative to men whenever they turn up to the RH facilities either as clients or as companions was perceived as if the clinics are only set to handle women issues. It is possible that the reaction from the RH service providers was partly caused by lack of space for men (e.g. in labor wards) or failure to immediately incorporate the new policy of MAP into practice. However there is evidence from other similar studies that RH service providers are not user friendly to male clients. Examples have been observed in many studies in East Africa show that structural and attitudinal constraints at the individual, community and health-facility level are acting as barrier for men involvement in RH. For

example is the study done in Kenya, respondents mentioned rude health care staff as an obstacle to male participation in RH services (Reynolds & Kimani, 2006).

While it is true that overcrowding and limited physical space at health facilities are challenges, it is also pertinent that women and health providers (majority of whom are female) are concerned with issues of gender, social space and privacy which define the levels at which male partners are allowed to participate in RH. The men can therefore remain as victims of circumstance as both the service providers and the Government is mainly responsible for their inability to provide the suitable environment for their involvement. Although privacy is required in many aspects of MAP including the investigation, diagnosis and treatment of RH issues like HIV, STDs and infertility, disclosure of status among the partners should be negotiated by counselors if the benefits outweigh the disadvantages. As far as access to service and education is concerned, there is a pending need for service providers and the women to be educated about advantages of MAP and available opportunities. These findings are similar to another study which was conducted in Chipata in Zambia where it was established that men were not fully participating in RH programs mainly due to lack of information and lack of a direct access between the potential male client and the RH providing facilities (Benkele, 2007).

As a new discipline of medicine, male involvement in RH services is a new phenomenon in Africa as it has just been started recently. Similarly in Tanzania, many important stakeholders are not yet aware about its existence; which makes MAP a slow process of change with more time and resources required to make it a national reality. Elsewhere, the programs with the longest history demonstrate many similarities in their development from start-up to maturity. For example, the efforts to involve men in Developed countries began way back in late 1970s, but not much progress has been made over the past 20 years (Gordon & DeMarco 1984), though men are generally more welcome than they are in developing country RH clinics. Men's involvement and understanding of their role as equal partner in RH is likely to develop along with the maturation of the services throughout the country and Africa at large.

Funding opportunities for RH in the era of HIV:

In deciding how much funding to channel towards a particular disease, one important factor to consider is its severity levels in terms of its morbidity and mortality rates. Malaria kills over 1 million people every year, AIDS kills 2 million, and diarrhea causes the death of up to 6 million (NIAID Malaria Research Program, 2009). The numbers are even harsh when specifically children are considered, as they should be, given that

the fourth millennium development goal relates to child mortality. In Nigeria and Ethiopia, 237,000 people died from AIDS (Global HIV/AIDS estimates, 2008). Over twice that number of children under five died of pneumonia and diarrhea (Dugger, 2009). Researchers at the Johns Hopkins Bloomberg School of Public Health and the WHO estimate that 10.6 million children die before their fifth birthday worldwide. Diarrhea accounts for 17% of these deaths and malaria for 8%. In fact, diarrhea has been described as the leading cause of death for children. In contrast, AIDS caused the deaths of only 2.5% of these children (AIDS funding, 2009). It makes sense then, that based solely on the relative majority and fatality of the diseases at hand, that diseases such as malaria and diarrhea should receive at least as much fiscal attention as AIDS. This is not the case.

On resource allocation, United States of America - the most powerful and wealthy nation, through its International agency for Development assistance (USAID), in 2008 alone, is financial aid mostly in the form of direct bilateral donations to combat AIDS and HIV, constituted half of the world's funds allocated to this particular problem (UNAIDS, 2009). Again, of the USAID's total Health budget of \$4.15 billion, 24%, combined, is allocated to fighting infectious disease, child mortality and promoting maternal health. HIV/AIDS alone constitutes a 64% slice of the whole budget, which amounts to over 2.5 million dollars (USAID, 2009). This enormously disproportional resource allocation to HIV/AIDS talks by itself about the way the world has shifted attention from RH, child health and infectious diseases to concentrate on just one aspect of the whole package – that is HIV/AIDS. The programs have also had their own advantages and disadvantages in each country and some have been beneficial to RH too. For example, education on prevention, couple counseling and testing of HIV, care for affected and infected couples and supplies like condoms; did not only improve the general HIV/AIDS support, but also provided a great support to the greater male involvement in RH. Looking on the negative aspect of the of HIV scale up programs, the shift of attention observed is accounted by the fact that both the government of Tanzania and the donors provide more support to HIV/AIDS and disproportionately low resources to other important aspects of health care, including RH. At the policy level, some of the decisions including the decentralization (regionalization) of HIV/AIDS support activities in Tanzania, the reallocation of programs with dual support in RH and HIV/AIDS was done without a consideration to the RH part of the program. This took away both the human and financial resources originally meant for larger part of the country to rather smaller area of the country. Suffice to say, the broader negative effects of the HIV/AIDS scale up ranges from the policy to implementation levels, and its manifestation appears in the limited access to RH services.

8. CONCLUSION AND RECOMMENDATIONS:

8.1 CONCLUSION:

From this study, the results indicate that, men in Tanzania already participate in reproductive health services although in a low level when compared to their female counterparts. Similar to other areas of East Africa and elsewhere in the world, the level of male involvement in RH services in Arusha and Arumeru districts of Tanzania is low. Three main findings appear to contribute to the factors influencing the poor male involvement in RH at that study area including culture, social-economic factors, and health system issues.

In culture, the issues to do with gender inequality, perception and attitudes are the main were the contributing factors. On the other hand, the health system factors such as: health workers' attitude, client unfriendly environment, clinics designed for women, limited space and privacy were responsible influences. In addition, the socio-economic factors such as economic status, education level, employment status, and access to information were responsible for poor involvement of men in RH.

