Men as Equal Partners in Reproductive Health: What are Their Own Perception and Roles? A Case of Dar es Salaam, Tanzania

Esther W. Dungumaro
Institute of Development Studies, University of Dar es Salaam
Email: dungumaro@gmail.com

Abstract
Since the 1994 International Conference on Population and Development (ICPD) in Cairo (1994) and the 1995 Fourth World Conference on Women in Beijing, there has been an increasing consensus on the importance of involving men in reproductive health care. This paper analysed the male perception of involvement and their roles in productive health in a study that was conducted in 2015 and used the Tanzania Demographic and Health Survey (TDHS) to complement the empirical data. Findings show male still perceive themselves main decision-makers on reproductive health issues. Their roles were mainly centred on decision making on matters of reproductive health, including family planning. About sixty-one percent (60.6 percent) indicated that the decision about sex has to be done by men. On the use of family planning, more than seventy percent (72.4 percent) indicated that men are the ones to make such a decision. The study established that while 78.7 percent of the respondents approve of family planning, less than fifty percent (43 percent) indicated that they discuss family planning issues with their spouse. This further demonstrates that men are the main decision-makers on issues of reproductive health. Analysis of their knowledge on reproductive health, using DHS data indicate that about 100% were informed of at least one family planning method and that the majority get information from authentic sources including radio, television and newspapers. Based on the results and understating that knowledge of men's own perception is critical for both pragmatic and policy interventions, it is recommended that deliberate efforts need to continue to have men change their perceptions and become equal partners in reproductive health for the benefit of the family and society at large.

Introduction and background

For a long time, male involvement in issues of family planning and reproductive health has been neglected. International family planning and reproductive health at the time were focusing almost exclusively on women (Green, 1998). Men were mostly involved in instances where there was a

need to diagnose and treat sexually transmitted diseases (Mbizvo *et al.,* 1996). While there is an increase in recognition of the importance of male involvement in family planning methods and subsequent initiatives to address the gap between men and women in reproductive health matters, such efforts and study continue to mainly focus on women (Hardee *et al.,* 2016). However, since the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing, there has been an increasing consensus on the importance of involving men in reproductive health. Countries which signed the ICPD Programme of Action were in agreement on the importance of men to be involved in reproductive health and that they should take more responsibility for their sexual and reproductive health. The Programme of Action, therefore endorsed and emphasised the need for gender equity with special focus on male involvement in sexual and reproductive health. The argument is that when men are involved in reproductive health services and regarded as equal partners as well as clients in their own rights, better outcomes in reproductive health would be realised (Pachauri, 2001). In other words, it is widely recognised that global and national efforts aimed at achieving improved reproductive health indicators cannot be realised without male involvement. Against this understanding, in more recent years, family planning and other reproductive health programme have become interested in involving men in reproductive health.

Consensus on the importance of male involvement in reproductive health has resulted in global and national efforts on meaningful and effective male involvement in reproductive health. However, it should be noted that challenges exist in the realisation of male involvement in reproductive health. A vast majority of literature points to not only the importance of male involvement in reproductive health but also challenges and opportunities to their engagements (Helzner, 1996; Karra et al., 1997; Ijadunola et al., 2010, Onyango et al., 2010; Kululanga & Sundby, 2012). Literature documented various barriers to male involvement in reproductive health such as male dominance, low social and economic status of women, low women self-esteem and lack of communication between partners (Donta et al., 2005). Furthermore, in many societies, men play a masculinity role and traditionally are not involved in parenting. This, coupled with poor

knowledge, contributes significantly to men's reluctance in seeking reproduction health information and services, limiting their meaningful involvement. Although some family planning programs include men as an integral part of their intervention strategy, men are more commonly involved as gatekeepers or decision-makers for women's health or as "add-ons" in activities that focus on providing information and services to women (Geleta, *et al.,* 2015).

