

Determinants of Men's Involvement in Sexual and Reproductive Health in Nigeria

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Abstract
For too long men's role has been seen as marginal in the area of sexual and reproductive health (SRH). Despite the decision from the 1994 International Conference on Population and Development (ICPD), and the place of men in reproductive health (RH), the notion of many health-care providers that men are uninterested in taking responsibility for family planning and other RH issues still persists. This study explored factors that influence male involvement in reproductive health. Qualitative methodswere used to collect data using in-depth interviews and focus group discussions involving twelve in-depth interviews and ten focus group discussions. Six in-depth interviews each were conducted in Adamawa and Bauchi States respectively, comprising four for males and two for females. Five Focus group discussions each were also conducted in Adamawa and Bauchi States. Three of the FGDs in each state had all males and two had all females. The study found out that religion, pursuit of confidentiality, culture, contraceptive types, concentration of programming on women, and male egocentrism play a role in decreasing male involvement in RH services. Other factors which positively influence male participation in SRH health are: sports activities through using sporting activities to pass RH messages, home videos with RH messages, music which pass RH messages, attempts at reducing family size, fear of and awareness of STIs & HIV/AIDS, increased level of RH programmes which provide testing for STIs and HIV/AIDS, treatment and care together and awareness of reproductive health issues.The study concludes by recommending that there should be emphasis on men's participation in reproductive health since this could help draw attention to the need to do more for women as well. In other words, policies to increase men's participation may help improve women's programmes because more men would understand what SRH entailed and support better reproductive health care for women, as well as for themselves.
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Introduction

Since the International Conference on Population and Development (ICPD) in 1994 in Cairo, there has been a shift away from programmes focusing solely on women's health and family planning towards sexual and reproductive health (SRH) more generally. For too long, men's sexual and reproductive health needs were overlooked; yet significant numbers of men, particularly in poorer countries, still engage in unprotected sex and are the major decision makers in reproductive health matters in their homes. Men want and need reliable and accessible information and services that can help them lead healthy sexual lives and to make vital decision about their families' reproductive health, but often, they do not get them, especially in developing countries (1). If men are to exercise their reproductive rights and responsibilities, they, as much as women, need access to information, counselling and services.

Traditional reproductive health (RH) programmes focus almost exclusively on women. Reproductive health services are commonly offered at clinics that have limited services for men and are frequented mostly by women (2). Programmes dealing with family planning, prevention of unwanted pregnancy and unsafe abortion, and the promotion of safe motherhood view women as their primary clients. One popular view holds that men know little about contraception, do not want their partners to use it, and are not interested in planning their families (3). Men

are perceived as gatekeepers who not only restrict their partner's and children's access to health services but also neglect and abuse their partners, thereby contributing to poor health outcomes(4,5).The scourge of HIV/AIDS has made it more imperative that men participate in reproductive health. Increasingly, the belief that men should be involved in sexual and reproductive health has increased in recent times. The Global plan for the prevention of mother to child transmission of HIV/AIDS declares that "efforts must be taken to secure theinvolvement and support of men in all aspects ofthese programmes and to address HIV and genderrelateddiscriminations that impede service accessand uptake as well as client retention" (6), because SRH

programmes and serviceshave been focused primarily on women, menhave often lacked information to make informeddecisions about healthy behaviours and theroles they might play in promoting overall familyhealth, including accessing HIV prevention, careand treatment services.

A plethora of studies have documented male involvement in reproductive health, especially the desire of men to be involved (7, 8, 9,10,11,12,13). The results from these studies indicated that the involvements of men have brought positive results and that programmes involving couples have better results. However, cultures in most African communities with well-defined gender roles have made the involvement of men challenging (14, 15, 16,17,18, 19).For example, Male gender norms that permit or promote aggressive behaviour, risk-taking, domination, multiple partners and violence as acceptable demonstrations of masculinity and male identity impact negatively on both men and women's health in African communities(6).

Literature on barriers' to male participation in reproductive health have adduced reasons for this stances from men to range from, fears that involving men in family planning education and services could further erode women's control over reproductive health decisions. Reproductive health services have allowed many women a degree of autonomy over their own lives. Many fear that, without genuine gender equity, involving men will perpetuate existing gender inequalities (20).

According to De Schutter (21), programmes involving men as partners will compete for funds with ones designed for women's health where resources are limited and needs abundant. Blanc (22) identified gap between men's desire to help and action as a barrier to men involvement in RH, since men's desire to help does not necessarily translate into action. Other barriers in the literature are:health workers attitude, (23, 17, 24, 25). In fact, there were incidences of experienced health-care workers who were reluctant to encourage male attendance in antenatal care at all (26). Many men felt unwelcomed and disrespected (25), and thought it was clear that services were designed without taking their particular needs into consideration (18). The charging of unofficial user fees was another barrier cited (24, 25). The lack of integration of services was mentioned as discouraging men from getting tested, since they felt they would be "exposed" through special clinics or opening hours (25).The idea that care work is intrinsically female: that women are defined by their caring nature and that caring and, by extension, care work partially defines what is feminine. This view lends credence to the social or cultural milieu in which we live, which has traditionally associated reproduction with the domestic sphere, or women – a sentiment highlighted repeatedly in the literature by men who view health clinics as woman's spaces, and by providers who may also hold negative attitudes towards male involvement in traditionally female services (6, 13); cultural/traditional barrier which supported health systems to structurally segregate men from reproductive issues (23).Gap in knowledge related to discordancy of HIV/AIDS between partners also posed a barrier - since some men questioned the need fortesting if their partners had already been tested,believing that they would have the same test resultsas their partners (19). Similarly, as it relates to HIV/AIDSthe feeling among men that their involvement in HIV/AIDS treatment services would create the perception that one or both partners was living with HIV (15) and they feared the stigmatising nature of HIV care (25). Women said that HIV related stigma was a significant factor in getting the support of their partners for basic activities, such as going to clinics to get infant feeding formula (13).