Some opportunities for MAP to grow exist as some health facilities are already putting it in practice. In addition, the consideration at the policy level, resource allocation and the greater male involvement in HIV/AIDS program, just to mention a few

Basing on these findings, I conclude that in order for the significant involvement of men in RH to take place in Tanzania, the Government and other stakeholders involved must put in consideration the various factors which influence the male involvement in RH including their culture, socio-economic status and the available health systems.

8.2 RECOMMENDATIONS;

In the ever-changing aspects of RH and its related challenges, Tanzanian society is increasingly able and willing to take on a Global perspective and strategy to tackle the concept of Male involvement in RH in accordance to the response to the millennium development goals and her actual RH needs at large.

However, some gaps exist in our national health care system including issues around coordination, resource allocation, infrastructure, access to educational information and little consideration to the culture and the social economic aspects of their surrounding communities.

Based on the above conclusions, the following recommendations have been made to highlight how the Tanzanian government and stakeholders including the NGOs and FBOs could more actively support male involvement in reproductive health.

- The Government should consider improving leadership, management and accountability to enable both joint monitoring and supervision and improve stakeholders' capacity building initiatives.
- Policy makers should include Male involvement in RH at policy level. A set of guiding principles needs to be developed to assist those involved in the health sector with mainstreaming male involvement into RH strategies. The MOHSW should take the lead in this process.
- The RH providing facilities should be better equipped with systems and infrastructures to provide quality and accessible services to both male and female clients. Respective DMOs should prioritize this in their basket fund budget.
- The men, communities and service providers should be educated on the multiple roles men can play as part of prevention and curative services of RH conditions if given the mandate to fully participate in RH issues. The RCHCOs in each region should have this in their work plans.
- Though it seems inappropriate by some women (and men) to involve their male partners while undergoing some sensitive procedures e.g. examination and delivery in labour wards, some couples will appreciate full involvement and facilities should endeavour that opportunity is provided to the couples in need. The MOHSW should ensure the availability of enough rooms in each hospital and include it at the policy level.
- Though still very sensitive, the issue of couple counselling for sexually transmitted diseases and HIV/AIDS should be more prioritized at any cost; as a measure to reduce new STD and HIV infection. NACP should include this in their policies.

- The mass media should be used more frequently and more effectively. Radio is widely accessible and can reach even highly mobile groups such as pastoralists, fishermen and the military. Television is hugely popular with the urban young. Both media are highly useful in conveying messages in a country with an illiteracy rate of 36 percent (UNDP/UNESCO, 2000), but the variations in access should be considered. The MOHSW and NGO providing RH services should implement this.
- Traditional role models, including community and religious leaders, should be promoted as peer educators and male involvement champions in all districts. The visible support of influential people in the community (most of whom are men) reportedly encourages people to perceive health programs as relevant and socially acceptable (KHANA, 2000). District welfare officers should be mandated by the MOHSW to supervise the implementation in their respective districts.
- Women should be educated on the aspects of women and gender rights to keep them abreast to their rights and encourage them to negotiate for safer sex and also better access to RH as individuals and also the couple in need. Ministry of gender and women affairs should supervise the implementation. Any measure that seeks to challenge gender roles must be introduced and implemented as sensitively and as appropriately as possible. e.g., men generally have negative attitude towards FP but they are also the protector and financial provider of families. So, educating men about the economic benefits of family planning might be more effective than attempting to persuade them to accompany women to family planning consultations purely on the basis of their responsibility as husbands and partners. NGOs and the ministry of education should promote this behavior change through education campaigns from the level of primary school to community level.

9. References:

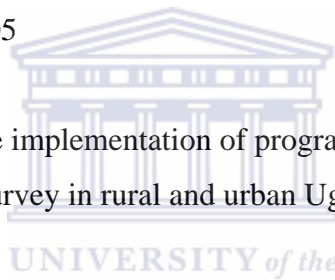
AIDS funding, 2009. *AIDS funding from national governments*. AVERT. November 19, 2009. <http://www.avert.org/aids-funding.htm>

Ali, M. Rizwan, H. Ushijima, H. (December 2004). Men and reproductive Health in rural Pakistan: The case for increased male participation. *European Journal of Contraception and Reproductive Health care*. 9(4): 260-66.9754471695

Anders, R. & Mattias, N. (2006), Tanzania: health sector policy overview. Stockholm Eute.

Armstrong, B. et al. (1999). Involving men in reproductive health: The young men's clinic. *American Journal of Public Health*,. 89(6):902–905

Bajunirwe F, Muzoora M: Barriers to the implementation of programs for the prevention of mother-to-child transmission of HIV: a cross-sectional survey in rural and urban Uganda. *AIDS Res Ther* 2005 , **2**:10



Barker, G. (2000). *Boys, men and HIV/AIDS*. Instituto Promundo, Rio de Janeiro, Brazil.

Barker, G. 2000. *What About Boys? A Literature Review on the Health and Development of Adolescent Boys*. Geneva: World Health Organization. Available from the Department of Child and Adolescent Health and Development, WHO. <http://www.who.int/child-adolescent-health>

Barker, G. (2005). *Young men and the construction of masculinity in Sub-Saharan Africa: Implications for HIV/AIDS, conflicts and violence*. World Bank. Social Development papers. Paper 26 :June 2006.

Beaufils, L. 2000. *Population Matters in Cambodia: A Study on Gender, Reproductive Health and Related Population Concerns in Cambodia*. Phnom Penh: UNFPA.

Benkele RG, 2007. *Male involvement and participation in prevention of mother to child transmission (PMTCT) of HIV/AIDS: the case of Chipata district*. In Bachelors. University of Zambia, Department of Nursing.

