**Men As Equal Partners In Reproductive Health: What Are Their Own Perception And Roles? A Case Of Tanzania**

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## Abstract

Since the 1994 International Conference on Population and Development (ICPD) in Cairo (1994) and the 1995 Fourth World Conference on Women in Beijing there has been an increasing consensus on the importance of involving men in reproductive health care. The paper analysed male perception of involvement in reproductive health. Findings show that age, educational attainment and religion are associated with men perceptions on involvement in reproductive health. Results indicate that although generally men perceive that they are the ones to make decisions and hence not equal partner in reproductive health, a small proportion perceive that decision making should be done by the couple. Furthermore, some of the respondents indicated willingness and interest to be equal partners in reproductive health. Seventy percent of all the respondents said they are willing to be involved in reproductive health, while only 30 percent said no. Reasons given by those unwilling to participate included limited time to be involved, its women's responsibilities assisted by domestic workers (commonly known in Tanzania as *house girls*) and women are the ones to ensure they are in good health for conception and delivery. It can be argued that argued that generalization should be avoided and that some men are indeed interested and willing to be part of the reproductive health issues as equal partners.

The paper informed and broadened our understanding of men's own perception in reproductive health. The knowledge of men's own perception is critical for both pragmatic and policy interventions.

## 1. Introduction and background

For a long time male involvement in issues of family planning and reproductive health has been neglected. International family planning and reproductive health at the time were focusing almost exclusively on women (Green, 1998). Men were mostly involved in instances where there was a need to diagnose and treat sexually transmitted diseases (Mbizvo et al., 1996). However, since the 1994 International Conference on Population and Development (ICPD) in Cairo (1994) and the 1995 Fourth World Conference on Women in Beijing there has been an increasing consensus on the importance of involving men in reproductive health care. Countries which signed the ICPD Programme of Action agreed that it is important for men to be involved and take more responsibility of their sexual and reproductive health. The Programme of Action therefore endorsed and emphasized the need for gender equity with special focus on male's involvement in sexual and reproductive health. The argument is that when men are involved in reproductive health services and regarded as equal partners as well as clients in their own rights, better outcomes in reproductive health would be realized (Pachauri, 2001). In other words, it is widely recognized that global and national efforts aimed at achieving improved reproductive health indicators cannot be realized without male involvement. Against this understanding, in more recent years, many family planning and other reproductive health programme have become interested in involving men in reproductive health.

Currently there is consensus on the importance of male involvement in reproductive health. As a result global and national efforts have been made to realize meaningful and effective male involvement in reproductive health. A vast majority of literature points to not only the importance of male involvement in reproductive health but also challenges and opportunities to their engagements (Helzner, 1996; Karra *et al.,* 1997; Ijadunola et al., 2010; Onyango *et al.,* 2010; Kululanga& Sundby, 2012) Literature documented various barriers to male involvement in reproductive health such as male dominance, low social and economic status of women, low women self esteem and lack of communication between partners (Donta *et. al.,* 2005). Furthermore, in many societies men play a masculinity role and traditionally are not involved in parenting. This, coupled with poor knowledge, contributes significantly to men's reluctance in seeking reproduction health information and services, limiting their meaningful involvement.

Stereotype thinking of the reproductive health clients also contributes to male's poor involvement in reproductive health issues. Furthermore, in most African societies males are expected to constantly prove their manhood through sexual activity. These include having more than one partner and being the main decision makers even in matters that can highly impact women. Masculinity norms influence men's sexual and reproductive health behavior and attitudes. For instance men's virility is measured by sexual conquests and number of children. Sexual initiation also begins earlier for males than females. Literature informs that in the patriarchal culture, husbands have the authority to make decisions for their wives, including the use of contraceptives, when to have a child, when and how often to visit health facilities (Balaiah *et al.,* 1999; Sharma, 2002).

Other factors are on service providers. Ndong *et. al.,* (1999) noted that there is a general assumption among program planners of the criteria for clients who pursue reproductive health care. The assumption is that the client is a married woman, in a stable monogamy relationship with an equal voice in reproductive health matters (*ibid*). They argued that holding such assumption places the entire burden of reproductive health issues on women. It should be noted that issues of reproductive health are neither women nor men issues, but they involve both parties. Studies have shown that when men are provided with the right information, they support their partners (Tsui, *et. al.,* 1997). It is therefore fair to argue that men have a bigger role to play in promoting and enhancing health behavior of their families. However, their involvement will remain largely poor if their own perceptions about involvement in reproductive health issues are not well known.

