MALE REPRODUCTIVE HEALTH IN LESOTHO: NEEDS, KNOWLEDGE, ATTITUDES AND PRACTICES

BY

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I declare that the dissertation submitted for the Master's Degree in Social Sciences (Nursing) to the University of the Free State is my own independent work and has not previously been submitted for a degree to another university.

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A. M. PHOOFOLO

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OPSOMMING

Reproduktiewe gesondheidsprogramme vir mans bestaan glad nie in Lesotho nie. Die meeste reproduktiewe gesondheidsprogramme in Lesotho fokus slegs op vrouens (soos die gesinsbeplanningsprogramme) met totale uitsluiting van mans. Maar mans, net soos vroue, het verskillende reproduktiewe gesondheidsbehoeftes en –bekommernisse gedurende die verskillende fases van hul lewensverloop.

Die doel van hierdie studie was om die behoeftes, kennis, houdings en praktyke van mans in verband met reproduktiewe gesondheid vas te stel. 'n Nie-eksperimentele ontwerp wat beskrywend van aard is, is gebruik. Die opname-metode is gebruik om die data in te samel. Gegrond op die waarskynlikheidseleksie-tegnieke, het die steekproef uit 794 manlike respondente woonagtig in die 10 distrikte van Lesotho bestaan. Fokusgroepbesprekings en gestruktureerde onderhoude is gebruik om die data by die respondente 15 jaar en ouer en woonagtig in stedelike en landelike gebiede van Lesotho, in te win. Daar is aan die etiese beginsels onderliggend aan navorsing oor menslike subjekte voldoen deur die verkryging van die nodige toestemming vir toetrede tot die veld en deur die menseregte van die respondente voortdurend in ag te neem. Die analise van die data is op die nominale beskrywende vlak gedoen.

Die bevindings van die studie toon dat die mans in Lesotho meer kennis en inligting oor menslike reproduktiewe gesondheid wil bekom; dat mans uiteenlopende houdings oor hul eie reproduktiewe welsyn en oor gesondheidsorgdienslewering toon; dat mans nie oor voldoende inligting in verband met veilige reproduktiewe gesondheidspraktyke beskik nie en dat mans aangetoon het dat hulle van manlike reproduktiewe gesondheidsorgdienste gebruik sal maak as dit voorsien sou word. Gegrond

op bogenoemde is aanbevelings gemaak dat die bestuurders van gsondheidsprogramme in Lesotho mans-vriendelike programme en dienste moet ontwerp en daar stel. Die opvoeding van gesondheidsorgpraktisyns moet gewysig word om manlike reproduktiewe gesondheidsorg in te sluit. Ook is aanbeveel dat verdere navorsing oor manlike reproduktiewe gesondheid en welsyn onderneem moet word. Laastens is 'n manlike reproduktiewe gesondheidsprogram ontwerp en voorgestel om as gids vir bestuurders van gesondheidsorgprogramme te dien.

SUMMARY

Most reproductive health programmes in Lesotho are designated for women only, such as the family planning programmes, which focus only on women and children and exclude men. Male reproductive health programmes do not exist in Lesotho. Yet men, like women, have different reproductive health needs and problems at different stages of their development.

The purpose of this study was to determine men's needs, knowledge, attitudes and practices regarding reproductive health. A non-experimental design of a descriptive nature was used. The survey method was used to gather data. Probability sampling techniques were used to select the sample of 794 male respondents from the 10 districts of Lesotho. Focus group discussions and structured interviews were used to collect data from the respondents aged 15 to 60 years and older, living in the rural and urban areas of Lesotho. Ethical principles as relevant to the conduct of research involving human subjects was adhered to, such as obtaining the necessary permission and complying with the human rights of the respondents. All data was analysed on a nominal descriptive level.