Berkman F., and Macintyre, S. (1997). "The Measurement of Social Class in Health Studies: Old Measures and New Formulations." In *Social Inequalities and Cancer*. eds. M. Kogevinas, N. Pearce, M. Susser, and P. Boffetta. Lyon: International Agency for Research on Cancer.

Bloom, S. Tsui, A. Plotkin, M. Bassett, S. (2000). What husbands in Northern India know about reproductive health: Correlates of knowledge about pregnancy and maternal and sexual health. *Journal of Biosocial Science*, (32): 237-251 Cambridge University Press

Bunce A, Guest G, Searing H, Frajzyngier V, Riwa P, Kanama J, Achwal I (.2007). Factors affecting vasectomy acceptability in Tanzania. *International family Planning Perspectives*.33(1), 13-21

Bustamante-Forest, R. Giarratano, G. (2004). Changing men's involvement in reproductive health and family Planning. *The nursing clinics of Northern America*. 39(2): 301-318

Byomire H:2003, *Prevalence and factors associated with male involvement in the prevention of mother-to-child transmission of HIV in Mulago Hospital*. Makerere University, Department of Medicine (Clinical Epidemiology Unit);

Cates, W. (1996). The dual goals of reproductive health. *Network*. 16(3): 3. Liege, Belgium.

Center for Reproductive Law and Policy(1998). *Report on women's reproductive rights in Tanzania*: crlp .New York.USA

Chikovore J, Lindmark G, Nyström L, Mbizvo MT, Ahlberg BM. The hide and seek game: men's perspectives on abortion and contraceptive use within marriage in a rural community in Zimbabwe. *J Biosoc Sci* 2002; 34: 317-32.

Coast, E. (2007) Wasting semen: context and condom use among the Maasai. *Culture, health and sexuality*, 9 (4). pp. 387-401. ISSN 1369-1058

Coreil, J. (1995). Group interview methods in community health research. *Medical Anthropology*, **16**: 193-210.

Creswell, J.W. & Miller, D. L. (2000). Determining validity in qualitative inquiry: Theory into practice.39 (3): 122-130

Danforth N, Roberts P. (1997). *Better Together: A Report on the African Regional Conference on Men's Participation in Reproductive Health*. Baltimore: Johns Hopkins Center for Communication Programs.

Dugger, C. 2009. *As Donors Focus on AIDS, Child Illnesses Languish*. New York Times. October 29, 2009. http://www.nytimes.com/2009/10/30/world/30child.html?_r=2&scp=1&sq=AIDS childhood mortality&st=cse

Dyer, J. Abrahams, N. Mokoena, N. & Van der Spuy, Z. (1996) 'You are a man because you have children': experiences, reproductive health knowledge and treatment-seeking behaviour among men suffering from couple infertility in South

Farquhar C, Kiarie JN, Richardson BA, Kabura MN, John FN, Nduati RW, Mbori-Ngacha DA, John-Stewart GC, (2004). Antenatal couple counseling increases uptake of interventions to prevent HIV-1 transmission. *J Acquir Immune Defic Syndr*, **37**:1620-1626.

Foreit JR, Garate MR, Brazzoduro A, Guillen F, Herrera MC, Suarez FC, 1992. "A comparison of the performance of male and female CBD distributors in Peru" *Studies in Family Planning Journal* .Jan-Feb;23(1):58-62.

Fryer, D. (1991). Qualitative methods in occupational psychology: Reflections upon why they are so useful but so little used. *The Occupational Psychologist*, *14* (Special issue on qualitative methods), 3-6.

Gordon, Philippa H., and Laurie J. DeMarco. 1984. "Reproductive Health Services for Men: Is There a Need?" *Family Planning Perspectives* Volume 16(1), January/February: 44-46, 49.

Gorgen, R., M. Yansane, M. Marx, and D. Millimounou. 1998. "Sexual behaviors and attitudes among unmarried youths in Guinea," in *International Family Planning Perspectives* 24, no. 2: 65-71.

Global HIV/AIDS estimates." AVERT. January, 2008. <http://www.avert.org/worldstats.htm>

Greene, M., & Biddlecom, A. 1997. "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles." Population Council Research Division Working Paper No. 103.

Haram, L (2005). AIDS and risk: The handling of uncertainty in Northern Tanzania. *The journal of Health, culture and sexuality* 7(1):1-11. [Available]: Online; <http://www.jstor.org/pss/4005459>

Hawley, J. (1993). Sati: The blessing and the curse: the burning of wives in India. New York: Oxford University Press.

Irvin A, (2000). *Taking Steps of Courage: Teaching Adolescents about Sexuality and Gender in Nigeria and Cameroon*. New York: International Women's Health Coalition.

Kabeer, N.(2003). Gender mainstreaming in poverty eradication and the Millennium Development Goals: a handbook for policy-makers and other stakeholders. London, Commonwealth Secretariat.

KHANA. 2000. *Integrating Care and Support into HIV/AIDS Prevention Projects. Report on Participatory Project Reviews and Re-Design Conducted by KHANA Partner NGOs in 2000*. Phnom Penh: KHANA.

Kirk, J., & Miller, M.L. (1986). *Reliability and validity in qualitative research. Qualitative Research Methods Series, 1*. Beverly Hills, CA: Sage Publications.

Kitzinger, J. (1993). Qualitative research: Introducing focus groups. *British Medical Journal*, **311**:299-302.

Leahy, E. Druce, N, Akitobi,E. Hardee, K.& Vogel,C (2009). "A case study of reproductive health supplies in Tanzania" Population action international. Available Online: http://www.populationaction.org/Publications/Reports/Reproductive_Health_Supplies_in_Six_Countries/Tanzania.pdf

Liamphuttong, P.R. & Ezzy, D. (2005a). Ch 3-In-depth interviews. In *Qualitative Research Methods*. Sydney; Oxford University Press: 54-74

Lincoln, Y. & Guba, E. (1985). *Naturalistic Inquiry*. California: Sage publications

Lyatuu MB, Msamanga G, Kalinga AK,. Client's satisfaction with services for prevention of mother to child transmission of HIV in Dodoma rural district. *East Afr J Public Health* 2008 , **5**:174-179

Holloway, I. & Wheeler, S. (1996). Ch 12-The search for truth in qualitative research. In *Qualitative Research for Nurses*. Blackwell Science. Oxford: 162-185.