Despite the general consensus and understanding of the importance of male involvement in reproductive health, little is known about their own perceptions of involvement. This paper focuses on what are men's perspectives and roles in reproductive health? This paper focuses on how men perceive reproductive health matters and their involvement in the same. The need to adequately understand male perspective about their involvement in reproductive health has been documented elsewhere (Mundigo, 1998; Collumbien & Hawkes, 2000; Hawkes & Hart, 2000). It is argued that to understand how men behave and how they perceive their role in sexuality and reproduction has important implications for various aspects of reproductive health. The concern arose when it became apparent that without understanding the male perspective, it would not be possible to change reproductive health-related behavior that is risky to both women and men. The argument is that success of

programmes to involve men in reproductive health largely depends on understanding of their own perception of involvement including whether they are interested to participate in the programmes. The understanding of males perceptions and willingness to participate will help them aware of what is expected and how they can be empowered, if need be, to meaningfully and effectively participate in reproductive health matters.

## 2. Data and analytical methods

### Data and Analytical Methods

The present paper, empirical and descriptive in nature, was conducted in Dar es Salaam City in Tanzania. This is the Capital City and Centre of Commerce and business. It draws the largest number of migrants from across the country, hence important in the study, quantitative in nature, required responses from subjects of different ethnicities and culture. The target was men (aged 18 above), currently married with wives in the reproductive age group (15-49). Males' perception of reproductive health and their involvement in the same is analyzed. Analysis also considers assessment of men's awareness, attitudes and practice of modern contraceptive methods and correlates of their opinion in their involvement in reproductive health were investigated.

### Results

#### *Socio-demographic characteristics*

Table 1 presents socio-demographic characteristics of respondents. The findings on age distribution show that show the majority of the respondents (more than two thirds) were in third and fourth decades of life. Almost 44 percent of the respondents were had attained tertiary education and only about five have no formal education. Education system of Tanzania is almost free for primary level (unless child is enrolled in a private school). The free primary education policy has attributed to an almost universal primary enrolment. On religion, Catholic and Islamic scored the highest (38.2 and 33.6 percent respectively) followed by Protestants and those who believe in traditional religion. 40sforties. at male perception on reproductive health is mainly on fertility and child care (48 versus 52 percent).

The majority (88.4 percent) of the respondents are employed. As stated earlier, Dar es Salaam is the Centre of Commerce and Business in the country, people are engaged in both formal and informal sectors hence the higher score on employment. Almost 85 percent of the respondents were in monogamous unions.

**Table 1:** Socio-demographic and family planning characteristics of respondents

| Characteristics | Percent |
|---|---|
| **Age (in years)** | |
| <30 | 16.3 |
| 30-39 | 33.1 |
| 40-49 | 37.6 |
| 50-59 | 13.0 |
| **Education** | |
| No formal education | 5.2 |
| Primary | 17.5 |
| Secondary | 33.6 |
| Tertiary | 43.7 |
| **Religion** | |
| Protestant | 24.1 |
| Catholic | 38.2 |
| Islamic | 33.6 |
| Tradition | 4.1 |
| **Employment** | |
| Yes | 88.4 |
| No | 11.6 |
| **Marriage type** | |
| Monogamy | 85.4 |
| Polygamy | 14.6 |

### *Knowledge about reproductive health*

Respondents' awareness of reproductive health is critical before investigating their perception on involvement in the same. Knowledge about reproductive health has been found to relate to safer sexual behaviors and a reduced likelihood of pregnancy (Kirby, 2007). These two, in the context of this paper are considered critical in the pursuit of decreasing maternal mortality and attain desired healthy families for both social and economic development. If men are to be aware of reproductive health and practice the same and adequately involved in reproductive health programmes, global desired reproductive health goals would be achieved. Table 2 presents results on knowledge about reproductive health by respondents. Responses

posted in Table 2a are related to questions asked to get information on safer sexual behavior and reduced likelihood of pregnancy.