The results of the study showed that men needed more knowledge and information related to male reproductive health; their attitudes towards their own reproductive health and the services to be delivered varied; they did not possess adequate information related to safe reproductive health practices and indicated that they (men) would utilise male reproductive health services provided they existed. Based on the above, recommendations were made that health care programme managers in Lesotho should design men friendly programmes and services. The education of health care providers should be modified to include male reproductive health and all health care providers should be trained to render quality male-friendly reproductive health care.

Furthermore the need for further research into male reproductive health was emphasized. Lastly, a proposed male reproductive health programme has been outlined as a guideline for health care managers.

CHAPTER 1

1.1 INTRODUCTION

Male reproductive health has been somewhat overshadowed by an interest in female reproductive health that began in the 1960s after development of modern contraceptive methods for women (Bergstrom, 1994:307). However, reproductive health programmes around the world are now increasingly recognising that men are important targets for their services. According to Bergstrom (1994:307), men do not only have reproductive health concerns of their own, but their health status and behaviours also affect those of their partners as well. Men's reproductive health problems come in several varieties such as sexually transmitted diseases, sexual dysfunction, infertility and urologic conditions. Herndon (1998:8) states that the lack of services to address these problems may contribute to stress, anxiety and loss of self – esteem. Therefore, emphasis on male reproductive health as influenced by their (men's) needs, knowledge, attitudes and practices is imperative.

1.2 PROBLEM STATEMENT

A number of reproductive health care programmes and providers around the world are seeing that men deserve more attention for their own sake and for that of their partners. Drennan (1998:3) explains that this new perspective on men comes from an evolution of thought about reproductive health rather than from a revolution in attitudes. Similarly, this interest and commitment to involve men in reproductive health intensified during the 1990s for a number of reasons, such as a growing concern about the spread of the human immunodeficiency virus and acquired immunodeficiency syndrome and the fact that men are more interested in family planning than is often assumed. As such men need programmes and services directed specifically at them so

that couples can talk to one another about family planning and reproductive health – resulting in the taking of better informed decisions by the persons as individuals or partners.

Involving men in reproductive health programmes and services by health care providers, is nowadays a strong impetus worldwide as well as in many African countries. According to Barnett (1998:23) gaps may exist between the services offered and what men need, therefore it is important that a better understanding of what men want from reproductive health programmes and services be sought, in order to bridge this gap. Wasileh (1999:181) adds that the first step towards increasing men's participation in reproductive health and reproductive health services is to understand their needs, knowledge, attitudes and practices regarding a range of reproductive health issues. With the human immunodeficiency virus spreading faster among women than among men and with men as the main decision makers in the family, men's needs, knowledge, attitudes and practices regarding reproductive health issues have become a major concern for the Ministry of Health of Lesotho, because a strategy for targeting men to utilise reproductive health services has to be decided on.

Following the 1994 International Conference on Population and Development in Cairo and the Fourth World Conference on women in Beijing, all the Member States of the African Region recognised the role of men and its centrality to reproductive health, and felt there was an urgent need to improve current family planning and other reproductive health services to include men (World Health Organisation, 1998:1). The International Conference on Population and Development programmes also actively encourage that all reproductive health programmes should move away from considering men and women as separate entities by adopting a more holistic approach to include both single and married men and all forms of marriages (monogamous and polygamous).

During the last century no studies were done in Lesotho to determine men's reproductive health needs, knowledge, attitudes and practices. Most available data concerns family planning in relation to women. In a survey on the evaluation of maternal and child health and family planning (Ministry of Health, 1993), women stated that they do use contraceptives secretly because of their husband's disapproval. In another study by Letšela, Mokitimi and Mochebelele (1997:49) on the evaluation of family planning awareness, men who were interviewed regarded family planning as an issue relevant to women only. From the above scenario, it is evident that men are not involved in their own nor in female reproductive health issues.