Peacock, D. Levack, A .(2004) The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and Reproductive Health. *International Journal of Men's Health*. 3(3), 173-188.

Porche DJ, Willis DG. 2004. "Nursing and men's health movement: considerations for the 21st century" *The nursing clinics of North America journal*. Jun;39(2):251-8.

Mack, N., Woodson, C., MacQueen, K.M., Guest, G & Namey, E. (2005). Qualitative research methods: a data collector's field guide. *Family health International*. [Online], Available: <http://www.search.fhi.org>

Marsiglio, W. 1988. "Adolescent male sexuality and heterosexual masculinity: A conceptual model and review," in *Journal of Adolescent Research* 3, nos. 3-4: 285-303.

Mbizvo, M. Bassett,M. (1996). Reproductive health and AIDS prevention in Sub Saharan Africa: the case of increased male participation .*Journal of health policy and planning*; 11(1):84-92.

Mead. S, (2006). Education sectors; research and Report: The truth about boys and girls. [Available]; Online ; http://www.educationsector.org/research/research_show.htm?doc_id=378705.

Miles, M. Huberman, M. (1994) *Qualitative Data Analysis: an expanded sourcebook*. London, Beverley Hills.

Miller,K. (December 2006.) Women in Africa. *Quazen* [Available]; Online: <http://www.quazen.com/Regional/Africa/Women-in-Africa.11289>.

Morgan, G., & Smircich, L. (1980). The case for qualitative research. *Academy of Management Review*, 5, 491-500.

Msuya, S. Mbizyo, E. Hussain, A. Uriyo, J. Sam, N. & Stray-Pedersen, B. (2004). HIV among pregnant women in Moshi Tanzania: The role of sexual behaviour, male partner characteristics and sexually transmitted infections. *Journal of Acquired Immune Deficiency Syndrome*. 2006 43(1): 85 -90.

Mullick S, Kunene B, Wanjiru M, (2005). Involving men in maternity care: health service delivery issues. *Agenda Special Focus*.

Mundigo, Axel I. 1995. "Men's Roles, Sexuality and Reproductive Health." International Lecture Series on Population Issues. Chicago, IL: The John D. & Catherine T. MacArthur Foundation.

Mwageni, A. Ankamah, A. Powell, A. (1998). Attitudes of men towards family planning in Mbeya region, Tanzania: a rural-urban comparison of qualitative data. *Journal of Biosocial Science*. 30(3):381-92.

National Bureau of Statistics (NBS) [Tanzania] and ORC Macro. 2005. *Tanzania Demographic and Health Survey 2004-05*. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro

National Population and housing census, 2002, United Republic of Tanzania. [Available], Online: <http://www.tanzania.go.tz/census/districts/arumeru.htm>

Necchi, S. and M. Schufer. 1998. *Adolescente Varón: Iniciación Sexual y Conducta Reproductiva*. [The adolescent male: Sexual initiation and reproductive behavior.] Buenos Aires, Argentina: Programa de Adolescencia, Hospital de Clínicas, Universidad de Buenos Aires/OMS/CONICET

NIAID Malaria Research Program, 2009. *National Institute of Allergy and Infectious Disease*. October 30, 2009. <http://www3.niaid.nih.gov/topics/Malaria/>

Nnko, S (2000). *Risk Behaviors of Male Adolescents in Tanzania: Motives and Patterns of Their Sexual Relationship*. Paper presented at the WHO/UNAIDS Afro Regional Meeting in Pretoria, South Africa (27–29 September 2000).

Oinyaku ,S. (2002); International Conference on AIDS. Using cultural leaders and parents as peer educators for HIV prevention among the rural maasai youth of Kenya. *Int Conf AIDS*. 2002 Jul 7-12; 14: abstract no. WePeD6334

Oldenburg, V. (1993). Dowry Murders in India: A Preliminary Examination of the historical evidence," In *Women's lives and public policy: the international experience*. Meredith, T & Briavel, H (Ed). Westport, Conn.: Praeger.

Pachauri, S. (2001). Male involvement in Reproductive health care. *Journal of Indian Medical Association*; 99(3): 138-41.

Patton, M Q. (1980). *Qualitative evaluation methods*. Newbury Park, CA: Sage.

Patykewich, L. Tien,M. Mielke ,E. & Rosche, T (2007). *Tanzania: Contraceptive Security Assessment*. Arlington, VA: USAID | DELIVER Project and New York: The ACQUIRE Project

Pile, J & Simbakalia, C. (2006). *Repositioning Family Planning—Tanzania Case Study: A Successful Program Loses Momentum*. New York: EngenderHealth/The, ACQUIRE Project

Report on the First Conference of French-Speaking African Countries on Men's Participation in Reproductive Health. (1994). *Men: Key Partners in Reproductive Health*. Johns Hopkins University Center for Communication Programs, Baltimore, MD.

Reynolds HW, Kimani J: Services for prevention of mother to child transmission (PMTCT). In *YouthNet Briefs. Volume 12*. Arlington, VA: USAID; 2006

Robey, B. Drennan, M. (1998). Male participation in reproductive health. *Network*; 18(3): 11-15

Sandelowski, M. (1983). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3):27-37

Setel P, (1999). *A Plague of Paradoxes: AIDS, Culture and Demography in Northern Tanzania*, Chicago: University of Chicago Press, 1999

Shelton, J, (1999). Prevention First: A Three-Pronged Strategy To Integrate Family Planning Program Efforts Against HIV and Sexually Transmitted Infections *.International Family Planning Perspectives* 3(25) September 1999 [Available]; Online: <http://www.guttmacher.org/pubs/journals/2514799.html> [16.06.07 06:12Pm]

Singh, K Blom, S. Tsui, A (1998). Husband's Reproductive health knowledge, attitudes, and behaviour in Uttar Pradesh, India. 29(4): 388-99.