Age is a factor in sexual history. Table 2a shows that the youngest respondents are the least likely to have had more than one sexual partner as oppose to older men (9.8 percent for younger men (less than 30) versus about 45 percent for older men (aged 50-59). Among those who had multiple sexual partners in the past year, 17.1 percent (aged less than 30 years) used a condom as opposed to 35.2 percent for older men (aged 50-59). Analysis shows that, generally condom use in the last sexual intercourse among women with more than one partner is inversely proportional to age; younger men are more likely to use condoms than older men. These results are consistent to those documented in the Tanzania Demographic and Health Survey Report (2010) and Brahme *et al.,* (2005). A study in India found that the difference in risk behavior between younger and older men, with the former reporting condom use more frequently than the latter Brahme *et al.,* (2005).

**Table 2a:** Information on multiple partners

| Characteristics | Percent who had 2+ partners in the past 12 months* | Percent who reported using a condom during last sexual intercourse |
|---|---|---|
| **Multiple partners and condom use** | | |
| <30 | 9.8 | 35.2 |
| 30-39 | 32.0 | 24.1 |
| 40-49 | 13.4 | 23.6 |
| 50-59 | 44.8 | 17.1 |

* Analysis considered only those reported to have had sexual intercourse with more than one partner (beside their wives)

Knowledge about HIV and HIV testing is one of the safe sexual behavior and an integral part of reproductive health. The study therefore enquired on this from respondents, asking them whether they had heard of AIDS and other related questions whose results are posted in Table 2b. Results show that knowledge on AIDS is nearly universal, with almost 100 percent of respondents across the age groups having heard of AIDS.

**Table 2b:** Information of HIV knowledge of AIDS)

| Characteristics | Percent heard about AIDS |
|---|---|

| | |
|---|---|
| **Age (in years)** | |
| <30 | 99.4 |
| 30-39 | 99.1 |
| 40-49 | 99.5 |
| 50-59 | 100.0 |
| **Education** | |
| No formal education | 98.6 |
| Primary | 99.5 |
| Secondary | 99.9 |
| Tertiary | 99.9 |
| **Marriage type** | |
| Monogamy | 99.9 |
| Polygamy | 99.8 |

Knowledge of preventing HIV transmission is also high among respondents. Respondents also are knowledgeable of the ways to reducing risk of getting infected with AIDS virus. However, unlike age differences noted with regards to having multiple partners and the use of condoms, knowledge of avoiding HIV transmission is inconsistent with age. The assumption could be that younger men are less knowledgeable but this is not observed in the present study. Results on education are consistent with the general understanding that the better educated are more likely than others respondents to be aware of the prevention methods.

**Table 2c:** Knowledge of HIV prevention methods

| Characteristics | Percent Mentioned using condoms | Percent Mentioned Limiting sexual intercourse to one uninfected partner | Percent Mentioned using condoms and limiting sexual intercourse to one uninfected partner |
|---|---|---|---|
| **Age (in years)** | | | |
| <30 | 76.0 | 79.9 | 56.7 |
| 30-39 | 74.7 | 88.0 | 75.3 |
| 40-49 | 79.8 | 89.3 | 77.5 |
| 50-59 | 75.2 | 85.6 | 72.6 |
| **Education** | | | |
| No formal education | 64.5 | 86.5 | 57.2 |
| Primary | 73.5 | 84.5 | 65.6 |
| Secondary | 78.0 | 91.4 | 75.2 |
| Tertiary | 76.4 | 95.3 | 72.3 |

Knowledge of likelihood to reduce pregnancy reflects reproductive health in that respondents are likely to abstain, use condoms or other family planning methods. Against this understanding, questions were asked and results are posted in Table 2d.

**Table 2d:** Knowledge of likelihood to reduce pregnancy

| Characteristics | Percent |
|---|---|
| **Attitudes towards Family planning** | |
| Approves | 78.7 |
| Disapproves | 21.3 |
| **Discussed Family Planning with spouse** | |
| Yes | 43.0 |
| No | 57.0 |

The majority of the respondents approved of the use of family planning (78.7 percent), citing the economic hardship behind limiting the number of children. Spousal communication about reproductive health including issues of family planning was very poor, where only 43 percent of the respondents indicating they regularly communicate with their spouses.