Male clients' concerns about their receptivity at health facilities seem to be well grounded based on self-identified barriers to men's participation on the part of health-care providers. For example, female providers' feared sexual assault from their male clients, and practitioners expressed discomfort about counselling men with a positive HIV result (27; 28,29). For too long men's role has been seen as marginal to women's health. Thus when men are involved in matters of sexual and reproductive health, such programmes are more likely to be effective (6). While men have specific and often neglected needs, their roles and responsibilities also impact on the health and well-being of women and children (13). Thus, in those cultures –notably the Africa - where men are the main decision makers in the family and community and are supportive of the goals of reproductive health, such programmes has been observed to achieve success (13,7, 8,10, 11,12). Inspites of these benefits of involving male in reproductive health programmes and activities, men have not be fully involved in reproductive health programmes in Africa, particularly in Nigeria.

The objectives of this study were to establish the status of male involvement in reproductive health services in Adamawa and Bauchi States and investigate the best strategies to involve male partners in reproductive health services. The study questions addressed are "What factors influence the status of male involvement in reproductive health services in two states?" and "What are some of the strategies suggested by study participants for involving men in reproductive health services in the study areas?

1. Methods

1.1 Study design

The data for this study were qualitatively collected using in-depth interviews with individual participants and focus group discussions (FGDs). FGDs were used to compliment the in-depth interviews and getting in-depth perspectives in line with the objectives of the study. The data for the study were collected in Adamawa and

Bauchi States between January, 2015 and August of the same year from CPED's sexual reproductive health project in Adamawa and Bauchi States, Nigeria.

1.2 Sampling and recruitment

Due to the nature of the work and location of our project in the two participating states, the participants were purposively selected from the urban areas and rural communities. In Adamawa, three key informants were purposively selected from our programme participants in Yola based on their knowledge of RH. These city participants included two key male informants and a female key informant. Three persons were also purposively picked at Ganye Local Government Area. The three persons here included a Primary Health Centre medical male from our project community, a community man and woman each from two project communities. The above process was repeated in Bauchi State (in Bauchi Town and Kirfi Local Government Area respectively). It is imperative to note that the participants in the rural communities were selected based on demonstration of knowledge of community culture, length of stay in communities and their general knowledge of RH as shown in the course of our community mobilisation for our project.

The participants for the FGDs were also purposively selected in the towns. In Yola town, two all- males and an all-female FGDs were conducted while one all-male and all-female respective were conducted in Ganye LGA. In Ganye LGA, Each project community provided oneparticipant and which was joined by two health workers from the LGA to make up seven persons for all - males and seven for all- female FGDs. The FGDs in the towns have seven participants each. The process above was repeated in Bauchi State.

1.3 Data collection and analysis

1.3.1 Interview guide

An interview guide with open-ended questions was used to conduct in-depth interviews and FGDs as adapted from the work of Onyango, Owoko and Oguttu, (30). The interview guide had a section for demographic information of the participants (age, location [urban/rural], years in school, marital status, and number of children). Some examples of questions included in the interview guide were: in your opinion, how should men in your community be involved in reproductive health services/programmes? What are the best approaches to include men in the reproductive health programmes? What are some of the factors that can encourage men to be involved in reproductive health programmes for themselves and their female partners? What are some of the factors that may prevent men from taking part in reproductive health programmes? The interview guide was in English. In Adamawa and Bauchi States, most people either speak English or Hausa as their General Language. Two research Assistants – both graduate of English Language who speak and understand English as well as Hausa fluently were trained for a week with questions piloted on them to be able to handle the interviews/FGDs in Hausa at the community level while the interviews and FGDs in towns where conducted largely in English Language(pidgin)by researchers since most participants were at home with the pidgin version of English. However, when it was necessary, some difficult issues were explained in Hausa.

1.3.2 In-depth interviews with individual key informants

Twelve in-depth interviews with individual key informants were conducted(with 6 in each state). In-depth interviews with identified individuals from the communities were conducted at a private space in the place convenient for the participants. The interview sessions lasted for 50 to 70 minutes. All interviews were tape-recorded. One of the research assistants took notes and made observations during each interviewto supplement the transcripts.