Singh, Susheela, Deirdre Wulf, Renee Samara, and Yvette P. Cuca. 2000. "Gender differences in the timing of first intercourse: Data from 14 countries," in *International Family Planning Perspectives* 26, no.1:21-8, 43.

Silberschmidt, M. Rasch, V. (June 2001). Adolescent Girls, illegal abortions and "Sugar daddies" in Dar es Salaam: Vulnerable victims and active social agents. *Social Science Medical Journal*, 52(12):1815-26.

Snegroff, C. (1998). Female circumcision in Maasai culture in Tanzania. Tanzania Wildlife society. Arusha , Tanzania

Stibbard, T, Robertson, Noormahomed, N. Report on Men, HIV & AIDS regional conference. 2003. VSO-RAISA

The marriage act, 1971. Tanzanian Law of Marriage Act. [Available]: Online <http://www.parliament.go.tz/Polis/PAMS/Docs/5-1971.pdf> . (29.05.07 06:18 pm).

Thomas, A. (1998). Introduction, Investigative Skills for Policy Development. In Thomas et al (Eds) *Finding Out Fast*. Open University, Walton Hall, Milton Keynes MK7 6AA

Ting-Toomey, S. (1984). Qualitative research: An overview. In W.B. Gudykunst, & Y.Y. Kim (Eds.), *Methods for intercultural communication research* (pp. 169-184). Beverly Hills, CA: Sage Publications.

Tshibumbu D, 2006. *Factors influencing men's involvement in prevention of mother-to-child transmission (PMTCT) of HIV programmes in Mambwe district, Zambia*. University of South Africa (UNISA).

Wanjohi, G, (2009), African Marriage, past and present, [Available]: Online,
<http://www.crvp.org/book/Series02/II-10/chapter-5.htm>. (13.05.09 08:30 Am)

Walston, N. 2005a. Cambodia: Family Planning Programmes and HIV/AIDS Services, Results of Focus Group Discussions. Phnom Penh: POLICY Project/Cambodia; Washington, DC: Futures Group.

Walston, N. 2005b, Challenges and opportunities for male involvement in Reproductive Health in Cambodia. [Available]; Online:
http://docs.google.com/gview?a=v&q=cache:S8mOzy1KI6kJ:www.policyproject.com/pubs/countryreports/MaleInvolv_Cam.pd (15.04.09 10:30 Am)

WHO, (1994). International conference on population and development. Cairo, Egypt.

UNAIDS, 2009. *Report on funding for AIDS by G8 countries and other major donors.* Kaiser Family Foundation & UNAIDS. July, 13, 2009. http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090708_kaiser_G8.asp

UNDP/UNESCO. 2000. *Report on the Assessment of the Functional Literacy Levels of the Adult Population in Cambodia*. Phnom Penh: UNDP, UNESCO

United Nations, (1995a). *Women: Looking Beyond 2000*, New York, USA

United Nations (1995b). *The World's Women: Trends and Statistics*, , New York, 1995

UNFPA, (2000). *The state of the World population. Gender and Reproductive Health*.

UNFPA, (2006). State of world population. UN International Conference on Population and Development, 1994. Network: spring 1998,18(3)

UNHCR, (2004). Economic and social council: Annual report of the special rapporteur on right to education. [Available]. Online: <http://www.righttoeducation.org/content/unreports/unreport12prt1.html#top> (19.05.07. 02:52)

USAID, 2009. “*Funding.*” USAID. November 20, 2009. http://www.usaid.gov/our_work/global_health/pop/funding/index.html

US Bureau Human Rights, and Labor (2007). Country Reports on Human Rights Practices in Tanzania – 2006. [Available], Online: <http://www.state.gov/g/drl/rls/hrrpt/2006/78761.htm> (20.05.2007 07:12pm)



10. Appendices

Annex 1: Participant Information Sheet



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592809, Fax: 27 21-959-2872

<http://www.soph.uwc.ac.za>

TITLE OF RESEARCH: Factors influencing men's involvement in reproductive health in Arusha and Arumeru districts, Tanzania

Dear Participant,

The research is being conducted for a mini-thesis by Paul Z. Mmbando. This is a requirement for a Masters degree in Public Health which I am completing at the University of the Western Cape. The purpose of this study is to identify and describe factors that influence the male involvement in Reproductive Health in Tanzania, as well as the challenges, knowledge, attitudes, perceptions and needs which shape their reluctance to participate in RH as individual clients, husbands, spouses or fathers. It is hoped that with your participation, a better understanding will be gained of the reasons for the poor involvement of men in RH issues in Tanzania. This study will be useful in providing relevant recommendations to the concerned stakeholders for the future improvement and promotion of RH in Tanzania.

If you agree to participate you will be asked to be part of a Focus Group Discussion with other men and/or an individual interview will be done with you. Interviews will be conducted with key people involved in leadership, coordination and advocacy role in RH issues. Questions about your experiences on the issues of men involvement in RH in Tanzania will guide the discussion and/or the interview that I will have with you.

Your name will be kept confidential at all times. I shall keep all records of your participation, including a signed consent form (which I will need from you should you agree to participate in this research study), locked away at all times and will destroy them after the research is completed. Your participation in this research is entirely voluntary, and if you choose to participate, you may stop at any time. You may also choose not to answer particular questions that are asked in the study. If there is anything you would prefer not to discuss, please feel free to say so.