At this time no baseline data exists in Lesotho that enables policy makers and programme designers to cater for men's reproductive health concerns beyond family planning and sexually transmitted diseases, such as infertility, sexuality dysfunction, prostate and testicular cancer. Lack of services to address these contributes to stress, anxiety and loss of self - esteem in men (Herndon, 1998:8). Even today some men in Lesotho still do not know whom to consult when confronted with reproductive health concerns. According to Herndon (1998:8) men, like women, face different reproductive health issues at different stages of development. According to Drennan (1998:16) young and unmarried men must be taught about contraception, sexually transmitted diseases, reproductive anatomy and physiology, sexuality, pregnancy and other related reproductive health matters to become responsible sex partners. If programmes reach men with appropriate information, more men would take better care of their own reproductive health as well as that of their partners. Furthermore, older men are often left out of reproductive health programmes under the assumption that they are not sexually active like young men. Because there are gradual changes in their (older men's) physical and sexual capacity they may have reproductive health concerns that need to be addressed. Homosexual and bisexual men are also underserved although they have the same reproductive health needs as heterosexual men.

According to Lesole (Sino, Anno[1]) efforts were made in the past in Lesotho to involve men in family planning services. According to the report, the Lesotho Planned Parenthood Association attempted to involve men by giving them information on family planning and sexually transmitted diseases – but men still remained aloof. In collaboration with the Lesotho Planned Parenthood Association, the Ministry of Health also held awareness workshops with village development officers, traditional healers, journalists, parliamentarians and factory managers with the intention that the participants had to pass on the information to the communities – but unfortunately these efforts failed.

Despite the efforts made by the Lesotho Planned Parenthood Association and the Ministry of Health, it is widely recognised that some men in Lesotho do not participate in existing reproductive health services in terms of utilization and support of their partners (Ministry of Health, 1993:14). This under-utilization of public services is probably attributed to the fact that such services do not specifically address the needs and concerns of men. Letšela *et al.* (1997:19) further note that former family planning programmes focused only on women to the exclusion of men. The reasons for this are that women bear the risks and burdens of pregnancy and childbearing and that most modern contraceptives are for women only. On the basis of the above, many men may have considered such programmes as serving only women and as such felt uncomfortable in seeking services and information regarding treatment and counselling on sexual dysfunction, information on family planning or any other male issues in such a setting. Another problem is that young unmarried men and boys often find it difficult to obtain male contraceptives such as condoms because they are scared that they may come across people who know them and who may tell their parents about their visit(s) to such services.

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[1] Sino, Anno: Indicates information obtained through verbal communication.

According to Kimane, Molise and Ntimo–Makara (1999:86) social and cultural factors also impede men from participating in reproductive health matters in Lesotho. Culturally, a husband is not allowed to be present during delivery of his child and may not take part in the immediate care of his wife and child following delivery. It is also expected that a man should abstain from intercourse with his wife during the post-partum period. Traditionally, it is also a practice to avoid intercourse especially while the mother is breastfeeding – a period which is indeterminate, but can last up to a year or longer. Another factor that complicates the situation is the fact that sexually related matters, according to Kimane *et al.* (1999:86), are still taboo for both men and women to discuss: a husband might consider his wife promiscuous or unfaithful if she tries to discuss contraceptives or insists on the use of condoms. Complicating the above, is the fact that some men believe that practising contraception is contrary to the teaching of their religion.

Another aspect of concern is the decline of traditional institutions (such as initiation schools, "Thankaneng"[2]) that socialised boys and girls regarding what to expect in life and included sexual and reproductive health matters (Mturi, 2001:3; Kimane *et al.,* 1999:90). These institutions are weak and in some cases they no longer exist, especially in the urban areas. As a result adolescent boys lack guidance regarding information on life skills and reproductive health matters. Therefore adolescent boys rely on their peers for information – information which may sometimes not be accurate.

Motlomelo and Sebatane (1999:14) further comment that men in Lesotho lack knowledge about reproductive health and do not have access to reproductive health facilities. According to these two authors, many men are unaware about the services that are rendered. Another complicating factor is the fact that the services are too far to visit and are not held on a daily basis in some facilities. Men also lack access to accurate information about male

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[2] Thankaneng: Is equivalent to what is now referred to as counselling.

contraceptive methods resulting in some men not even knowing how to use these methods correctly. Other obstacles that prevent men from using male reproductive services are misinformation and rumours and myths surrounding them.

