

Male involvement in reproductive health: a management perspective

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Aims The present study outlines the perceptions of participants on male involvement in reproductive health (RH) from a management perspective.

Background Namibia is one of the African countries affected by cultural and socio-economic influences that have persuaded gender roles in a way that hinders male-partner involvement in RH.

Method A qualitative, exploratory, descriptive design was followed. The target population included all male and female partners attending a health facility and all nurse managers (registered nurses in charge) that provided RH services in the health facility in a northern region in Namibia. Individual interviews were conducted until data saturation occurred.

Results The results indicate that the management principles, policy and legislation, as well as resources to facilitate male involvement in RH, were indicated as barriers for nurse managers to facilitate male involvement.

Conclusion Male involvement in RH care is needed for an interpersonal and interactive partnership.

Implications for Nurse Managers Recommendations are made to establish a partnership within the current health care framework in which reproductive health is provided.

Introduction

Previously, Jamison *et al.* (2006) as well as Abu-Raddad *et al.* (2010) have indicated that the majority of people in Africa have a limited knowledge of sexuality and reproductive health (RH), although statistics show that 250 000 mothers and 3 million babies die in Africa annually from complications that are related to sexuality and RH. The current health framework for reproductive health care (RHC) in public health care facilities in Namibia is designed to meet the needs of ante- or prenatal women. However, this framework lacks a focus on including male partners (PANOS/NRCS/SAFAIDS 2003).

The World Health Organization (WHO) regards RH as a basic human right of men and women, because it enables them to be well informed and to have access to safe, effective, affordable and acceptable methods of family planning of their own choice; allowing women to go through a safe pregnancy and childbirth and providing couples with the best chances of having healthy infants (WHO 2006). RH care is defined by the World Health Organization (WHO) (2006) as: 'A constellation of methods, techniques and services that

contribute to reproductive health and the well-being of the individual and the family by preventing and solving reproductive health problems'. It also includes sexual health and the purpose of enhancement of life and personal relations, counselling and care related to reproduction and sexually transmitted diseases [United Nations 1995, United Nations Population Fund 1997, Tavrow 2005, World Health Organization (WHO) 2006, 2008a, International Conference on Population and Development (ICPD) 2009].

In order to achieve these objectives, people need to be empowered with knowledge and skills that will enhance positive outcomes in terms of human development and maturation; sexuality and sexually transmitted infections (STIs); fertility and infertility; pregnancy; as well as creating an environment in which people can use sexual and reproductive health programmes effectively (ICPD 2009).

In Eastern Europe and Central Asia, RH is viewed in a positive manner and men participate actively in sexuality and reproductive health programmes. This active participation has been brought about by the rapid increase of HIV/AIDS and STIs among young people; inadequate access to quality services for counselling on, and the diagnosis and treatment of STIs; as well as a high maternal death rate (UNFPA 2003).

In India, a previous study conducted by Mavalankar *et al.* (1998) aimed at investigating the higher morbidity of males resulting from sexual complications and reproductive ill health. These researchers revealed that such ailments occurred as a result of the lack of human and material resources in rendering reproductive health services to males (Mavalankar *et al.* 1998).

A study on the reproductive health system conducted in Sierra Leone revealed that male clients were considered to be a constraint in terms of family planning programmes, as only female clients were targeted by health care providers (Planned Parenthood of Sierra Leone 1998). In addition and as a result of both the dominance of men over women and male sexual promiscuity, gender discrimination and inequality have been critical factors in the spread of reproductive health diseases such as HIV/AIDS in Africa (Lule *et al.* 2009). In Africa, traditionally, RH care has been regarded as specifically applicable to females and children, owing to the fact that these services have been concerned with pregnancy and birth. However, it was realised that men could play an important role in RHC delivery. It ought to be pointed out that the partners and individuals have the right to decide freely about their treatment and to have all the information and education about RH. It can only take place in an environment where men participate fully in RH (UNFPA 2001: 3).