1.3.3 Focus group discussions (FGDs)

Ten FGDs were conducted, five each in each in Adamawa and Bauchi State Respectively. In Yola town, two all-males and an all-female FGDs were conducted while one all-male and all-female respective were conducted in Ganye LGA. In Ganye LGA, Each project community provided one participants each and two persons who are LGA health works to make up 7 persons for all - males and 7 for all- female FGDs. The FGDs in the towns have seven participants each. The process above was repeated in Bauchi State. The interview date had been scheduled about seven days in advance and those present had already taken time away from their busy schedules.The FGDs participants were not the same as those who participated in in-depth interviews. Before starting each FGDs sessions, the study was explained to participants individually. After confirming their acceptance to take part, the FGDsprocess started. Selection of the locations for the FGDs were based on privacy, quietness, and adequate lighting. The investigators as well as the research assistants put the participants at ease and explained the purpose of the FGDs, the kind of information needed, and how the information would be used. The participants were encouraged to communicate and interact with each other during the FGDs. Each session lasted approximately one hour. All discussions were tape-recorded, and the research assistants took notes.

1.3.4 Data analysis

Tape-recorded interviews were first transcribed verbatim. Before coding the data, the researchers read the typed interview transcripts and field notes line by line and word by word. The type transcripts were imported into N6

software to code and conduct content analysis. During the coding process, data were continuously reviewed and revised, emerging patterns noted, and relationships between constructs identified.

1.3.5 Ethical Considerations

As traditional with study of this type, approval was done by the CPED ethics committee. Study participants were reassured that taking part in the study was voluntary. Confidentiality was maintained from data collection to report writing. The field notes and audiotapes had no identifiers that could be linked to a particular study participant. Consent form were not signed by participants in view of the fact the study was of no more than minimal risk.

2. Data analysis/results

2.1 Background information on participants

2.1.1. In-depths interviews

The total participants in the study were 12 including 6 persons from Adamawa and Bauchi respectively (Table 2a and 2b). Of these number eight are male while 4 are female comprising four male each and two female respectively in each state. Among the 12 participants, 6 were from urban and 6 from a rural communities. Most of the study participants came from the age group of 31-40 with 3 participants in Adamawa State with 41-50 being the dominant age group in Bauchi State indicating older participants from Bauchi State compared to Adamawa. The participants also have more married persons in Bauchi6 compared to Adamawa with 5 participants. A vast majority of the participants in the two states have 3 or more children with a greater proportion of them having more children in Bauchi. More participants in the two states have 16 -20 years in school.

Table 1: Number of in-depth interviews and FGDs

Adamawa State/Location	**Urban/Rural**	**In-depth Interviews**		**FGDs**	
		Male	Female	Male	Female
Yola	Urban	2	1	2	1
Ganye LGA	Rural	-	-	1	1
Sugu	Rural	1	0	-	-
Yebbi	Rural	1	0	-	-
Gurum -Pawo	Rural	0	1	-	-
Sub-Total		4	2	3	2
Bauchi State/Location					
Bauchi	Urban	2	1	2	1
Kirfi LGA	Rural	-	-	1	1
Dewu	Rural	1	0	-	-
Wanka	Rural	0	1	-	-
Cheledi	Rural	1	0	-	-
Sub-Total		4	2	3	2
Total		**8**	**4**	**6**	**4**
Total IDs and FGDs		**12**		**10**	

Source: Field survey 2015.

2.1.2. Focus group discussions

Seventy participants took part in the ten FGDs across the two states of Adamawa and Bauchi. Among them, 28 were female while 42 male with equal proportion of males as well as female taking part in the study in both states. The dominant age groups in Adamawa and Bauchi were 31-40 and 41-50 which have 13 and 12 participants in Adamawa State and 10 each in Bauchi State. Similar to in-depth interviews, a greaternumber of FGDs participants had 16 -20 years of schooling in both states (Table 2a and 2b). Also, a greater number of the FGDs participants lived in rural areas compared to those who lived in urban areas. Like the in-depth interviews also, a greater number of the FGDs participants have 3 or more children in Adamawa and Bauchi States respectively.

Table 2a: Characteristics of study participants for In-depth Interviews and FGDs in the study area (Adamawa State)

	In-depth Interviews (N=12)				Focus Group Discussions (N=35)	
	Yola (n=3)	**Sugu (n=1)**	**Yebbi (n=1)**	**Gurum-Pawo n=1**	**Yola (n=21) 3 FGDs**	**Ganye LGA (n=14) 2 FGDs**
Age Group (yrs)						
20 -30	0	0	1	0	3	2
31-40	2	1	0	0	8	5
41-50	1	0	0	0	6	6
51-60	0	0	0	1	4	1
Sex						
Female	1	0	1		7	7
Male	2	1	1	0	14	7
Marital Status						
Married	2	1	1	1	15	11
Single	1	0	0	0	6	3
Year in School						
< 10	0	0	0	0	3	3
10 -15	1	0	0	0	5	3
16-20	1	1	1	0	10	7
21-25	1	0	0	1	3	1
Place of Resident						
Urban	3	0	0	0	17	0
Rural	0	1	1	1	4	14
No. of Children						
1-2	0	0	0	0	3	2
3-4	1			1	5	5
5-6	1	1	0	0	4	3
7-8	0	0	1	0	3	1

Source: Field Survey 2015

Table 2b: Characteristics of study participants for In-depth Interviews and FGDs in the study area (Bauchi State State)

	In-depth Interviews (N=12)				Focus Group Discussions (N=35)	
	Bauchi (n=3)	**Dewu (n=1)**	**Wanka (n=1)**	**Cheledi n=1**	**Bauchi (n=21) 3 FGDs**	**Kirfi LGA (n=14) 2FGDs**
Age Group (yrs)						
20 -30	0	0		0	5	3
31-40	1	0	0	1	6	4
41-50	1	1	1	0	5	5
51-60	1	0	0	0	5	2
Sex						
Female	1	0	1		7	7
Male	2	1	1	0	14	7
Marital Status						
Married	3	1	1	1	19	13
Single	0	0	0	0	2	1
Year in School						
< 10	0	0	0	0	3	3
10 -15	1	0	0	0	6	6
16-20	1	1	1	0	10	5
21-25	1	0	0	1	0	0
Place of Resident						
Urban	3	0	0	0	14	0
Rural	0	1	1	1	7	14
No. of Children						
1-2	0	0	0	0	1	3
3-4	0	0	0	0	6	5
5-6	2	1	0	1	8	3
7-8	1	0	1	0	3	2

Source: Field Survey 2015

2.2 Are men involved in reproductive health?

To determine whether men were involved in reproductive health and to answer our first research question: What factors influence the status of male involvement in reproductive health services in Adamawa and Bauchi States? It was a general consensus in Adamawa and Bauchi States in urban and rural areas where the study took place that men have not been sufficiently engaged in reproductive health programmes as well as family care inspites of the agreement that involving them will bring better result to RH in the states, thus agreeing with VSO (6) that RH has only focused on women. An excerpt from as a participant supports the above:

> "Kai (Hausa exclamation).We may be pretending that reproductive health is a woman's job. You and I know how useful it is when a man is by you when there is one problem relating to birth. Financially, you fill more secure especially when it comes to paying the bills for children as well as other gynecological treatments. Yes, men helps to pay the bills and help you with one domestic errand or the others and this for sure make a whole lot of difference but this has never be case with most of our men (A woman in a focus group in Yola)

A participant from Bauchi FGD also has this to say about the lack of participation by men in RH:

> "It is a man thing in this part of the country for them not to join in matters of reproductive health. Men actually feel their role ends with making their wives pregnant and that is all"

The content analyses of the data from the study indicated that two broad themes were dominant as factors determining the participation of male in reproductive health in the two states where the study took place. The first related to Tradition, Power/ Gender norms and Religion and the second Facility-Based and Social Factors.

2.2.1 Tradition, power/ gender norm and religion

Despite a growing body of evidence indicating that manybenefits can accrue to the overall reproductive health of families when men critically examine norms of power, acquire new knowledge and skills and challenge prevailing gender norms (13), Africa men including those of Nigeria have held tight to such traditions and norms and the notion that the man must show his dominance and power including his masculinity in all situations including his relationship to his spouse and women in his domain. The attempts to dominate and show his supremacy over the woman in his environment manifest in various negative forms which are inimical to best practice in RH of the family as done in many developed world. A participant in an in-depth interview captured this very well in his statement in Adamawa State:

> "The world is a man's place. Women must learn to be where they are supposed to be. All the fight for women to be seen is not necessary. There is nothing we will achieve which they women will not enjoy. If I become a governor, my wife automatically becomes one. Traditionally, women are supposed to depend on their men in everything. If you talk of this subject of reproductive health, can the woman give birth without the husband? We are doing our job to make sure we satisfy our women sexually and I think it should all end there. Am I not involved in reproductive health? Or how else will I be involved more than that? Perhaps, I should sit at home to nurse the children while she goes to get the money for the home upkeep"

The tradition of our communities was a repeated issue that was constantly mentioned by participants whether during in-depth interviews or FGDs. Reproductive Health was seen as woman space and it should remain as such. Any attempt to change the existing order is an affront on the culture and disrespect for one mother's land as found in the assertion here:

> "It was an established fact that in my community right from the time of our great grandfathers that the woman should be the one to carry the baby on her back. Who I am I to change that. Does my not carrying my baby in the shoulder with my wife exclude me from participation in reproductive health activities? Not at all, our tradition must be strictly followed. We must mind how we copy the white people who believed all about us are wrong" (An FGD contributor from Bauchi)

The influence of tradition on the involvement of men in reproductive health derives it power from ignorance of our men to reproductive matters and this has continuously worked in the favour of existing proponents adhering to tradition and maintaining the status quo. An in-depth interview participant in Yola, Adamawa State captured this very well.

> "One major reason why it will be difficult to involve men fully in reproductive health in the state is that too many people do not really know what RH is all about. Take for example; I grew up to know that a woman must feed her young baby with breast milk while still giving the baby water and some other infant formula. Today, all that has changed. We talk of baby friendly today. Will my brothers, in the rural community get this message inspites of the benefits? Under this kind of situation, he will not be friendly with a wife who attends the clinic and wants to practice what she was told. What I am saying here is that there is a gap in knowledge which makes it difficult to fully involvement in RH".