Other problems that limit men from participating in reproductive health in Lesotho are associated with men's attitudes towards the services. Letšela *et al.* (1997:49) indicated that men feel reproductive health is only for women and are uncomfortable to discuss family planning issues openly and publicly. Most men also felt it was a woman's responsibility to discuss family planning with children. In support Motlomelo and Sebatane (1999:79) and Kimane *et al.* (1999:103) contended that parents generally are reluctant to discuss sexual and reproductive health issues with their children because this is culturally unacceptable. Parents mostly emphasize good behaviour and abstinence from premarital sex. As a result young men and boys resort to information from their friends, magazines, radios, television, movies and newspapers – information which is limited and sometimes inaccurate. Drennan (1998:16) argues that where men participated in reproductive health programmes and services, they were more positive regarding family planning. In a study done by Letšela *et al.* (1997:49) the researchers found that most male respondents indicated that male reproductive health issues and family planning should be taught in secondary schools and in initiation schools. The unfriendly attitude of service providers is also an obstacle that men in Lesotho face when trying to seek reproductive health services (Letšela *et al.,* 1997:19). Drennan (1998:2) cites a similar incidence in a South African study in which young field workers, who posed as clients, reported that some clinic staff resisted their requests for condoms and often provided no information on how to use them.

Regarding the knowledge of men about reproductive health, Hulton and Falkingham (1996:90) state that although numerous studies regarding knowledge, attitudes and practices had been done in less developed countries on family planning and contraceptives use, these only focused on women, excluding their partners (married or unmarried). Recent studies done in Africa, about men's knowledge of reproductive health and other issues, indicate that African men are knowledgeable regarding family planning and sexually transmissible diseases such as acquired immunodeficiency syndrome. Similarly studies done by Sawyer, Tully, Dovey and Colin (1998:226) regarding the knowledge of males concerning reproductive health and other issues also showed that men with cystic fibrosis know that they are infertile.

Contrary to the above, Bloom and Tsui (1998:388) found that men's knowledge of the physiology of reproduction and the pathology of sexually transmitted diseases is very scanty. The researchers concluded that efforts must be made to increase men's knowledge about male reproductive health issues. Armstrong, Cohall, Vaughan, Scott, Tiezzi and McCarthy (1999:904) recommend that existing family planning services be complemented with reproductive health programmes that are specifically designed for men.

Regarding the sexual behaviour of men in Lesotho, this country is confronted with problems associated with a high prevalence of premarital and extramarital sexual activity. Kimane *et al.* (1999:85 –86) found in their research study that the practice of extramarital relationships is long-standing and to a large extent generally acceptable when practised by men – even in contemporary times. Furthermore extramarital relationships are traditionally justified on the ground of the following: they provide for men's sexual needs at a time when their wives are breastfeeding as well as in cases where couples cannot conceive children because of the infertility of a partner. Morojele (in Motlomelo & Sebatane, 1999:21) also found that young men in Lesotho are engaged in sexual activities at an early age and have multiple sexual partners without prior information on sexuality, sexual practices and

sexually transmitted diseases, in addition, the young men were not only engaged in sexual practices with young females but were also sexually active with older women who possess money and cars. According to Drennan (1998:17) the tendency of unmarried young males to be sexually active, can be to attributed the influence of high levels of testosterone, a hormone that motivates males to engage in sexual activities. Drennan (1998:17) further accentuates the fact that this factor is very important but is often overlooked in the sexual behaviour of young males.