Background

Day *et al.* (2009) have identified gender imbalance, violence towards women and male chauvinism as the main problems in terms of sexuality and reproductive health. These problems emanate from the social and cultural structure of society, which, in turn, bred violence. For example, a woman is raped every 26 seconds in South Africa (Duncan *et al.* 2007). Some of the other problems between male and female partners include poor or limited communication between partners, as male partners are not well versed in the issues or problems that affect the reproductive health of their female partners;

manifestations of masculinity, frequently aggravated by the abuse of alcohol, which often involve violence against women and children; limited financial or other resources and the involvement of the male partners in risky sexual behaviour as a result of negative attitudes and either a lack of, or limited knowledge on the part of male partners in respect of reproductive health issues (Uys 2007a). Male partners are also far less likely than females to attend clinics for sexually transmitted diseases (STDs) in significant numbers.

Namibia is one of the African countries that has been affected by the challenges that arise as a result of the cultural and socio-economic influences which determine gender roles that hinder male-partner involvement in RH. Negative attitude problems emanate from culture although no recent research has been undertaken in Namibia. The negative attitude on the part of the male partners stems from the fact that the males tend to make all decisions autocratically in the home, and this dominant behaviour results in their wives being inferior and more dependent on their husbands (Gorgen *et al.* 1998).

In Namibia, mothers and children are the main target population in respect of the available reproductive health systems, including a minimum fee for antenatal care (ANC) and postnatal care (PNC) in public healthcare services. In general, males do not accompany their female partner when they attend these clinics, nor do they participate fully in the antenatal and postnatal care of their partners. Age and geographical factors also play a role in RH (Roudi & Ashford 2004). Senior citizens, illiterate people and those who live in rural areas tend to manifest negative attitudes towards RH as compared with the young, the educated and those who live in the city (Roudi & Ashford 2004). It is not clear how male partners perceive, or what they expect from, these ante- and postnatal care departments (Ministry of Health and Social Services 1994). Male partners could perceive RH policies as major de-motivating factors in respect of participation within the system (Bureau of Reproductive Health 2002). Mabote (2003) explains the nature of man, as men perceive themselves as strong, independent and unlikely to ask for help, and they are uneasy when discussing anything related to sexual problems.

Namibia is ranked fifth in the world in terms of the prevalence of HIV/AIDS and males are regarded as the main cause of the spread of both this and other reproductive diseases (Jackson 2002). This spread, however, affects mothers and children and the nation as a whole. Much of this problem could be prevented if male partners were to be equipped with adequate knowledge and skills in respect of RH.

In order to overcome these problems, the WHO (1999) has suggested that governments and institutions develop models of RH that can serve as platforms for male partner involvement. In the context of Northern Namibia, it is common practice that only one registered nurse is available at a RH care service facility (clinic), who also acts in the capacity of the nurse manager. In terms of RH models, nurse managers could play an important hands-on role in the implementation of models using various strategies or

recommendations. Such an approach could motivate and involve male partners in respect of the use of the available facilities and resources of the RH services in the same way as women. The Ministry of Health and Social Services (2001, 2002) has identified two important male partner roles when assisting female partners, which are necessary in terms of the implementation of an effective RH system. These roles, first, include an advisory role in terms of which men take the lead in providing information related to reproductive health, and second, is a supportive role in respect of family planning during which male partners support their female counterparts in terms of suitable methods of contraception.

Problem statement

It appears that there is a disparity in the delivery of RH services in Northern Namibia, as mainly women and children are targeted by the available RH programmes and services. Males, especially males in African countries (including Namibia), have not been participating fully; neither have they been actively involved in RH (Holtz 2008).

A problem that female partners have cited during their visits to RH care facilities is poor or limited communication between partners, as male partners have not been well versed in the issues or problems that affect the RH of their female partners (Uys 2007b). Mullick *et al.* (2005) stated that RH services such as family planning, pregnancy and childbirth have been regarded as exclusively the domain of women and, generally, men do not accompany their partners to facilities offering such services and that the exclusive use of such services by women have to a great extent made these RH services unfriendly for men.

It is for these reasons that the following two research questions were posed:

1. What are the perceptions of male partners, female partners and nurse managers about the involvement of male partners in a reproductive health care facility in the northern region of Namibia?
2. What should be done in order to involve male partners in the RH context? Perception is defined as a process in which individuals receive and make sense of or give meaning to their environment (Shajahan & Shajahan 2007).

Purpose of the research

The aim of the study was to explore and describe the perceptions of stakeholders (male partners, female partners and nurse managers) in the northern region of Namibia in respect of male partner involvement at a RH care facility. The main purpose of the study was to increase our knowledge and understanding regarding the challenges of reproductive health care services in Namibia.