You may not get any direct benefits from this study. However, the information we learn from participants in this study may help in guiding the service providers, the policy makers, NGOs, the men and the community at large on how to build better functioning RH services in Tanzania. There are no costs for participating in this study other than the time spent in the Focus Group Discussion and/ or interviews.

Your signed consent to participate in this study is required before I proceed to interview you. I have included the consent form with this information sheet so that you will be able to review it and then decide whether you will be able to participate in this study or not.

Should you have further questions or wish to know more, I can be contacted through the following address:

Dr Paul Z. Mmbando

Evangelical Lutheran Church in Tanzania

P.O.Box 3033

Telephone: +255 784 666165

Arusha, Tanzania



My supervisor is Dr Thubelihle Mathole of the School of Public Health, University of the Western Cape.

She can be reached using the following contacts;

Dr Thubelihle Mathole

University of the Western Cape

Private Bag X17, Belville 7535

Email: tmathole@uwc.ac.za

Telephone: (021)959-9384



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Ndugu Mshiriki,

Asante kwa utayari wako wa kushiriki katika utafiti huu. Yafuatayo ni maelezo yahusuyo jinsi utafiti huu utakavyofanyikwa ajili yako ikiwa utapendelea kushiriki. Utafiti huu unafanywa kama sehemu ya kukamilisha shahada yangu ya uzamili katika afya ya jamii, ambayo ninamalizia katika cguo kikuu cha Western cape huko Afrika ya Kusini. Tafadhali tumia anwani yangu hapo chini ikiwa kuna kitu chochote usichoelewa/ungehitaji maelezo zaidi kuhusiana na utafiti.

Ushirikishwaji wa akina baba katika afya ya Uzazi: Mbinu za kuwashirikisha wanaume wa Tanzania. Utafiti huu unafanywa ili kugundua na kuanisha mambo yanayochangia ushawishi wa wanaume kushiriki katika maswala mbalimbali ya afya ya uzazi, ikiwa ni pamoja na afya changamoto, elimu, upeo, tabia na mahitaji mbalimbali ambayo yanachangia wanaume kutokushiriki katika afya ya uzazi kama wateja, wanandoa, wenzi, au wazazi. Inaaminika kuwa kwa ushauri wako, uelewa mzuri zaidi wa mambo yanayochangia kuzorota kwa afya ya uzazi hapa nchini Tanzania utapatikana. Hii itawezesha kupatikana kwa suluhisho la tatizo hilo na hivyo kuboreshwa kwa huduma za afya ya uzazi yapa Tanzania.

Utafiti huu utashirikisha vikundi vya majadiliano pamoja na mahojiano ya na wanaume au wadau muhimu wa afya ya uzazi katika sehemu husika katika utawala, uratibu na utetezi wa afya ya uzazi. Maswali yahusuyo uelewa wako wa uhusishwaji wa akina baba katika afya ya uzazi hapa Tanzania yataulizwa.

Wakati wowote, ushiriki wako katika utafiti na Jina lako havitatajwa. Fomu yako ya makubaliano ya kushiriki katika utafiti huu itahifadhiwa wakati wote na kuharibiwa pindi utafiti huu utakapokwisha. Ushiriki wako katika utafiti huu ni wa hiari, na kama ukiabadilisha mawazo wakati wowote waweza kujitoa.

Unaweza kuchagua kutokujibu baadhi ya maswali pia ikiwa utachagua kufanya hivyo. Na kama kuna jambo usilopenda kujadili katika utafiti huu uwe huru kufanya hivyo.

Hakuna faida ya moja kwa moja ambayo mshiriki atapata kwa kujihusisha na utafiti huu.,Ingawa maelezo utakayotoa yaweza kusaidia katika kuboresha huduma za afya ya uzazi kwa jamii, wanaume na taasisi mbalimbali zinazojihusisha na afya ya uzazi hapa Tanzania. Hakuna gharama utakazoingia kwa kushiriki zaidi ya muda wako.

Hati hii itahitajika kabla kabla sijaanza kukuhoji. Nimeweka fomu yenye maelezo ya hati hii ili uweze kurejea yaliyomo kabla ya kuamua kushiriki au vinginevyo.

Ikiwa utakuwa na maswali yeyote, usisite kuwasiliana nami kupitia anwani ifuatayo:

Dr Paul Z. Mbandoo

Kanisa la Kiinjili la Kilutheri Tanzania (KKKT)

S.L.P 3033

Simu: +255 784 666165

Arusha ,Tanzania



Msimamizi wangu ni Dk. Thubelihle Mathole wa Shule ya Afya ya Jamii ya Chuo Kikuu cha Western Cape. Anaweza kupatikana kwa kutumia anwani ifuatayo.

Dr Thubelihle Mathole

University of the Western Cape

Private Bag X17, Belville 7535

Email: tmathole@uwc.ac.za

Telephone: (021)959-9384

Annex 2: Consent Form



1.1

UNIVERSITY OF THE WESTERN CAPE

1.2

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-959-2872
<http://www.soph.uwc.ac.za>

TITLE OF RESEARCH: Factors influencing men’s involvement in reproductive health in Arusha and Arumeru districts, Tanzania

As was mentioned in participant Information sheet, your participation in this research is entirely voluntary. Refusal to participate or withdrawal from the study will not result in penalty nor any loss of benefits to which you are otherwise entitled.

If you choose to participate, you may stop at any time. You may also choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so. The information collected in this interview will be kept strictly confidential. If you choose to participate in this research study, your signed consent is required before I proceed with the interview with you

I have read the information about this research study on the participant information sheet, or it has been read to me. I have had an opportunity to ask questions about it, and all the question I asked, have been answered to my satisfaction. I consent voluntarily to be participant in this project and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study. By signing this consent form, I declare that I am willing to participate in this study.