Homosexuality is one of the sexual practises in Lesotho which is still practised among some Basotho men. However, it proved difficult to investigate as it is regarded as a taboo (Kimane *et al.*, 1999:89). According to Kimane *et al.* (1999:89) some males do practise their homosexual tendencies in the public services. Other sexual practices found to be common among males according to the authors include inter – femoral coitus (involves rubbing or holding male genitals between thighs thus avoiding any penetration of the vagina or anus), masturbation and initiation of young men reaching puberty. However, there is limited information related to these practices. Another aspect pertaining to male sexual practices, is the fact that Lesotho is experiencing a rapid increase in the prevalence of the acquired immunodeficiency syndrome (Maw, 1998). It is estimated that about 9.2% of men and women were infected with the human immunodeficiency virus and 0.6 % had acquired immunodeficiency syndrome in 1998. According to Letšela *et al.* (1997:17) men very seldom use condoms to protect themselves from sexually transmitted diseases.

Based on the problems outlined, it becomes imperative that men's needs, knowledge, attitudes and practices with regard to male reproductive health be looked into. If the needs of men with respect to reproductive health are not considered, the promotion of better health for both the male and his partner will be hampered. In order to involve men in their own reproductive health issues it is imperative to understand their needs, knowledge, attitudes and practices. The importance of baseline information on men's needs,

knowledge, attitudes and practices regarding reproductive health in Lesotho cannot be underestimated. Therefore this study is crucial and long overdue because it will provide empirical information and rationale for the Ministry of Health in the planning of health programmes, policies on male health issues and services to be rendered to males.

1.3 AIMS AND OBJECTIVES

1.3.1 Aim

The aim of this study is to determine men's needs, knowledge, attitudes and practices regarding reproductive health in Lesotho.

Based on the aim, the study has the following objectives:

(1) To identify men's needs regarding male reproductive health.

(2) To determine men's knowledge regarding male reproductive health.

(3) To assess men's attitudes regarding male reproductive health.

(4) To identify men's practices regarding male reproductive health.

(5) To determine factors that may facilitate/limit male participation in male reproductive health services.

(6) To make recommendations for establishing comprehensive male reproductive programmes sensitive to the needs of men.

1.4 RESEARCH DESIGN AND METHODOLOGY

A qualitative (non-experimental) design of a descriptive and phenomenological nature will be used because the needs, knowledge, attitudes and practices of men in Lesotho regarding reproductive health have never been researched or described (Burns & Grove, 1997:225).

A survey method will be used to obtain the necessary data, because information on men's actions, knowledge, intentions, opinions, attitudes and values can be collected; all the age groups of the male population of Lesotho can be accommodated, and surveys can focus on male reproductive health issues with the result that the information obtained can then be used for the designing of reproductive health programmes responsive to the needs of different groups of men (Polit & Hungler, 1993:148).

Research techniques

Semi-structured and structured interviews will be used as research techniques for this study. The semi-structured interviews (focus group interviews) will be used because deeper insights into men's needs, knowledge, attitudes and practices regarding reproductive health will be provided and these will help clarify topics to be included in the structured interview. The structured interview will be used as an appropriate research technique to collect the necessary data from men in the age categories: 15 to 19 years, 20 to 39 years, 40 to 59 years and 60 years and older. Structured interviews are also chosen, according to Burns and Grove (1997:385), for their convenience in ensuring anonymity, which is critical in obtaining information about unspoken cultural and human life subjects such as reproductive health issues. Validity of the study, semi-structured and structured interviews will be ensured. The research techniques will be pretested.

Population and sample

The population of this study will include all men in Lesotho in the following age categories: 15 to 19 years, 20 to 39 years, 40 to 59 years and 60 years and older. The sampling population will be drawn from men in the 20 villages selected in the 10 districts of Lesotho who meet the inclusion criteria.

A simple random sampling technique will be used to select 1,000 respondents. The unit of the sample is males stratified by age, dwelling, districts and urban/rural areas. The proportional stratified sampling technique for different levels of stratification, namely population level, randomization level and data level will be used to structure the sample.

Data collection process

Prior to data collection, permission to conduct the study will be obtained from gatekeepers (Ministry of Health, principal chiefs of the concerned districts). Consent from parents of young boys and potential respondents will also be obtained. Data will be collected during December 2000. Ethical considerations will be taken into account.

Results

The analysis of all the data obtained, will be done using descriptive statistics on the nominal level. The Department of Statistics at the University of Lesotho will do the data analysis while the Department of Biostatistics of the University of the Free State will serve as a consultational agent. The data obtained through focus group interviews and from open-ended questions in the structured interview will be analysed according to the method described by Tess (in Crewswell, 1994:144-155). The closed-ended questions will be analysed using the epidemiology computer program office for Windows

(www.cdc.gov/epiinfo). All the results will be presented on a nominal descriptive level enabling the interpretation and communication of the collected data.

1.5 CONCEPTUAL FRAMEWORK

The conceptual framework for the study is as follows and has been developed using the variables to be examined, namely needs, knowledge, attitudes and practices. The services to be rendered are based on these variables.

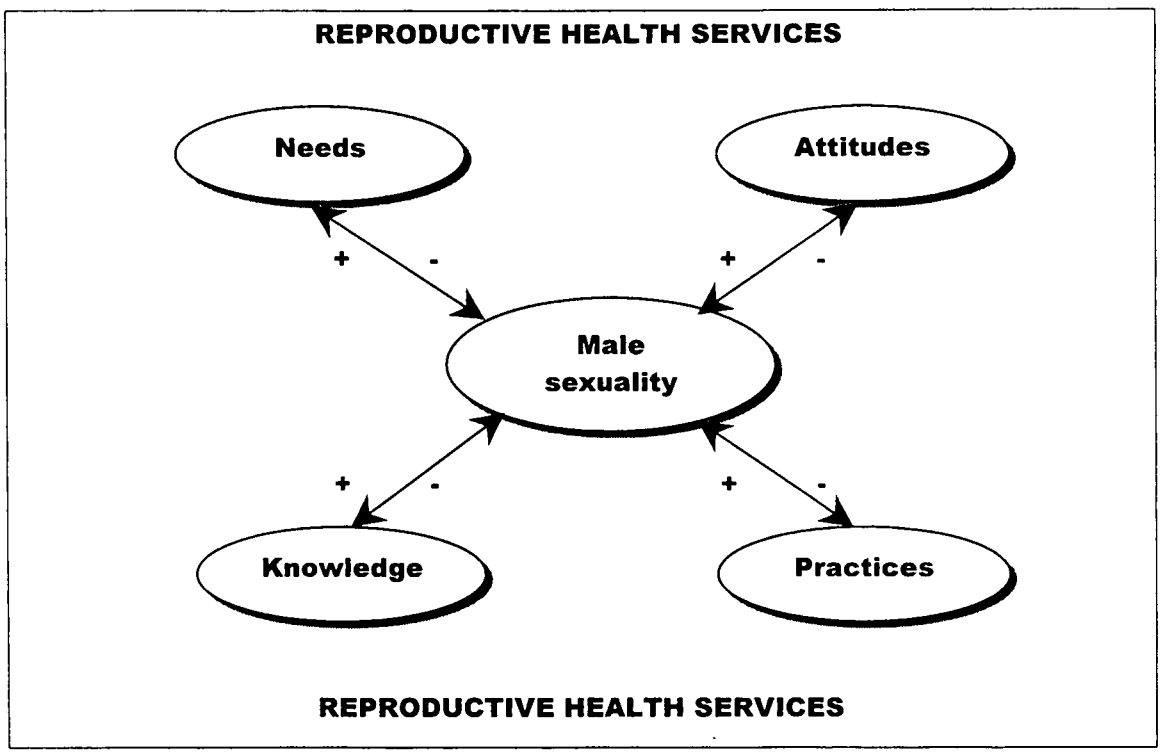

FIGURE 1.1: Conceptual framework

Men's needs, knowledge, attitudes and practices can have either a negative or positive impact on their participation in reproductive health services. When men's needs are not considered when designing the services and the programmes to be conducted, they may decide not to participate. Conversely, knowledge deficit regarding reproductive health issues may compel men not to appreciate the value of participation in such programmes. Negative attitudes also may limit men to be involved, since the likelihood that an

individual will take any action is influenced by the perceived benefits of the action weighed against barriers to acting. On the other hand, when reproductive health programmes are congruent with men's needs and even if their knowledge of reproductive health issues is scant, men will be more likely to support and utilize such services. It must also be accepted that some men may be knowledgeable about and approve of reproductive health services and programmes but may decide not to use the services.

1.6 THE VALUE OF THE STUDY

The results will serve as a basis for policy makers and programme managers of the Ministry of Health in Lesotho to design comprehensive reproductive health programmes and services that are responsive to the needs of different groups of men. This study will not only help Lesotho but may also benefit other African countries which need to develop male reproductive health programmes.

1.7 DEFINITIONS

Attitudes

Are viewed as some internal affective orientation that would explain the actions of a person (Reber, 1995:67).

Knowledge

Collectively refers to the body of information possessed by a person or, by extension, by a group of persons or a culture (Reber, 1995:401).

Sexual health

Entails the enhancement of life and personal relations, sexual health services which should not merely consist of counselling and care related to reproduction and sexually transmitted diseases (Lundgren, 2000:3).

Male reproductive health

Male reproductive health is a component of sexual health which focuses on prevention and treatment of diseases that impair the male reproductive function, such as infertility, sexual dysfunction, prostate cancer and testicular cancer including sexually transmitted diseases (Bergstrom, 1994:307).

Need

Because of the diverse range of meanings of needs the following definitions will be used:

- Need is considered as a tension or disequilibrium in the organism. A living organism strives to keep itself in balance. The term "need" is used to designate the tension. Need is satisfied when the tension is eliminated (Liss, 1998:11).

- Teleological view: A need is a situation of lack/gap related to a goal – there is a need when the goal is not realized and there is a need of a certain thing when this is necessary for realizing the goal. Health care is a particular kind of need: health care is needed in so far as this is necessary for realizing a certain goal (health).

- According to Maslow's view of teleogical needs, basic needs are human goods that are not only wanted and desired by all human beings, but also needed in the sense that they are necessary to avoid illness and psychopathology (Maslow, 1970:xiii in Baldwin, 1998:12). For the purpose of this study, male reproductive health is seen as a particular kind of need as it is necessary for realizing the goal of optimum health.

Participation/involvement

The terms are used interchangeably and mean to take part in something (Hawkins, 1991:370) in this study.

Practice

Any habitually performed action, or ritualized behaviour (Reber, 1995:587).

Reproductive age

This is the average age when men reach full spermatogenesis (by their fourteenth year) and as such continues throughout life (Verralls, 1993:151).

1.8 OUTLINE OF THE STUDY

The following is an outline followed in presenting the outcomes (results) of the study:

Chapter 1: Consists of the introduction and problem formulation.

Chapter 2: Reviews the literature on male reproductive and sexual health including men's knowledge, attitudes, practices, needs and programme approaches that focus on men.

Chapter 3: Outlines the methodology used.

Chapter 4: Presents the findings of the study.

Chapter 5: Constitutes the discussion of findings, the conclusion reached and the recommendations made.

Chapter 6: Presents the proposed model for the establishment of a male reproductive health programme.

Chapter 7: Consists of the conclusion of the study.

1.9 SUMMARY

In this chapter the problem statement, aim and objectives of the study, the methodology to be used and conceptual framework underlying the study were discussed. In the next chapter a literature review of male reproductive health will be given.

CHAPTER 2

2.1 INTRODUCTION

Reproductive health is a very important aspect in the quality of life of men. Male reproductive health needs, knowledge, attitudes and practices are embedded in the sexuality of men – from the moment of conception until death occurs. