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Ruprecht-Karls-Universität Heidelberg

Department of Tropical Hygiene and Public Health

Master of Science Course

Community Health and Health Management in Developing Countries

Determinants of Male involvement in reproductive health at the community level: A case study in Bheri zone, Nepal.

Study proposal

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Principal Investigator

Dr. John Were Wadenya

Alte Eppelheimer Str. 20

69115 Heidelberg

Tel/fax: 06221-182347

e-mail jwere@ix.urz.uni-heidelberg.de

Thesis Tutor

Dr. Johannes Sommerfeld

Field Tutor

Ms Anne Erpelding, MSc

1. Introduction

Nepal is among the only three countries in the world where the life expectancy of women is lower than that of men. This is mostly due to the high burden of mortality among the girl children and women during the child bearing years (National Commission on Population, Nepal 1990 Cited in " Children and Women of Nepal: A situation analysis 1992, National Planning Commission, HMG, UNICEF ")
There is, therefore, need for greater emphasis on reproductive health with involvement of not only women but also men. Men play a key role in decision making both at family and community levels and are key actors in the control of resources. Their involvement is therefore crucial for the success of reproductive health programs.(Kara et al 1997, Robey and Drennan 1998, Barnett 1998, Ndong and Finger 1998, Wells 1997, Mundigo , 1995, Danforth and Roberts 1997). This is possibly one of the reasons why male involvement has suddenly become the focus of substancial attention.

Very little is known however, about the perception of men and their participation in reproductive health issues. Surveys most relied upon usually direct reproductive health questions to women only. (UNFPA 1998). According to the 1994 Cairo Conference on population and development definition, reproductive health basically consists of two components:- "that couples have a satisfying and safe sexual life" and that "they are able to reproduce safely and have freedom to decide if, when, and how often to do so ". I have defined male involvement as participation in a positive way in the domains of reproductive health as outlined in *Annex A*.

Barely one year after its inception, the GTZ reproductive health project in Nepalganj (Nepal) is already aware of the importance of male participation. The project is therefore very much interested in this particular research. The present proposal outlines research on the positive involvement of men in two domains of reproductive health namely:- Family planning and prevention of STD/HIV.

2. Literature Review

Male involvement in reproductive health is a fairly recent field on which little has been written. Most of the available literature concerns family planning with barely anything on the other domains (*see Annex A*).

In a pre-feasibility study on reproductive health in Nepal, Erpelding and Schönhals (1997) identified opposition by men to contraception, their unawareness and disregard of the needs and risks of pregnant women and their irresponsible behaviour with regard to sexually transmitted diseases including AIDS as being one of the major contributing factors to poor reproductive health of women. There is also a common myth, especially among health care providers, that men are not interested in family planning, resist its use by their partners, do not care about spreading STDs, never share in the responsibility of raising children and perpetuate violence against women (Bobey and Drennan 1998, Green et al 1995, Aguma 1996, Ndong and Finger 1998).

However recent surveys seem to contradict this and further indicate that many more men would participate if they had more opportunity. Data collected from men in 15 developing countries indicate that the reproductive health preferences and attitudes of men and women toward Family Planning are similar (Ezeh et al 1996)[1]. A review of studies conducted in Pakistan on the involvement of men in reproductive health in the past 10 years also indicates that Pakistani men are similar to their female counterparts in their fertility preferences, attitudes and knowledge of family planning (Douthwaite 1998). Inspite of these findings, men´s contraceptive use is lower than might be expected given their overall levels of approval of and knowledge about family planning. (Mbizvo and Adamchack 1991, Pitrow 1992, Khalifa 1988). Most observers agree that family planning programs have made little effort to consider men`s reproductive health needs or reach them and that, as a result men have few contacts with the reproductive health care system, and that reaching them is more difficult than reaching women.

The perception that family planning clinics were orientated towards serving women and the men`s lack of familiarity with the health system were identified as barriers to male utilisation by Schulte et al (1995) when they analysed results of a survey of family planning units in the USA. In the same study presence of male providers and seperate clinics or specific clinic hours for men were identified as motivators. Casterline and Perez (1997) from their analysis of data collected from currently married women and their husbands in two provinces in the Philippines, identified fear of side effects, the desire of another child by the husbands, men`s perception of cost of the services and the conflict with social and religious values as hindering factors. Women desiring to postpone child birth (54%) or those desiring to stop (46%) could not fulfill their desires because their husbands wanted another child soon or later. This is consistent with the Zimbabwe male fertility survey of 1988, which interviewed 711 currently married men aged 20yrs and above and identified men`s want for more children as a significant barrier for male use (Mbizvo and Adamchack 1991).

In a review of studies (AGI 1997) cited provision by predominantly female staff, negative attitudes of staff and lack of staff training as barriers. In a survey among Sudanese men in Khartoum (Khalifa 1988), men reffered to vasectomy as a way of „castration" and 20% of them considered it as reducing potency. In the same survey men who had previously used family planning mentioned side effects (48.1%), dissatisfaction with method (23.6%), negative social cultural influences (14.8%) and inneffective method (9.9%) as reasons for discontinuation. Similarly Gillyart (1993) cited concern of men about percieved side effects following vasectomy in the USA.