Design

The approach in this study was qualitative, exploratory, descriptive and contextual in nature. Qualitative research is a systematic, subjective method utilized to describe experiences of life and ascribe meaning to these experiences (Burns & Grove 1995, p. 14). A qualitative approach was chosen specifically because it was regarded as a systematic approach that would allow the researcher to explore the perceptions of the participants and their problems in totality, and it took place within the natural setting of a health care facility in the specific region (Babbie 2010). The exploratory approach enabled a broader range of data with a richness of detail (Creswell 2011). Descriptions were used to gain accurate and complete information and a comprehensive understanding of the participants as well as the setting of RH.

Population

In the study, the accessible target population included all male and female partners attending a health facility and all the nurse managers of the health facility that provided RH services in the specific Health Region of Northern Namibia. During the study in July 2009, it was found that no specific data were recorded in the health facilities about the number of male and female partners attending them. At the time of the study, 30 registered nurses were the nurse managers in charge of these health facilities.

Sample and sampling

The purposive sampling method was selected. In terms of a purposive sample, participants were included in the study because they happened to be in the right place at the right time (Babbie 2010). The selection of participants was based on the following set of criteria:

- The participants were all able to speak English.
- The male participant was in a relationship with a female partner and visiting the RHC care facility with or without the partner.
- The female participant was in a relationship with a male partner visiting the RH care facility with or without the partner.
- Male and female participants had an interest in providing input into the research process, agreed to participate on a voluntary basis and were in the reproductive age group of 15–59 years.
- The nurse participant was the nurse manager working at the health facility, offering a programme dealing with RH services, in the northern region of Namibia.

Sampling continued and the point of data saturation was reached after 10 individual interviews (four male partners, three female partners and three nurse managers) were conducted. Only one male partner and one nurse manager were married. The three nurse managers were registered nurses with more than 5 years work experience. Only one male partner had a Bachelors degree.

Method

Pilot study

A pilot study was conducted in order to identify unforeseen problems and to assess the feasibility of the study (Burns & Grove 2005). This pilot study was conducted during 2008 in the same region and four male partners from a RH facility were interviewed individually. A female partner and a nurse from a facility were also interviewed to ensure representation in the pilot study. The following question was posed: 'What are your perceptions in respect of male involvement in RH?', to determine if the interview question was clear, understandable and lead to trustworthy results. The data obtained from the pilot study were not included in the findings of the present study.

Data collection

The triangulation method for data collection was used; namely, individual interviews, fieldwork notes and tape-recorded data. The researcher chose in-depth inter-views, as it was a useful method for eliciting facts from the participants (Burns & Grove 2005). Participants had to sign a written consent form to indicate their voluntary participation. The benefits of the study were explained to them as well as that their names would not be revealed in the results. They were further informed that they could withdraw at any stage of the study. These individual interviews were held in a private room in which there was no possibility of intrusive noise. Field notes were taken both during and after the interviews. The aim of this process was to incorporate and relate information with the tape-recorded data in order to meet the requirement of trustworthiness. Field notes also served to supplement the data that could not be portrayed by audio-taped interviews, for example, non-verbal communication as well as a description of the layout of the health facilities. The field notes consisted of, first, observational notes that the researcher wrote down about what he heard and saw and a description of events, which was derived from watching and listening (Monette *et al.* 2011). Second, reflectivity notes/personal notes included the researcher's reflections on his feelings, thoughts and experiences during the interviews (Creswell 1994).

During the interviews the researcher demonstrated warmth, caring and a non-judgemental understanding of the participants (Cohen *et al.* 2007). The researcher also used various responsive communication techniques as tools, to encourage the participants to share their perceptions, such as reflection, timing, language and terminology, paraphrasing, clarification, focusing, silence and probing (Cohen *et al.* 2007).

Data analysis

The tape-recorded data were transcribed verbatim by the translator (researcher). In order not to lose any meaningful information and to incorporate non-verbal data, such as the tone of voice or facial expressions, the data were transcribed soon after the interviews had taken place. The following data analysis processes were adopted: reading, coding, displaying,

reducing and interpreting (Hardy & Bryman 2009). The data were reduced by selecting, focusing, simplifying, abstracting and transforming the information that had emerged. The data reduction/transformation processes were repeated until conclusions were drawn and verified (Ulin *et al.* 2002). An independent coder was also used to analyse the data. One main theme, two categories and six (6) sub-categories (Table 1) were identified using Tesch's eight steps, as cited in Punch (2009). Once a number of interviews were conducted the transcripts were read through to get a sense of the whole and notes were made. Once a general idea of the content of the interviews had been gained, random transcripts were chosen out of the pile. The main theme emerged as 'Optimum functioning of a health care delivery system to facilitate male involvement in RH'. The selected transcripts were sorted into separate piles according to the categories and the sub-categories leading to refinement of the schemes. Descriptive wording was used in labelling the categories and sub-categories so that it was possible for these to be identified in the transcriptions. Schemes were marked in colour in the transcripts. The data were analysed within the categories and sub-categories (Creswell 1994, p. 155).

Trustworthiness

Important principles guided the researcher in maintaining the true value, applicability, consistency and neutrality of the entire research process. Credibility was maintained by prolonged engagement, persistent observation, triangulation, referential adequacy and member checks (Houser 2008). Transferability was ensured by selecting and inviting participants who had had the experience of visiting the clinic and that were willing to partake in the study. After completion of the study, the findings were evaluated at a regional meeting of nurse managers, for usability by other RP health facilities in Namibia. The findings were received positively. Dependability was maintained by an external inquiries audit, a dense description of the research method and triangulation of data. The researcher ensured the safekeeping of the recorded tape cassettes and written documents and notes from the interviews (conformability).

Ethical considerations

The research proposal was approved by the Ministry of Health and Social Services and by the University of Namibia in 2008. Permission to use the health facility as well as the services of the nurses was obtained from the district primary health supervisor for the clinic and health centre and the regional director to the Permanent Secretary of the Ministry of Health and Social Services. The ethical aspects involved in this study included informed consent from participants who were informed about the purpose, objectives, method and duration of the study (Babbie 2008). The worth and dignity of the participants were protected at all times during the study. During data collection the researcher did not, at any time, gather information illegally, for example, by recording conversations without the knowledge of the

individuals concerned. All data collection methods were scrutinised to protect the privacy of the participants (Phillips & Stawarski 2008).

Results

The main theme focused on optimum functioning of health care delivery systems to facilitate male involvement in RH. The theme referred to, in fact, shortages and deficiencies that prevented favourable or the best possible circumstances for RH care services.

Table 1
Theme, categories and sub-categories

<i>Main theme</i>	<i>Category</i>	<i>Sub-category</i>
Functioning of a health care delivery system to facilitate male involvement in RH	Accessibility of health facilities that cater for RH	Distances and availability of transport for male and female partners to attend the health facilities for RH services Costs involved in the RH services and treatments Periods of time spent at the health facilities that provide RH services
	Management principles and structures in respect of the facilitation of male involvement in RH	Policy and legislation in respect of male involvement in RH Building and structures housing the RH services Human and material resources in respect of the RH services Networking between stakeholders and within the health facilities that provide RH services

RH, reproductive health.

A need for efficient and purposeful approaches in providing adequate RH care structures was perceived. This was expressed in terms of the inaccessibility of those health care facilities for the partners, inadequate management principles and inadequate building facilities.

Accessibility of health facilities that provide RH services

This category referred to three sub-categories related to distances and availability of transport for male and female partners to attend services, high costs involved in services and treatments and time spent at the health clinics (Table 1).

The findings indicated that, in fact, long distances and unavailability of transport for male and female partners to visit the health facilities providing RH services were challenges that

made it difficult for male partners to accompany their female partners. Some of the female participants expressed their concern about the distance of the facilities from their homes as it sometimes prevented their male partners from attending the services. This situation could be exacerbated by a lack of financial resources to pay for transport to the health care facility and for the medication. In this regard, a female participant expressed the following:

'Yes, money is a problem, sometimes both of us could not go, due to transport fares constraints' (Female Informant, Interview no. 1).

With the current high cost of living, health care services and treatment we are facing constant cost increases in respect of services. Limited income made it difficult to attend RH services on a regular basis. It was a major concern of nurse participants who stated the following:

'Men's treatments, especially for infertility, are very expensive' (Nurse manager Informant, Interview no. 7).