Giving further credence to how tradition inhibits the involvement of men in reproductive health is the link between a man and his family even when he believed that he must participate actively in the affairs of his family. A woman participantfrom Bauchi has this to say during one of the focus group discussion:

> "Families –especially the man's family is a big obstacle to getting men involved in maternal health. I have got 4 children and my husband and I agreed that we needed to do something about further birth, the mother was in our house the other day to warn my husband that the fact that there is only one boy in my children is not good enough since for close to three years I have refused to give birth to children. My man refused to use condom since her mother has consistently pestered his life. As you can see, I am

pregnant again and do not know how to stop this"

A culturally related issues connected to men's exclusion from participation in reproductive health is that you cannot give what you do not have. Most children in Africa including Nigeria were raised to believe that matter of sex and indeed reproductive health are sacred issues which can only be discussed in secret and this traditional has persisted over time as an in-depth interview participant from Adamawa state puts it:

> "What do you expect? A miracle off course! We cannot talk about sex and reproductive health openly because that is what most of our traditions support and so the discussion between a man and his wife is limited. I cannot ask my husband for sex since he may give a wrong impression that I am becoming wayward. I keep silent even if I am hungry for sex. Tradition dictates what we do even if not palatable to us".

Power norm severally was mentioned in Adamawa and Bauchi States as crucial to the participation of men in RH as the statements below support:

> "As the head of my home, it is not my place to do those works a woman should do. I am a man and should not be seen to lose that status because I want to help my wife. I love her and I am doingeverything to make her and my children happy but they must recognise my place as the father and a traditional Africa man and concentrate on their duties while I do likewise"---- ***a man from one of the Kirfi LGA FGDs in Bauchi.***

Another participant in an FGD has this to say in Adamawa State

> "Why should I be the one to act the woman in my house? That is "un-africa". Women should carry the load of giving birth and caring for the family. Men do not descend to that level of taking over the care of children that a woman should do because he wants to be seen as helping his family. A man must be man. That is how it must be".

Religion also plays some roles in preventing men from taking part in reproductive health as this extract from Ganye LGAs FGD revealed:

> "Before I became a Christian, our traditional god I worshipped at the time forbids that I sleep with my wife in the same house during her menstrual cycle. Even when my wife was tired and our baby crying in her room, there was no way I can give her a helping hand even if I had wanted to because there was bound to be serious consequences. But all that has changed since I became a Christian"

2.2.2 Facility-based (supply) and social (demand) factors

Study participants identified a variety of facility-based and social factors that serve as barriers to the meaningful participation of men in RH services. Yet perhaps the most important barriers are the conceptual and policy barriers that inadvertently support men's exclusion from reproductive health services. Interventions to protect the rights of women are important in their own right in contributing to reproductive health equity but some of these have worked to prevent men from active participation in RH as evidence from comments from our study's participants in an interview in Yola, Adamawa State.

> "Medical ethics like I know forbids medical personnel from disclosing the health of a woman to a man unless she consents. Men who know about the oat that medical personnel have sworn to; do not just bother to dig into what their wives are doing whether in reproductive or other areas"

A woman participant in Bauchi in an FGD has this to say

> "You are talking of men involvement in reproductive health. If a woman tested positive to HIV in the course of her ante-natal pursuit, you expect her doctor to tell you if she says no, that cannot happen unless it is secretly done and working against the ethics of the profession".

A participant in Yola has this to say;

> "One thing I think that is making men not to participate in Reproductive health is the requirement of testing for HIV/AIDS were couple are handled separately in the name of

confidentiality"

Still a woman in an FGD in Ganye, Adamawa has this to say

> "My husband used to go to ante-natal care with me, but you have "questioning eyes" all around him each time he went with me to the clinic. At a time, he stopped- insisting that I go alone and that is how he refused to be part of such activity till today since many people called him "woman wrapper"

Participants both in Bauchi and Adamawa Statesspoke with particular virulence about the kind of services they experienced at most heath centres and hospitals and it is evidence from the data that it a major factor for men notparticipating in RH as indicated in the comments below from one of the men FGDs:

> "You expect me to go back to that hospital were the nurses lack courtesy? Gaskiya! (True) I do not think I will want to be part of the insults. Why should a nurse walk me out of a room like a military person just because she needed privacy? While I am not against this, the manners most of them go about it leave much to be desire"

Another participant in Adamawa interview echoed the same sentiment about the behaviours of some medical personnel as the extract below indicated:

> "Though I sympathized with my wife, the behaviour of some medical personnel had put paid to my visit to any hospital with my wives. A pregnant woman being harassed and abused by some so-called nurses who do not think they are women? Well, my wife can continue to bear all that nonsense but I am done with going to any clinic"

In Kirfi local government area, in one of the maternities, a woman participants in an interview noted;

> "It is good that CPED came to talk to our hospital staff on courtesy to patients. When you go to some hospitals, they just talk to you as if you are one of their children. A woman is in labour pain, yet a nurse is telling you all sorts of nonsense that you do not want to ordinarily take from anybody. This is not related to all of them, but some of them are really bad. My husband who used to go to the clinic with me got tired of them and had a serious quarrel with a few of them. Today, it will take real effort to get him to any clinic with you, except it is something very serious"

The FGDs in Yola as well as Bauchi towns and some enlightened participants agreed to the fact that traditionally, reproductive health programmes concentrated all their focus on women and so most projects see RH as connected to maternal health. Besides, most contraceptives were related to women and all you see is a testimony that all programmes are for women as noted by some of our participants below

> "One thing that excluded men from actively taking part in RH is the fact that traditional medicine came with the focus that RH is about the woman. At first all we call RH today was maternal health. It was in that conference in-----I cannot remember the name again (a participantin an FGD in Yola)

Another contributor in an FGD in Bauchi noted

> "Almost all contraceptives are meant for women, that is an indication of where the focus of reproductive health lies and men are helpless in this regard"

A participant during an interview noted in Ganye Local Government Area thus:

> "I have six children with my wife and we decided to go for family planning but my wife is always having problem with the contraceptive she is using and I do not enjoy sex with condom. Doctor says I need to go to cut my sperm duct which I refused insisting on alternative to condom; it is like every other contraceptive is connected to women and helping my wife in this case has been difficult. She is currently pregnant with our seventh child".