Wells (1997) in another review of sudies identified orientation of services towards women and children, limited types of male methods, rumours and mis-information, provider bias against male methods, unfavourable social or religious climate as important barriers. According to him motivating factors were:- involving men in program design and implementation, intergrating other services with family planning, providers being more aware about men`s reproductive health needs, men being provided with information and personal follow up and absence of policy barriers like strict selection criteria for vasectomy as identified by the UNFPA technical report no.

[1]cited in (Bobey and Drennan, 1998)

28 (Green et al 1997). The same report also identified messages which were properly targeted towards men as motivating factors; this was consistent with Robey and Drennan`s findings (1998). Traditional ideas about roles and responsibilities of men have also been identified as barriers (Best 1998, Ndong and Finger 1998).

I fully agree with the authors about the barriers and motivating factors towards male participation. I would also postulate from personal experience, that the educational level of the men also has a significant role to play. To a certain extent the level of participation should increase with increasing educational level attained.

3. Objectives

The principal objective of this study is to elucidate on hindering and enabling factors that affect the involvement of men 18 to 45 years of age in two domains of reproductive health (see Annex A) at community level in Bheri zone, Nepal.

Specific objectives include:-

1. to describe the level of male involvement with respect to the two domains of reproductive health.
2. to determine what motivates men to desire a certain number of children.
3. to determine what motivates or hinders men from using male methods of family planning.
4. to determine what motivates men to decide for or against family planning
5. to determine what motivates or hinders fidelity of men towards their partners.
6. to determine what motivates or hinders men from using condoms.
7. to determine what motivates or hinders men from seeking early and proper treatment of STDs

4. Methodology

4.1 Methods

To fulfill the above objectives we shall carry out a descriptive study using mainly qualitative methods. The sampling strategy will consist of one or any combination of three purposeful methods namely:- opportunistic sampling, homogenous sampling, and purposeful random sampling. We shall start initially with Focus group discussions (FGD), Key Informant interviews and informal interviews with groups and individuals. Later a semi-structured questionaire survey will be carried out. Each information source will be analysed seperately. Triangulation of the various methods is expected to increase validity of the study.

4.1.1 Focus Group Discussions

Married male adults 18 to 45 years will be interviewed through this method. A total of 5 FGD`s of between 8-10 persons each are envisaged. The discussions will be moderated by a local facilitator and assisted by an observer whose function will be to take notes of proceedings including non-verbal communication. The facilitator and observer will be trained by the principal investigator who will be in attendance at each of the sessions. The first two FGDs will serve as practical training for the facilitator and observer and also for pretesting the interview guidelines. The groups will be

chosen in such a way as to ensure fair representation of the various age groups and uniformity within themselves as much as possible. Discussions will be tape recorded after obtaining informed consent from the participants. Memory protocols will be made immediately after the discussions. Selected parts of the recordings will be transcribed and translated into English. Analysis of the traslated transcriptions will be done in conjuction with the observer notes and memory protocols.

4.1.2 Key Informant Interviews

A total of 10 in depth interviews will be conducted with people known to be knowledgable about the issue under study. These may be opinion leaders, social workers, religious leaders, government officials, health personel etc. We anticipate help from the local partners in identifying potential key informants to be interviewed. These interviews will be carried out by the principal researcher with or without an interpreter depending on the ability of the respondents to speak English. The interviews will also be tape recorded after obtaining informed consent from the persons. Selected parts of the recordings will be transcribed and translated into English. Several repeat and back translations will be made with different translators to check validity.

4.1.3 The Survey.

Information collected from the above methods will be used to update a semi-structured questionnaire which will be applied to a sample of 250 married men in Bheri zone. This sample will be determined using purposeful methods (*see above*). In addition to other social groups we shall also specifically target men regularly attending family planning services or who have had a vasectomy. The latter will help us discover motivating factors. These family planning users will be traced through the records of the clinics. For the other social groups the sampling unit will be the household. To check the validity of the information collected, 10% of the husbands will have their partners also interviewed but separately. Local interviewers will be adequately trained and the questionnaires will be pre-tested prior to the actual survey. Results will be analysed semi-quantitatively using EPI info.

4.2 Ethical considerations.

Permission to conduct the study will be sought from both the GTZ project and the responsible Nepalese Authorities. Informed oral consent will be obtained from each of the study participants prior to the interview and confidentiality will be ensured at all stages. The questionnaires and the transcripts will be kept anonymous. Tapes will be destroyed right after transcription.

4.3 Dissemination of results

Preliminary presentation and discussion of results will take place in the field to the local partners and other interested individuals and groups. The study will be compiled and presented to the University of Heidelberg as a thesis for the award of the degree of Master of Science in Community Health and Health Management in Developing Countries (CHHM, DC).

5 Resources required

5.1.1 Equipment

* 1 tape recorder
* 24 battery cells
* 25 cassette tapes
* 1 Note book Computer (lap top) to facilitate easy data entry and analysis in the field

5.1.2 Stationary

* 12 note books
* 12 Pens and 12 pencils
* 2 reams typing/photocopying paper
* photocopying costs
* binding costs for the Thesis

5.1.3 Personnel

* 2 interpretors for 21 days (also to work as facilitator and observer respectively for the FGD´s)
* 1 transcriber for 14 days Bistaji
* 10 Interviewers for two weeks
* 1 translator for three weeks Radhika (-> Kawalpur)

5.1.4 Travel

* return ticket Frankfurt-Kathmandu-Nepalganj-Kathmandu-Frankfurt
* transport during research

5.1.5 Others

* Accomodation and feeding during the field study
* hire of discussion rooms for the FGD´s for 10 days
* motivation for 50 Focus Group participants.

5.2 Budget Sources

* DAAD
* own resources
* well wishers

6 Time Plan

Week	Activities
1	travel to Kathmandu, processing of official documents, meeting of government officials, interview of key informants in Kathmandu
2	travel to Nepalganj, acclimatisation, assembling of local resources, identification of key informants, training of FGD facilitator and observer, making of appointment for 1st Focus Group discussion.
3	training of the interviewers, pretesting of the survey questionaires, 1st focus group discussion.
4	data collection
5	data collection
6	data collection
7	transcription continued, translation and data analysis
8	data analysis cont. presentation of preliminary results return journey to Heidelberg.

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Annex A
Domains of positive male involvement in reproductive health in Nepal.

Domain	*issues involed*	*hypothesized hindering factors*	*hypothesized enabling factors*	*proposed investigatory methods*
family planning	desires less than 5 children	• cultural values • desire for child labour • lack of desired sex of children • desire for dowery • children as gift from God mentality	• education level • access to health information • high cost of living • scarcity of resources	• focus group discussions • individual semi-structured interviews • informal interviews • key informant interviews
	uses male methods of family planning	• limited choice available • fear of side effects • cultural values • rumours and mis-information	• has access to proper information and service • knows of some people using similar methods	• as above
	decision making in favour of use of family planning	• see no. of desired children (above)	• as above in no. of children	• as above
prevention of STD/HIV	• fidelity	• social cultural values • unsatisfying family sex life • lack of communication between partners	• knows associated dangers • sex education • strong religious beliefs	• as above
	• use of condoms	• not readily available • high cost • rumours and mis-information • religious values • lack of information	• IEC • readily available and affordable • extra-marital affairs	

Annex A
Domains of positive male involvement in reproductive health in Nepal.

child rearing continued	participates in care of his children 0-3 yrs	• cultural and social values	• women emancipation • social change	• focus group discussions • individual semi-structured interviews • informal interviews • key informant interviews
	participates in bringing up children 3yrs and above	• as above	• as above	• as above
	provision of good nutrition	• cultural taboos • farmine and starvation • poverty • ignorance	• nutritional education • IEC • increasing Income per capita	
	education provision	• high cost • large number of children • low educational level • low social class • segregation on sex of child	• increasing educational level • high social class • free or affordable education	
Natal and postnatal care	accompanies wife to or attends together Antenatal and Post natal clinics	• social cultural values • no provision for men made by the health services	• provision made for couples to attend ANC and PNC together	
Natal and postnatal care continued	provision of required good nutrition	• social cultural taboos • farmine and starvation • poverty • ignorance	• increasing income per capita • nutritional education • better farming practices	

Annex A
Domains of positive male involvement in reproductive health in Nepal.

prevention of STD/HIV continued	early and proper treatment seeking behavior	• low education level • innaccessibility of services • false beliefs as to causation • illegal drug dealers in the community	• increasing educational level • good access to services • has information about health	• as above
health awareness	seeks information about reproductive health and RH services	• social cultural values • low educational level • innaccessible services • ignorance	• accessible and affordable services • increasing educational level	• individual semi-structured interviews • informal interviews • key informant interviews
	passes on information to others in the community	• lack of information • lack of communication skills	• motivation • holds influential position in community	• individual semi-structured interviews • informal interviews • key informant interviews
child rearing	does not abandon or deny own children	• children from extra-marital relationships • separated families • child not of desired gender		• as above + focus group interviews

Annex A
Domains of positive male involvement in reproductive health in Nepal.

	encourages wife to go for regular screening for Breast or Cervical cancer	• Ignorance • traditional beliefs for causation of disease • innaccessible services	• accessible services • IEC good educational level	
safe delivery	ensures that wife is assisted by qualified personnel	• social cultural values • innaccessibilty of services • high cost of services • Ignorance	• accessible services • affordable services • IEC • increasing educational level	
	accompanies wife to clinic or present during birth	• social cultural values • no provision made for men to by the services	• provision made for men by the services	