***Males understanding of their involvement in reproductive health matters***

It is important to understand what male involvement means, before assessing their involvement. Many terminologies are used to refer to male involvement in reproductive health services and programmes. For instance other perceive male involvement in reproductive health as setting a room to educate men about their health and those of women; setting a bowl of condoms for men to pick, accompanying their wives to clinics. Yet other programmes to involve men in reproductive health use terms such as, including men's participation, men's responsibility, male motivation, male involvement, men and partners as well as men and reproductive health (Danforth and Jezowski, 1997; Finger et al., Verme et al., 1996). In this premise, there seem to be no consensus on which terms best define male involvement in reproductive however. In this study male involvement is considered as participation in order to influence both social and behavioral changes in reproductive health. Such changes include roles in relation to couple's decision-making about sex, contraception and raring of children.

Results of analysis of men's perception about their involvement in reproductive health notably in decision-making about sex and contraception, their responsibilities as compared to that of women is guided by that of Grady *et al.,* (1996). Furthermore, individual attributes, which may have an influence on men's perception and practice, are analyzed. Five questions are used to assess men's perception of their involvement in reproductive health and help determine whether or not they are equal partners (as women in reproductive health issues). As stated above, reproductive health encompasses of issues related to safer sexual behaviors and a reduced likelihood of pregnancy, therefore the following questions were asked[1]:

(i) A man is the one who decides whether or not the couple will have sex;
(ii) A woman is the one who decides whether or not the couple will have sex;
(iii) It is the woman's responsibility to make decisions about using birth control;
(iv) It is the man's responsibility to make decisions about using birth control;
(v) Men have the same responsibilities as women in decision about sex and use of family planning methods.

As was done by Grady *et al.*, (1996) responses from the above questions were used to determine what their perceptions were and whether or not they can be regarded as equal partners in reproductive health. Men who scored higher on men oriented questions were considered male-oriented; those scored equal levels of agreement were considered to have an egalitarian orientation; and finally those who indicated higher level of agreement on the female focused statements are considered to have female-oriented perception. The egalitarian group is the one considered as perceiving themselves as equal partners in reproductive health.

Results on men perceptions are presented in Table 3. As opposed to what was documented by Grady *et al.,* (1996), the present study found that the majority of respondents do not agree with the statement that men and women have the same responsibility on decision about sex and family planning methods (78 percent). This observation suggests that men are yet to be come equal partners in reproductive health. They still believe that they are the ones to make decisions about sex and family planning methods.

[1] These questions have been adapted from Grady *et al.,* 1996.

**Table 3:** Male perception on their involvement in reproductive health

| Measure | Female oriented | Egalitarian | Male Oriented |
|---|---|---|---|
| Decision about sex | 10.3 | 29.1 | 60.6 |
| Contraception | 6.1 | 21.5 | 72.4 |

Age, education and religious were as explanatory variables were tested using Pearson's Chi Square. Multivariate logistic regression model was used to examine independent correlates to male involvement in reproductive health.

Analysis of the standardized probabilities by respondents' orientations regarding decisions about sex and contraception by demographic characteristics show that age was inversely associated with a less egalitarian scoring pattern. This is caused by an increase in the likelihood of male-dominanat score among older men. Respondents of Catholic and Islam were had higher probability of male-oriented pattern than Protestants.

## Discussion

The paper analysed male perception of involvement in reproductive health. Preliminary findings show that age, educational attainment and religion are associated with men perceptions on involvement in reproductive health. Results indicate that although generally men perceive that they are the ones to make decisions and hence not equal partner in reproductive health, a small proportion perceive that decision making should be done by the couple. Furthermore, some of the respondents indicated willingness and interest to be equal partners in reproductive health. Seventy percent of all the respondents said they are willing to be involved in reproductive health, while only 30 percent said no. Reasons given by those unwilling to participate included limited time to be involved, its women's responsibilities assisted by domestic workers (commonly known in Tanzania as *house girls*) and women are the ones to ensure they are in good health for conception and delivery. It can be argued that argued that generalization should be avoided and that some men are indeed interested and willing to be part of the reproductive health issues as equal partners.

The paper informed and broadened our understanding of men's own perception in reproductive health. Results on their knowledge on various reproductive health issues presented above can be linked to their perception of their involvement in the RH matters. The knowledge of men's own perception is critical for both pragmatic and policy interventions.

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