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

Other factors are on service providers. Ndong *et al.* (1999) noted that there is a general assumption among program planners of the criteria for clients who pursue reproductive health care. The assumption is that the client is a married woman, in a stable monogamy relationship with an equal voice in reproductive health matters (*ibid).* They argued that holding such assumption places the entire burden of reproductive health issues on women. While there is an increase in recognition of differences in the use of family planning methods between men and women, and subsequent initiatives to address the gap between them, such efforts and study continue to mainly focus on women (Hardee *et al.,* 2016). Studies have shown that when men are provided with the right information, they support their partners (Tsui *et al.,* 1997). It is therefore fair to argue that men have a bigger role to play in promoting and enhancing health behaviour of their families. However, their involvement will remain largely poor if their own

perceptions about involvement in reproductive health issues are not well known.

Understanding men's own perspective on their involvement in reproductive health has so far received less attention, despite the general consensus and understanding of the importance of male involvement in reproductive health. Against this backdrop, the present study aims to contribute knowledge in this area.

This paper focuses on what are men's perspectives and roles in reproductive health. The need to adequately understand male perspective about their involvement in reproductive health has been documented elsewhere (Collumbien & Hawkes, 2000; Hawkes & Hart, 2000). It is argued that to understand how men behave and how they perceive their role in sexuality and reproduction has important implications in various aspects of reproductive health. The concern arose when it became apparent that without understanding the male perspective, it would not be possible to change reproductive health-related behaviour that is risky to both women and men. The argument is that the success of programmes to involve men in reproductive health largely depends on an understanding of their own perception of involvement, including whether or not they are interested in participating in the programmes.

Data and analytical methods

The present paper, empirical and descriptive in nature, was conducted in Dar es Salaam City in Tanzania. To realise the objective of assessing men involvement in reproductive health and what are their own perspectives, extensive documentary review on socioeconomic and demographic factors was conducted, and also structured questionnaires in a household survey were administered to randomly selected married men in Dar es Salaam. The target was men currently married with wives in the reproductive age group (15-59). The sample size was 250 calculated by employing the following formula:

$$n = \frac{z^2pq}{d^2}$$

where n= sample size

z= standard deviation
p= estimated of key proportion (0.2069)
q= 1-p
d=desired degree of accuracy (0.05)

$$n = \frac{1.96^2 \times 0.2069 \times 0.7931}{0.05^2}$$

n= 252.2

Lwanga & Lemeshow (1991)

Male's perception of reproductive health and their involvement in the same is analysed using descriptive analysis.

In addition, the study used Tanzania Demographic and Health Survey (DHS) 2015/16 data to compliment on the empirical information on male involvement in reproductive health. Based on variables available in the datasets, items selected for analysis were age, areas of residence and level of education. Tanzania is one of the countries conducting Demographic and Health Survey (DHS) every five years. The last DHS was conducted in 2015/16. DHS are nationally representative cross-sectional surveys collecting information on men and reproductive and family planning matter. The data has rich information that allows for the analysis of men and reproductive health issues.

Results

Social-demographic characteristics

Table 1 presents the socio-demographic characteristic of respondents. The findings on age distribution show that the majority of the respondents (more than two thirds) were in the third and fourth decades of life. Almost 44 percent of the respondents had attained tertiary education, and only about five have no formal education. Tanzania, since independence, has made a commitment to the provision of education to her people. Through that commitment, the country has made significant advancements in the Education Sector. In 2015, the Government issued Circular 5 which implements the Education and Training Policy 2014 and directs public bodies to ensure that secondary education is free for all children. The

Government, through this initiative, has gone beyond its Constitutional obligation to provide free, quality primary education. The implementation of this Circular brings the country in line with the Sustainable Development Goal 4 (SDG 4) which requires States to ensure that everyone "completes free, equitable and quality primary and secondary education". The implementation of free education from primary to secondary already contributes to not only almost universal primary enrolment but also the proportion of people attaining tertiary education. In the context of reproductive health, disparities in the use of fertility regulation and a number of children, are observed between women with primary and secondary education, the latter having a few numbers of children.

The majority (88.4) of the respondents are employed. As stated earlier, Dar es Salaam is the Centre of Commerce and Business in the country. The majority of the people are engaged in both formal and informal sectors hence the higher score on employment. Almost 85 (84.6) percent of the respondents were in monogamous unions.