Participant Name (Printed)

Participant Signature..... Consent Date

Name of the Researcher (Printed).....

Researcher’s SignatureConsent Date



1.3

UNIVERSITY OF THE WESTERN CAPE

1.4

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-959-2872
<http://www.soph.uwc.ac.za>

JINA LA UTAFITI: *Ushirikishwaji wa wanaume katika afya ya uzazi: Mbinu za kuwahusishwa wanaume wa Tanzania.*

Kama ilivyoelezwa awali katika fomu ya maelezo ya mshiriki, Ushiriki wako katika utafiti huu ni wa hiari na waweza kujitoa ikiwa utaamua hivyo, na hakuna hasara yeyote utapata kwa kujitoa.

Na kama utaamua kushiriki, waweza kujitoa saa yeyoye. Waweza pia kuchagua kutokujibu baadhi ya maswali, au kutojadili baadhi ya mada za utafiti huu.

Maelezo yako yote yatahifadhiwa kwa usiri mkubwa na pia hati yako ya kukubali kushiriki itahifadhiwa mpaka mwisho wa utafiti na hatimaye kuharibiwa.....

Nimesoma/nimesomewa maelezo yote na kuyaelewa. Nimeuliza maswali na majibu yote niliyopewa ni ya kurishisha.

Kwa kusaini Hati hii, ninakubali kwa ridhaa yangu mimi mwenyewe kuwa mshiriki katika utafiti huu. Nina haki ya kujitoa wakati wowote, ikiwa ni pamoja na haki ya kukataa kujibu baadhi ya maswali au kushiriki katika baadhi ya mijadala katika utafiti huu.

Kwa kusaini hati hii, ninaahidi kuwa nimeridhia kushiriki katika utafiti huu.

Jina la Mshiriki

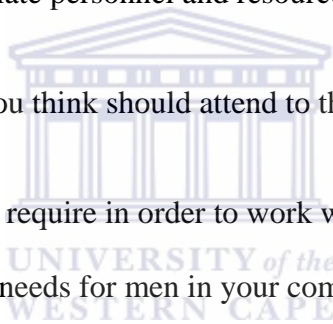
Saini ya Mshiriki.....Tarehe

Jina la Mtafiti.....

Saini ya Mtafiti

ANNEX 3: The Guidelines for the Focus Group discussion

1. What is your understanding of the term ‘Men as partners in Reproductive Health?’
2. What are the perceived challenges for involving the men in RH in Tanzania?
3. In your opinion, who are the main coordinating bodies/players/stakeholders as far as Men involvement in RH are concerned
4. In your opinion, what kind of reproductive health services for men exist in these district health facilities?
5. What do you think about the way men in this district have been involved in RH matters?
6. What do you think the process has achieved in improving men’s health?
7. In your opinion, what is the relationship between culture and RH for men in your community?
8. Does the health facility have appropriate personnel and resources to support the men as partners in RH? And why do you think so?
9. As far as RH is concerned, who do you think should attend to the RH clinics/facilities services between women and men, and why?
10. What resources will your community require in order to work with men in the field of RH?
11. What do you think are the major RH needs for men in your community/district?
12. How well do the services being offered by the district RH facilities complement men’s needs in RH?
13. What do you think should be done (by who) in order to improve the male involvement in RH from the current state



Annex 4. Male Involvement Questionnaire for Key informant Interviews

A. The Challenge/Issue

1. What do you think the term “male involvement” in reproductive health means?
2. What are the issues of male involvement in reproductive health in Tanzania?
3. Describe the Ministries, Agencies or Groups that have been specifically supporting male involvement in reproductive health and what issues are they focused on.
4. What opposition has there been to male involvement in reproductive health?

B. Background on Organizations’ Current Male Involvement Work

5. Please describe briefly your organization’s work in reproductive health (including family planning, maternal health, STI prevention, diagnosis and treatment, and HIV/AIDS).
6. Who are the beneficiaries of your organization?
7. As far as RH is concerned, please describe any activities in your organization that men are involved either as direct clients or partners or spouses.
8. With reasons, please explain what are your future plans to work with men in your reproductive health programs?
9. Besides your beneficiaries, in what other ways does your organization have contact with men? (e.g., as service providers, policymakers, program managers, or community leaders). Please describe.
10. How do the women beneficiaries of your RH programs want men to be more involved?

C. Possible Areas in Which to Expand Work with Men

11. In your own views, why would any organization prefer to work with men in reproductive health?
12. In what additional ways would you like men to be involved in your reproductive health programs?
13. What would make it easier to work more extensively with men?
14. If there were guidelines on working with men in reproductive health, How do you think your organization could benefit.

D. Overall Benefits and Challenges

15. What are the benefits of working with men?
16. What are the difficulties of working with men?

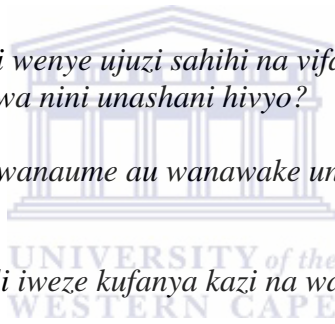
E. Policies, Laws, and Regulations and the Development of Guidelines

17. In your experience, please describe any policies, laws, or regulations that are related to male involvement in reproductive health? If so, which ones?
18. Describe any policies, laws, or regulations (if any,) that could make it more difficult to involve men in reproductive health.
19. What are the aspects of the Tanzanian culture that you think could be a barrier to male involvement in reproductive health? How do you think these could be overcome?
20. What do you see as the most important components of a program that works with men in reproductive health?
21. Which sources/resources do you look for guidance on working with men in reproductive health?