'Another problem is financial related, the medical aid cards that we are using from the government, do not cover treatment cost, for RH-related problems or prescriptions for men related to reproduction' (Nurse manager Informant, Interview no. 8).

'Medicines of such nature are so expensive, client refer to the infertility treatment' (Nurse manager Informant, Interview no. 7).

'Travelling to health facility to receive such treatments, it's also very costly' (Nurse manager Informant, Interview no. 9).

'It is very clear that income is very low' (Nurse manager Informant, Interview no. 8).

Male participants stated their frustration with the extended periods of time they had to spend at the health facility to obtain treatment and services because they were forced to leave their household activities unattended for that time. They pointed out their problems as:

'One has to stay there for quite a long time waiting to be served' (Male Informant, Interview no. 2).

'Like right now I cannot even count them, they even more than maybe 70 people here'. (Male Informant, Interview no. 2)

'If you want to do a good job you take, take time Hum... and then you don't finish this entire people in a limit time' (Male Informant, Interview no. 4).

One female participant confirmed the waiting in queues:

'Wait for quite a long time in those long queues at the antenatal clinics' (Female informant, Interview no. 10).

The male participants further advised that the facilities needed to be upgraded and that they needed to include more services. One participant stated:

'Need to add something like to build health and social facilities/training centres directly for males'. 'Because in some cases the male partners can get information from his partner saying that he is sick, or the child is very sick and they need to go then they can go'. (Male Informant, Interview no. 3).

Management principles to facilitate male involvement

This category referred to four sub-categories related to policies and legislation in respect of male involvement, buildings and structures, human and material resources and networking between stakeholders.

A nurse participant was of the belief that the lack of strategies to encourage male partners to participate in the RH process was a deficiency and needed to change as a matter of urgency. In this regard the nurse manager had this to say:

'We do not really have such a policy at this clinic but (policies)... No, we do not have these strategies on how to approach them'. (Nurse manager Informant, Interview no. 8).

The female participants were of the opinion that policies and legislation needed to be passed to encourage male partners to participate. One participant (Female Informant, Interview no. 6) stated that:

'I think that, in Namibia, this thing of involving males in the RH is not important because if it is important, why there is no policy that telling us to go together'.

On the other hand, male participants felt cheated or unsupported in the sense that health programmes aimed at prolonging life and detecting ailments were exclusively for women. Accordingly, they felt there was no need for them to participate in something that would not benefit them. It was expressed in an emotional way by participants who said:

'...woman they are having many health services, for example, immunization start until they get old' (Male Informant, Interview no. 4).

'...for us it end up at the age of 15 years, some of this thing discourages male partners' (Male Informant, Interview no. 4).

'Yes, what we have observed there is no proper care for males, it just start here then it end there but woman it end up until they get old' (Male Informant, Interview no. 5).

In respect of buildings and structures for RH services, female participants and the nurses expressed their concerns as follows:

'Buildings are not enough or they do not have private rooms where a husband and wife can get treatment together' (Female Informant, Interview no. 1).

'We usually go there but it seems that doctors do not have enough time because of the overcrowding' (Nurse manager Informant, Interview no. 8).

The male participants felt that the equipment and the buildings where the women were attended to needed to be upgraded. They were of the opinion that more facilities

needed to be built in order to accommodate more women. They insisted that privacy was an issue when the rooms were overcrowded and sometimes this led to unhygienic conditions. In this regard they had the following to say:

'I have also experienced that the place is very small – it's so small that the women can be from up to seventy women a day even (pulling his face again) I see things are not well organised or placed' (Male Informant, Interview no. 4).

'There is no privacy at all' (Male Informant, Interview no. 2)

The nurse participants also expressed concern about the lack of privacy in the buildings used for RH services. In view of the fact that counselling was a long process (time factor), the participants expressed concern about the lack of sufficient staff to do the work as well as insufficient space in the buildings, and so forth. The participants stated:

'Clinic is the place with limited freedom for some the people' (Nurse manager Informant, Interview no. 7).

'Sometime one may have good feelings of accompanying his partner but he does not know where he will be able to stay' (Nurse manager Informant, Interview no. 8).

'I think to strengthen this education I know that we will assist many male partners' (Nurse manager Informant, Interview no. 9).

In terms of material resources, male and female participants stated the following:

'Well, hmm... to talk what I expect is first of all for the infrastructure to be upgraded, for this building (showing on the roof of the building) to be at least expanded' (Male Informant, Interview no. 3).

'Hmm... you can't even put two beddings in this department to at least limit your time hmm... to get time as a factor in here and I think that if they expand it a little bit more like make it a little bit bigger' (Male Informant, Interview no. 5).

'I suggest there should be a clinic, specifically for them (men) to guarantee their sense of freedom' (Female Informant, Interview no. 10).

The shortage of nursing professionals in the Health Ministry of Namibia had been a source of concern for many years and was also perceived as a problem by the nurse participants. In fact, they expressed themselves as follows:

'Counselling is a very long process and in most cases three nurses are counselling more than 200 hundred a day' (Nurse manager Informant, Interview no. 7).

'We are requesting for the additional staff and especially for school leavers who can play a vital role in the health sectors' (Nurse manager Informant, Interview no. 8).

'The majority of us we are going to be retired, and we need the government to participate fully as well the nation' (Nurse manager Informant, Interview no. 9).

The use of resources was highlighted during the interviews with the male participants. The most important issues that were raised included the professional training of nurses to enable them to provide proper information to all stakeholders at RH services. In respect of human resources, a male participant expressed himself as

follows: 'And there should also be government nurses, trained specifically to suit the programme related to RH' (Male Informant, Interview no. 5).

The nurses expressed concern, especially in cases where the nurses were rushed when seeing clients:

'In regard to the clinic, we have a lack of enough staff, by this way, it will also discourage people' (Nurse manager Informant, Interview no. 7).

'Sometimes, I have to attend to clients at the antenatal clinic, giving them their prescription, and sometimes I would even fail to attend to them and they will go back' (Nurse manager Informant, Interview no. 9).

One female participant (Female Informant, Interview no. 6) expressed her feelings of hopelessness about staff shortages as follows:

'... always having more patients than staff'.

Participants also expressed the need for networking and collaboration with key stakeholders. The nurse participants expressed the following:

'Networking should be strengthened' (Nurse manager Informant, Interview no. 9).

'We need a good networking with women who already are trained' (Nurse manager Informant, Interview no. 9).

'Inter-sectoral collaboration between government and non-government organizations is needed' (Nurse manager Informant, Interview no. 8)

'Incorporate it (male involvement in the RH process) within the school curriculum'. (Nurse manager Informant, Interview no. 7)

Networking and collaboration meant sharing of information and providing support to partners in RH. This support was seen as essential in encouraging favourable involvement on the part of couples involved in RH.

In respect to urgent needs for official networking and collaboration, the male partners reiterated/stated the following:

'There should be a strong relationship between male and female partners' (relationship). (Male Informant, Interview no.2)

'Government institution and non governmental organisation should work together' (working together) (Male Informant, Interview no. 2).

'Good communication is needed for male partners to participate in the RH' (Male Informant, Interview no. 5).

'There should be policies and regulations on how to involve male partners in the RH' (Male Informant, Interview no. 3).

Discussion

The first category focused on the challenges of optimum functioning of health care delivery systems to facilitate male involvement in RH. Factors hampering male partner

involvement in RH included distance, transport and travelling costs. O'Neil (2007) has suggested that, for partnerships in RH to thrive, the male partners who were targeted by such a programme ought to find it worthwhile for them to assist their partners and to share their resources with these partners, such as paying for their partners' transport to the facility, fees and all other necessary expenses. A male partner could experience these problems as an obstacle in assisting their female partner. A further problem was the medical aid schemes which did not include or made provision for either RH or the travelling costs to facilities as part of a medical plan. If medical aid did not cover these costs then the male partner had to have sufficient disposable income available. Both the time factor and overcrowding at the health facilities were issues which also featured prominently during the interviews with the male partners.

A main category was related to management principles to facilitate male involvement in RH. This category focused on policy and legislation pertaining to male involvement in RH, buildings and structures, the human resources needed for rendering the services and networking. The participants indicated that policy was sometimes not clear about the way in which male partners should be involved; both in terms of the health care provider and also in terms of stakeholders in RH.

Policies were also sometimes unilateral, which meant that only the mothers and children were favoured by the government when it came to resource distribution.

Hossain and colleagues (2004) have suggested that, in order for RH to be successful, it is essential to have an appropriate intervention and action plan in place. These simple, but concrete steps could create a structure for effectively involving male partners in RH. The mentioned plan should address sustained participation of male partners in RH and for encouraging them to accept services from the existing government.

All the participants (male and female partners and nurses) emphasized that involving the male partner in RH was not an easy task because it required adequate resources, human and material, and also sufficient time for the programme to succeed (Betchen 2005). Based on the participants' responses it was obvious that, in order for a collaborative process to succeed, the following was needed:

- adequate, effective and efficient human resources such as well-trained nursing staff;
- adequate, effective and efficient materials, including buildings; and
- the effective utilization of time.

Physical and material resources such as buildings and the facilities offering RH services were felt to be inadequate. Male partners found the privacy in buildings, the time spent waiting about, the equipment and the idea of RH buildings offensive. The health facility that provided RH services was observed

as being accessible for female partners only. These factors all constituted serious obstacles to male participation in RH.

Another issue addressed, was the shortage of staff that resulted in low quality of the services. Health care workers, even although willing to complete their tasks diligently, had limited time and resources at their disposal in spite of the demands of their patients. These challenges were found discouraging by partners. Similar findings have been described also by Mehtar (2010). The health facilities that rendered RH were predominantly staffed by female healthcare workers. Should the male partner decide to go to a health facility it would be important to take into consideration that they may, culturally, respect females however view them as subordinates. Males and female members of a certain cultural tradition have shared beliefs of the authoritarian position of a man in their society that becomes their reality (Peoples & Bailey 2009).

In view of the fact that the male partner, with his African culture, regarded the female as subordinate, the dominance of the female health caregiver was not likely to appeal to the male partners. In order to involve the male partner, McGinn *et al.* (1996) have suggested that government and institutions that provide RH services should pay more attention to the planning of their activities, especially with respect to the management of human and material resources in order to support the facilitation of male partner involvement in RH.

Insufficient networking, collaboration and partnerships between the stakeholders (male partners, female partners, community member's health facilities that provided RH services) were found in the present study. This could be regarded as contributory factors in respect to the poor participation and involvement of male partners in RH.

Networking and collaboration are needed in RH services. Networking refers in the RH context to the process in which individuals, institutions and organizations in both the public sector and the government sector form a support system in order to pave the way for involving male partners in RH. Networking is employed in the decision-making process and also in handling conflict within or between groups. It also refers to the sharing of expertise and services and helps to extend political influence (Gargiulo 2011).

Implications for Nursing Management

In terms of the RH programme, there needs to be a partnership between the male and female partners, nurses and nurse managers. A partnership establishes a relationship between individuals or groups that characterizes mutual cooperation and responsibility (American Heritage Dictionary 2007). The culture and the capabilities of each individual should be respected (Molle & Djarova 2009). The nurse manager needs to acknowledge that stakeholders have a right to participate and have the ability to access all

activities based on the scope of their participation and involvement in a RH programme. The nursing management strategies to be used for the establishment of a partnership to facilitate male partner involvement in RH should include a shared vision; networking; cooperation; collaboration; shared responsibility; joint decision making; and motivation.

Although these management concepts may be well known in first world countries, they seem to remain a challenge in the northern part of health care facilities in Namibia.

A vision could create an attractive future and long-term goal(s), motivate stakeholders to find their own roles in a specific programme and to work purposefully towards the defined concrete, short-term goals (Fulton *et al.* 2010). When the vision is clearly communicated to the stakeholders and the goals are set together, then negative attitudes and behaviour are also changing step by step, and the key stakeholders become committed to and optimistic about the programme. In that regard, a shared vision among the partners may facilitate male partner involvement in RH as well.

The nurse manager and nursing management have to facilitate the networking processes as described by Mackoff (2011). The stakeholders in the community (youth leaders, political leaders, traditional leaders and church leaders) and the stakeholders in the health facilities environment (nurses, medical doctors, social workers and psychologists) should be identified for the purpose of networking. Inter-sectoral collaboration between government ministries, National Government Organizations and health facilities should be identified and encouraged. During networking, exchange of ideas and information, offering of support and direction to the stakeholders, the sharing of expertise and services are essential.

Mutual cooperation has been defined as the state of doing something together or of working towards a shared goal (Oxford Dictionary of English 2005). This cooperation is only possible if the nurse manager understands her role in the RH environment. Through collaboration, different perspectives should be examined, new ideas and possibilities explored and common knowledge derived from the integration and synthesis of those ideas that are relevant to the facilitation of male partner involvement in RH (Beyerlein *et al.* 2006). The nurse manager should show respect towards the male partners' knowledge and privacy and be committed to equal opportunities for and confidentiality of all stakeholders to participate and to be involved in RH.

Effective communication promotes the sharing of information and the enhancing of decision making which may be relevant to the stakeholders during the development of strategies to promote male partner involvement in RH (Elliot *et al.* 2007). Networking could be used as a process that includes developing and using contacts for information, advice and support as

described, for example by Lussier (2009). It is essential that the nurse manager possesses positive attitudes in order to facilitate this process.

The nurse manager should promote the sharing of responsibilities of male partners and the female partners in terms of those activities that are related to RH. Both the male and the female partners are jointly responsible for participating in RH services for the benefit of their health and that of any siblings alike. The nurse manager should engage the male and female partners in discussion in order to encourage each partner to share his/her experiences with the other partner (Lauwers & Swisher 2010). The nurse manager is responsible for creating an environment that provides the stakeholders with the opportunity to share in decision making.

In order to gain trust and respect, the nurse manager ought to exhibit knowledge and skills in both the theory of RH as well as in practice. It will help her/him to be of assistance to the partners when they present their problems in respect of RH issues. It is also vital that the nurse manager spend some time with the partners and be visible by being involved, listening, interpreting their body language, showing sympathy and responding to their problems.

Confidentiality may be defined as a situation in which the nurse manager is expected to keep secret any information with which he/she is entrusted by the partners or nurses (Oxford Dictionary of English 2005, Muller *et al.* 2011). It may relate either to an interpersonal problem or to the reproductive disease itself. It is vital in the context of the RH services that the nurse manager maintains the highest standards of professionalism by keeping confidential any information given to him/her by the stakeholders (Ford 2006).

The nurse manager, in his/her role of facilitating male partner involvement, needs to motivate the male partner by ensuring that the male partner realizes the importance of active involvement in RH services. For example, attending RH facilities with their partners, in order to benefit both partners as such attendance could assist the partners to understand their problems and needs in totality and also lead to a greater understanding of their families and the community in general.

Limitations

The findings are based only on the involvement of participants at one RH care facility in the Namibian context. The tone of some interviews was very negative possibly because of a lack of, or limited, knowledge on the part of male partners in respect of reproductive health issues (Uys 2007b). The researchers were able to maintain a scientific objective by suspending his/her everyday assumptions in order to view the processes by which the apparent concreteness of the perceptions is verified (Polit & Hungler 1995, Gubrium & Holstein, 1997, Polit & Beck 2004). This technique enables the researcher to deal with personal biases by 'bracketing out' the self and examining their own prejudgement in order to become a clear receptor of

the phenomenon under examination. In the present study, the researcher suspended his prejudgement of what was needed to facilitate male partner involvement in RH during the data collection, the analysis and the conceptualization phases. Prior to each interview, the researcher wrote a full description of his own perceptions – the aim of this self-examination was to enable the researcher to gain clarity in respect of his own preconceptions. The self-examination is part of an ongoing process rather than a single, fixed event (Patton 1990).

It is suggested that another study could examine the nursing leadership roles, barriers, facilitators and challenges that reproductive healthcare managers face in Namibia. The small sample of participants in this qualitative study are not representative of those males (the majority) who do not have a permanent sexual partner or those who do not have any contact with the service.

Conclusion

This study revealed that a partnership (relationship) between the male partners, the female partners and the nurses is almost lacking. Strong input from both partners is essential if a partnership is to be successful. O'Neil (2007) has suggested significant points in respect of partnerships which could be applied to the stakeholders in the RH programme. Partnership is an ongoing, flexible and dynamic matter which needs strong input from all stakeholders. Reproductive health care enables both men and women to be well informed and to have access to safe, effective, affordable and acceptable methods of family planning of their own choice. Male partners have an interpersonal and interactive role to play in assisting female partners, which is necessary in terms of the implementation of an effective reproductive health system. These roles first include an advisory role in terms of which men take the lead in providing information related to reproductive health, and second, a supportive role in respect of family planning in which male partners support their female counterparts in terms of suitable methods of contraception.

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