Table 1: Social-demographic characteristics of respondents

Characteristics	**Percent**
Age (in years)	
<30	16.3
30-39	33.1
40-49	37.6
50-59	13.0
Education	
No formal education	5.2
Primary	17.5
Secondary	33.6
Tertiary	43.7
Religion	
Protestant	24.1
Catholic	38.2

Islamic	33.6
Tradition	4.1
Employment	
Yes	88.4
No	11.6
Marriage type	
Monogamy	85.4
Polygamy	14.6

Source: Field data, 2015

Knowledge about reproductive health

Respondent's awareness of reproductive health is critical before investigating their perception of involvement in the same. Knowledge about reproductive health has been to relate to safer sexual behaviours and reduced likelihood of pregnancy (Kirby, 2007). These two, in the context of this paper, are considered critical in the pursuit of decreasing maternal mortality and attain desired healthy families for both social and economic development. If men are to be aware of reproductive health and practice and adequately involved in reproductive health programmes, global desired reproductive health goals and outcomes would be achieved.

Table 2a presents analysis on safer sexual behaviour and reduced likelihood of pregnancy. Age is a factor in sexual history. Table 2a shows that the youngest respondents are the least likely to have had more than one sexual partner as oppose to older men (9.8 percent for younger men (less than 30 years)) versus about 45% percent for older men (aged 50-59). The analysis shows that generally, condom use in the last sexual intercourse among men with more than one partner is inversely proportional to age; younger men are more likely to use condoms than older men. These results are consistent with those documented in the Tanzania Demographic and Health Survey Report (2015/16). A study in India found the difference in risk behavior between younger and older men, with the former reporting condom use more frequently than the latter Brahme *et al.,* (2005).

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

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

Source: Field data, 2015

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

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

Table 2b: Information about HIV

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

Source: Field data, 2015

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

Table 2c: Knowledge of HIV prevention methods

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

Source: Field data, 2015

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

Table 2d: Knowledge of likelihood to prevent pregnancy

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

Source: Field data, 2015

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

Males understanding of their involvement in reproductive health matters

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

reproductive health. Such changes include roles in relation to a couple's decision-making about sex, contraception and raring of children.

Results of analysis of men's perception about their involvement in reproductive health notably in decision-making about sex and contraception, their responsibilities as compared to that of women are guided by that of Grady *et al.,* (1996). Five questions are used to assess men's perception of their involvement in reproductive health and help determine whether or not they are equal partners as women in reproductive health issues. As stated above, reproductive health encompasses issues related to safe sexual behaviour and a reduced likelihood of pregnancy; therefore, the following questions were asked:

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

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

As opposed to what was documented by Grady *et al.,* (1996), the present study found that the majority of respondents do not agree with the statement that men and women have the same responsibility on the decision about sex and family planning methods (78 percent). This observation is in line with

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

results in Table 3, where the highest scores are male-oriented, meaning that they are the ones to make decisions about sex and family planning methods. This observation suggests that men are yet to be equal partners in reproductive health because they believe that they are the ones to make decisions about sex and family planning. Similar findings were observed in a qualitative study in Kenya. The study established that male involvement is poor and influenced by gender norms (Onyango, *et al.,* 2010). These observations suggest a low and rather poor male involvement in reproductive health matters. In this premise, deliberate efforts are needed to realise meaningful male involvement in reproductive health. The need to do that is particularly linked to the benefits of male involvement in reproductive health which include among others improved family health and ability to exercise reproductive rights of both men and women (Justus, *et al.,* 2016) as well positive reproductive health outcomes for mother and child. Benefits of male involvement in reproductive health cannot be realised if men still perceive themselves as decision-makers in matters of reproductive health and that women rights to freely access family planning will not be fully exercised.

Table 3: Male perception of their involvement in reproductive health

Measure	Female Oriented	Neutral	Male Oriented
Decision about sex	10.3	29.1	60.6
Contraception	6.1	21.5	72.4

Source: Field data, 2015

Male knowledge of family planning methods

It is of interest to establish male knowledge on reproductive health, notably family planning, especially since they are the main decision-makers on reproductive health matters. In most cases, the use of any contraceptive methods by women is influenced by their husbands (Wambui & Alehagen, 2009). Burger and Inderbritzen (1985) also noted that men's involvement in the decision about sex strongly links to the use of contraceptive. In Africa, men are traditionally perceived as household heads who make decisions on all matters of the family, including the number of children and the use of

contraceptives (Wambui & Alehagen, 2009). While empirical data collected from the field has shed light on male perception in reproductive health, it is important to find out their knowledge on reproductive health issues and attitudes from nationally representative data. To realise this, we use DHS 2015/16, which has questions for men on matters of reproductive health, including family planning.

Table 4: Knowledge of contraceptive method

Method	Percentage
Any method	99.6
Any modern method	99.6
Female sterilisation	89.7
Male sterilisation	60.7
Pill	97.6
IUCD	82.4
Injectable	96.3
Implants	90.1
Male condom	98.5
Female condom	86.7
Emergency contraception	24.5
Standard days method	33.6
Lactational amenorrhoea (LAM)	36.8
Other modern method	4.2
Any traditional method	85.8
Rhythm	71
Withdrawal	77.1
Other modern method	0

Source: DHS, 2015/16

Table 4 informs that about 100% (99.6 percent) of the currently married men, aged 15-49, know at least one method of contraception (see Table 4).

It of interest to establish source of family planning methods as some sources could provide wrong information. DHS 2015/16 has information on

exposure to family planning messages. Results are posted in Table 5 suggest that across all age groups except 15-19-year-olds get family planning messages from radio, television and newspapers than sources other than those four. This indicates that information on family planning is from authentic sources since all the sources have mechanisms in place to scrutinise information before its published.

Table 5: Exposure to family planning messages

Background characteristic	Radio	Television	Newspapers	Mobile phone	None of the four media sources
Age					
15-19	65.8	38.7	25.3	3.4	27.5
20-24	75.1	49.7	35.7	6.2	19.1
25-29	81.9	50.4	38.8	7.6	11.6
30-34	78.6	53.6	37.9	9.4	14.3
35-39	81	51.9	42.9	7.1	14.8
40-44	77.2	48	40.3	9.4	18
45-49	75.8	39.3	39.4	3.6	21.4
Residence					
Urban	79	69.4	51.7	9.7	11.1
Rural	72.4	33.9	26.3	4.3	23.8
Education					
No education	60.9	205	3.8	3.1	36.4
Primary incomplete	65.4	29.7	15.4	1.9	30.2
Primary complete	77	43.5	34.3	5.6	18.1
Secondary+	81.3	68.8	57.4	10.7	10
Wealth quantile					
Lowest	63	22.3	17.5	3.7	34

Second	70.7	28.8	20.1	2.3	24.3
Middle	73.9	34	27.7	4.2	23
Fourth	85	52.5	41.1	7.3	14
Highest	81.8	77.4	57.2	10.9	8.1

Source: DHS, 2015/16

Conclusion

The paper analysed the male perception of their involvement in reproductive health. Findings show men are yet to be equal partners in reproductive health. It has been established that men still perceive themselves as main decision-makers on sexual and reproductive matters. The majority of the respondents indicated that they make decisions on family planning but do not discuss family planning issues with their spouse. Male knowledge on family planning issues is quite high, almost 100%. This is impressive, given that men are the main decision-makers on matters of sexual and reproductive health. Results presented in this study and literature review indicates that while male involvement has increased following the International Conference on Population and Development in 1994, no impressive results have so far been registered. Some of the reasons behind minimal results on meaningful male involvement in reproductive health issues include the assumption by both policymakers and reproductive health providers that men are not interested in matters of reproductive health (Walston, 2005). Traditionally, reproductive health issues were mainly centred around pregnancy and childbirth hence involve women and children, leaving out men (Justus, *et al.,* 2016). Provision of reproductive health services had far too long been a women domain to be expected to change in two decades (from 1994). While health providers should not give up on the full and meaningful male involved, a lot needs to be done since male involvement in reproductive health issues is critical for both policy and pragmatic purposes. However, caution needs to be taken, given some documented unintended outcomes from male involvement. Garg and Singh (2014) noted that if male involvement in family planning is not done carefully, it risks making the male more powerful as they are the ones to make decisions on reproductive health issues.

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