ANNEX 3: (Kiswahili Version)

Muongozo wa kikundi cha majadiliano (KCM)

1. *Unaelewa nini kuhusu neon “wanaume kama wadau wa afya ya uzazi” ?’*
2. *Kwa maoni yako, ni nani ni wadau wakuu wa uhusishwaji wa wanaume katika afya ya uzazi?*
3. *Kwa maoni yako, ni huduma gain za afya ya uzazi zinapatikana kwa ajili ya wanaume katika vituo vya afya vilivyopo katika wilaya hii?*
4. *Nini maoni yako kuhusiana na jinsi wanaume wanavyohusishwa katika afya ya uzazi katika wilaya hii?*
5. *Kwa maoni yako, mchakato huu umefanikiwa kiviipi katika kuboresha afya ya akina akina baba?*
6. *Kwa maoni yako, kuna uhusiano gain kati ya mila/utamaduni na afya ya uzazi kwa wanaume katika jamii unamoishio?*
7. *Je, Vituo vya afya vina watumishi wenye ujuzi sahihi na vifaa vya kuwawezesha wakina baba kama wadau wa afya ya uzazi? Na ni kwa nini unashani hivyo?*
8. *Kwa maoni yako, ni nani kati ya wanaume au wanawake unadhani wanastahili kuhudhuria kliniki za afya ya uzazi? Kwa nini?*
9. *Ni vitu gain jamii yako itahitaji ili iweze kufanya kazi na wanaume katika maswala ya afya ya uzazi?*
10. *Ni mahitaji gani makubwa ya afya ya uzazi ambayo unadhani wanaume katika jamii/wilaya yako wanayahitaji?*
11. *Kwa kiasi gani unadhani huduma za afya ya uzazi zinazotolewa na wilaya yako zinakidhi mahitaji ya wanaume?*
12. *NI kitu gain kifamywe (na nani) ili kuboresha uhusishwaji wa wanaume katika afya ya uzazikuliko ilivyo sasa?*



Annex C. Kiswahili Version)

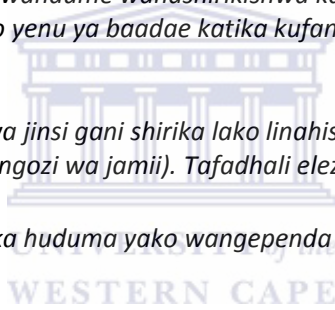
Dodoso kwa ajili ya washiriki teule

A. Changamoto

1. Kwa maoni yako, ni nini maana ya neon “uhushishwaji wanaume” katika afya ya uzazi?
2. Kuna changamoto zipi katika uhusishwaji wa wanaume katika afya ya uzazi hapa Tanzania?
3. Taja Wizara, mashirika, au vikundi ambavyo vinajishughulisha na uhusishwaji wa wanaume katika maswala ya afya ya uzazi na ni maswala gani wanalenga hasa?
4. Kume kuwa na pingamizi gani katika kuwahusisha wanaume katika afya ya uzazi?

B. Ushiriki wa mashirika katika kazi za uhusishwaji wa wanaume

5. Tafadhali elezea kwa kifupi kuhusu kazi za shirika/jumuia yako katika afya ya uzazi (ikiwa ni pamoja na uzazi wa mpango, afya ya mama, kuzuia magonjwa ya zinaa, upimaji na tiba ya VVU/UKIMWI).
6. Ni nani walengwa katika shirika lako?
7. Ni huduma gani katika shirika lako ambazo wanaume wanashirikishwa kama wateja, wapenzi au wanandoa?
8. Ukitoa na sababu, tafadhali elezea mipango yenu ya baadae katika kufanya kazi na wanaume katika huduma za afya ya uzazi?
9. Mbali na walengwa wa huduma zenu, ni kwa jinsi gani shirika lako linahisiana/wasiliana na wanaume (kwa watoa huduma, wanasiasa, watawala wa miradi, viongozi wa jamii). Tafadhali eleze.
10. Ni kwa jinsi gani wanawake washiriki katika huduma yako wangependa wanaume washirikishwe?



C. Njia za kuongeza ushirikishwaji wa wanaume

11. Kwa maoni yako, ni sababu zipi zingefanya mashirika yapendelee kufanya kazi ya kuwahusisha wanaume katika afya ya uzazi?
12. Ni kwa njia zipi za ziada ambazo ungependa wanaume washirikishwa katika afya ya uzazi?
13. Ni kitu gani kingerahisisha upanuzi wa kufanya kazi ya kuwashirikisha wanaume katika afya ya uzazi?
14. Kama kungelikuwa na masharti na mipangilio ya kufanya kazi ya ushirikishwaji wa wanaume katika afya ya uzazi, unadhani shirika lako lingefaikika kiviipi?

D. Mafanikio na changamoto za ujumla

15. Kuna faida gani katika kuwashirikisha wanaume katika afya ya uzazi?
16. Kuna changamoto zipi katika kuwashirikisha wanaume katika afya ya uzazi?

E. Sera, sheria, mipangilio na maendeleo ya Uratibu

17. Kwa kutumia ujuzi wako, tafadhali fafanua sera, sheria au mipangilio inayohusiana na uhusishwaji wa wanaume? Kama zipi, zitaje?
18. Fafanua, sera, sheria, au taratibu (kama zipo) ambazo zifanya ushirikishwaji wa wanaume kuwa mgumu.
19. Ni vipengele vipi vya mila za Tanzania zinazoweza kuwa kizuizi cha ushirikishwaji wa wanaume katika afya ya uzazi? Ni jinsi gani twaweza kujikwamua kutokana na hilo?
20. Ni kipengele gani cha program yako ambacho unaona ni cha muhimu zaidi katika ushirikishwaji wa wanaume?
21. Ni vyanzo/vyombo gani huwa unatazamia kutafuta ushauri katika kufanya kazi ya ushirikishwaji wa wanaume?