A health system related barrier though connected to the pride of men has to do with the nature of power between men and women; since men most timesare not comfortable disclosing sensitive matters to women as noted by a

participant in the extract of an interview in Bauchi town showed below:

> "I would have really love to take part in family planning and the health of my family in general but you see thatman in the hospital is not just good. One even insisted my wife should pull off her clothes for examination the other day when I was still there. I was not even comfortable at all, he is the only one in our area and I decided by wives should be doing the visitation to the hospital themselves"

3. Involving men in reproductive health in Adamawa and Bauchi States

This section of the paper presents findings that answer the second question in our study "What are some of the strategies for involving men in reproductive health services in Adamawa and Bauchi States?

3.1 Mind Set Change

A vast majority of the study participants including male and female as well as urban and rural dwellers in their answers to interviews and contributions to FGDs believed that for men to become effective partner in reproductive health, there will be need for a change of their minds. According to them, most of the problems they have are related to attitude and beliefs over times which are deeply embedded in their reasoning which will be difficult to change overnight. A number of strategies to overcome these were stated as a ways of raising awareness:

3.1.1 Raising awareness of the significance of male involvement in RH

The findings from study participants indicated that the need to get more men involved in RH will require conscious efforts on the part of different stakeholders including: the governments, health practitioners and their associations,communities, religion bodies and donor agencies. In the first place, traditional rulers who are the custodians of our culture to be reached with RH information if we must make head way as this participant noted in an interview in Kirfi LGA in Bauchi State:

> "To change the minds of men is to change the society. It will not be easy but we must try. One place will must focus is the traditional institution especially the rulers. Yes, the rulers are the only people most time who can talk to their subjects on sensitive issues like sex and reproductive health. They are the watch dogs of our cultures and people will listen to them"

Another participant acknowledged the creation of awareness but with a reservation of how to do this as seen from her comment in Adamawa

> "We need to re-orient the minds of our men but I am thinking of how this will be done to be effective considering the nature of men and their works. We need to think seriously of the modalities to employ to achieve maximum results"

A comment from FGD in Kirfi gave insights on what to do

> "Getting men involved in reproductive health will not be a bread and butter affair considering how much they are used to the traditional way of doing things. One way to achieve this is to target them at the appropriate time. Peer education will work well as well as using teachable moments. Men always have informal places of meeting, getting some of their colleagues as peer educators will encourage them to learn. As for teachable moment, almostall Nigeria men love football. This is something the government can catch on at the national, state, local and community level to use football activities to promote programmes that encourage men to participate in reproductive health using mass media. Considering our rural nature, government can promote football activities which are used as teachable moments in communities. Community festivals are equally very useful but we must be careful that our messages are not against what such festival is promoting"

In Bauchi a participant distinguished urban and rural strategies since according to him, strategies could be classified as either they are urban or rural. This classification was based on the fact that the populations in an urban area and those of rural area have different characteristics which make reaching them peculiar. For example, he talked about the demographic attributes of these populations. In the urban areas, there is the likelihood that we

have more educated; wealthier and people with access to mass media and information compared to their counterpart in the rural areas; who do not have access to these things. He advocated that town hall meetings, community sporting activities and peer education be promoted among community associations and groups while the urban areas be programmed to have such things like TV and other advertorials, rallies, mass media discussions and aware creation using TV and radio and newspapers as he noted:

> "People require different medications for different ailmentsand it is so in reproductive health programming. We need to be sensitive to many things in our works localities if we are to make meaningful impacts and get men to be part of what we are doing in RH. The reason why urban men are not participating in RH may just be different from those of rural dwellers and targeting them may require different strategies based on their peculiarities"

Another finding from the interviews and FGDs revealed the powers people attach to music and the place of music in mind set change as these participants noted in Adamawa and Bauchi State as the extracts revealed below:

> "Getting men involve in maternal health can easily be done if the messages for this is woven into the lyrics of a song and with time people will get the message. Music, especially local music is powerful means of getting to the people"***……interview in Bauchi***

Another participant has this to say

> "Give me my music in fulfude which talk about how men can help their wives and then you will be on your way to getting to the soul of our men. Music is powerful if effectively deployed during programming"***---- An extract from an FGD in Yola, Adamawa State.***

Still a woman noted

> "Awareness creation may be difficult using other strategies but put your message in music using the dialects of the people concern and you will see how voluntarily they want to listen to such messages"***------an interview extract in Bauchi State***

Like Music, a good number of participants suggested the use of drama to drive home the message of male participation in RH as this participant noted in an interview in Ganye LGA in Adamawa:

> "Drama! This is a powerful tool. It is appropriate in passing difficult messages. Community dramas targeted at male participation will be very useful. A new version of this is to put the message of male participation in home videos which are today being watch by many"

A dimension which most participants supported in the study was the need to address the problem of male participation from the school level. These persons believed that it is easy bending young people than people used to a particular culture as this participant asserted

> "The attempt at making men to participate in reproductive health should start from now on. We should target the schools and young people in the communities since one challenge we are having with mindset change; is the entrenched cultures that people are used to. Let us catch them young"

Another participant advocated thus;

> "One thing family life education should promote is the place of male participation in reproductive. Let us drive the message into the hearts of our children before they grow into adulthood. In this way, it will be part of them"

3.2 Addressing issues related to facilities and staff attitudes

A great deal of study participants agreed that facilities for reproductive health been made more attractive for male participation in reproductive health. Traditionally, people believed that the maternity is a place to be attended by only the women. Men do not see the need to be part of this. Therefore, services within such location should be made friendlier to men to participate by dedicating a section to their activities as this participant noted in an interview in Yola, Adamawa State.

> "If our objective is to get more men to take part in reproductive

> health we need to think of a unit withinthe hospital which will be solely dedicated them to feel at home when they visit with their wives. I am not talking of male ward. I mean a facility created within the hospital for them and operated by male"

On the attitude of health workers a participant in an FGD has this to say as a way of promoting men participation in RH:

> "Staff needto know that no man or woman is a happy person when visiting the hospital. There should be continuous sensitisation of how staff needs to relate with their patients. They need to be told to be more considerate in dealing with their patients. Agreed that some patients can be troublesome sometimes, but under such provocations, medical personnel need to learn the psychological chemistry of most of them and tolerate whatever they do"

From the perspective of another participants

> "Medical personnel need to abide with their oat of confidentiality and make sure every patients get the level of cover or confidentiality that he or she desires"

3.3 The need for effective policy

A good number of participants in the study suggested that if participation is needed to deal with some reproductive health challenge and the men are not giving the necessary cooperation, then the government will have no choice than to come in with relevant policies that will make this to work as this participants noted

> "Government has an obligation to make sure that any policy that will bring sanity to the society is promoted in all spheres of our living and that includes men participation in reproductive health"

4. Discussions

The themes from the analyses of data and results from this study revealed that the key issues in male participation in reproductive health in Adamawa and Bauchi Statesare tradition and power/gender in line with what VSO(6) observed. This is followed by health facility and staff attitude problem (23, 17, 24, 25) combining in different proportion to prevent men from actively taking part in the reproductive health affairs of his family. Men traditionally believe that reproductive health activities are for women and so it should remain in that domain therefore, attempt at involving men is rebuffed –seeing that attempt as a way of encroaching into a territory that is not meant for men. This is in line with WHO(13). The traditions which inhibit men from effective participation in RH are fueled by the people ignorance and lack of adequate knowledge and from the point of view that the man see the woman as one of his "property" to be use according to his wish.In Adamawa and Bauchi States, Staff attitude as well as the nature of the health facilities themselves are a challenge to involving men in reproductive. Also, religion, gender of medical personnel, some medical ethics, lack of RH socialisation, men intention to dominate women and family pressure are some of the barriers to effective male participation in reductive health.

Suggestions to involve men in reproductive health include mindset change through awareness creation using the traditional rulers/community forums, mass media, music peer education depending on the locality of the audience we are trying to reach whether they are urban or rural. Additionally, the re-orientation of medical personnel in term of attitudinal change and confidentiality of service are needed to get more men involved in RH. Participants equally recommend greater spousal communication and the need to involve men in RH through policies enactment.

5. Policy recommendations

- Male involvement in reproductive health is crucial for better results from reproductive health generally especially with the problem of HIV/AIDS since men will be able to do this from the point of view of knowledge and awareness;
- Women success in reproductive health is to a large extent dependent on the men. Therefor promoting RH for men will create general awareness on the part of men which will enhance women's programme and reproductive health benefits since men are the major decision makers in most family matters including RH;
- Promotion of reproductive health from family life education in schools;
- Hospitals as well as other health facilities need to be friendlier to men by creating unit for their waiting each time they accompany their wives to such places since will get more men to be part of RH process.

- Continuous re-orientation of medical personnel is needed for better RH results through promotion of male involvement.
- Governments need to come up with policies that encourage couple participation.

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References

1. Guttmacher (2003). In their own right: Addressing the sexual and reproductive health needs of men worldwide. (Online). Available:https://www.guttmacher.org/pubs/itor_intl.pdf (2003).
2. Maharaj, P. (2000). Promoting Male Involvement in Reproductive Health. *Agenda No 44, AIDS Concerns for Women*. 37-47.
3. Family Health International (1998). Male Participation in Reproductive Health *Network.* 18 (3).
4. Sternberg, P.& Hubley, J. (2004) Evaluating men's involvement as a strategy in sexual and reproductive health promotion. *Hlth Prom Intl* 19, (3): 389-396.
5. FAO (1998).Male involvement in reproductive health: Incorporatinggender throughout life cycle. (Online). Available: http://www.fao.org/docrep/x0257e/x0257e00.htm (June, 1998).
6. VSO, (2012). Male involvement in Community and home-based Care in Namibia. 27a Carlton Drive, Putney, London, SW15 2PN, United Kingdom ibia
7. Msuya, S.E. et al. (2006). HIV among pregnant women in Moshi Tanzania: the role of sexual behavior, male partner characteristics and sexually transmitted infections. *AIDS Research and Therapy*, 3:27.
8. Desgrees-du-Lou, A. (2008). Orne-Gliemann J. Couplecentered testing and counseling for HIV sero-discordant heterosexual couples in sub- Saharan Africa. *Reproductive Health Matters*, 16:151–161.
9. Peacock, D. et al. (2009). HIV/AIDS, and human rights. *Journal of Acquired Immune Deficiency Syndromes*, 51(Suppl. 3):S119–125.
10. Conkling, M. et al.(2010). Couples' voluntary counseling and testing and nevirapine use in antenatal clinics in two African capitals: a prospective cohort study. *Journal of the International AIDS Society,* 15; 13:10.
11. Ndagije, F. (2011).“Cost-effectiveness of male involvement in PMTCT/ANC”. Presentation delivered atthe *sub-regional consultation to discussstrengthening male involvement in theelimination of mother-to-child transmission ofHIV*, 25 August 2011, Kigali, Rwanda,.
12. Peltzer, K. Sikwane, E. Majaja, M. (2011). Factors associated with short-course antiretroviral prophylaxis (dual therapy) adherence for PMTCT in Nkangala district, South Africa. *Acta Paediatrica*, 100(9):1253–1257.
13. WHO (2012). Male involvement in the prevention of mother-to-child transmission of HIV, 2012. Geneva, World Health Organization.
14. Gilbert, L.& Walker, L. (2002). Treading the path of least resistance: HIV/AIDS and social inequalities: A South African case study. *Social Science and Medicine,* 54(7): 1093-1110.
15. Peacock, D. (2003).*Men as partners: promoting men's involvement in care and support activities for people living with HIV/AIDS*. Brasilia, EngenderHealth.
16. Chege, J.(2005). Interventions linking gender relations and violence with reproductive health and HIV: Rationale, effectiveness and gaps. *Agenda Special Focus*, 114-123.
17. Reece, M. Hollub, A., Nangami, M. & Lane, K. (2010). Assessing male spousal engagement with prevention of mother-to-child transmission (PMTCT) programs in western Kenya. *AIDS Care*, 22(6):743-50.
18. Orne-Gliemann, J. et al. (2010). Couple-oriented prenatal HIV counseling for HIV primary prevention: an acceptability study *BMC Public Health*, 10:197.
19. Falnes, E.F. et al. (2011) It is her responsibility": partner involvement in prevention of mother to child transmission of HIV programs, northern Tanzania. *Journal of the International AIDS Society*, 2011, 14:21
20. RHO,(2004). Men and reproductive health. (Online). Available:http://www.rho.org/html/menrh_overview.htm (December 19, 2004)
21. De Schutter, M. (1999). Men and Women's Sexual and Reproductive Health Needs: Competition for Limited Resources or Shared Concerns?"Pan American Health Organization/World Health Organization. Paper presented at *AWID Conference Panel on* "MaleInvolvement in Sexual and Reproductive Health: Hindrance or Help to Gender Equity?"(November 12, 1999).
22. Blanc, A. K. (2001).The effect of power in sexual relationships on sexual and reproductive health:an examination of the evidence. *Studies in Family Planning.* (32). 3: 200.

23. Theuring, S. et al. (2009). Male involvement in PMTCT services in Mbeya region, Tanzania. *AIDS and Behavior*, 13:S92–S102.
24. Byamugisha, R. et al. (2010). Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: a cross-sectional survey *Reproductive Health*, 7:12
25. Larsson, E.C. et al. (2010). Mistrust in marriage-Reasons why men do not accept couple HIV testing during antenatal care- a qualitative study in eastern Uganda. *BMC Public Health*, 10:769.
26. Misiri, H.E., Tadesse, E., Muula, A.S. (2004). Are public antenatal clinics in Blantyre, Malawi, ready to offer services for the prevention of vertical transmission of HIV? *African Journal of Reproductive Health*, 8:64–70.
27. Aluisio, A. (2011).Barriers to male engagement in PMTCT: research from primary stakeholders. Presentationdelivered at the *sub-regional consultation todiscuss strengthening male involvement in theelimination of mother-to-child transmission* ofHIV, 25 August 2011, Kigali, Rwanda.
28. Shemsanga, M.A.(2011).Barriers to male engagement: perspectives from health care providers.Presentation delivered at the *subregionalconsultation to discuss strengthening maleinvolvement in the elimination of mother-to-childtransmission of HIV*, 25 August2011,Kigali, Rwanda,.
29. UNAIDS (2011). Global plan towards the elimination of new HIV infections among children by 2015 and keepingtheir mothers alive, 2011–2015. (Online). Available: http://www.unaids.org/believeitdoit/the-global-plan.html.
30. Onyango, M.A., Owoko, S.& Oguttu, M. (2010).Factors that Influence Male Involvement in Sexual andReproductive Health in Western Kenya: A Qualitative Study, *African Journal of Reproductive Health*,14(4): 33-43.

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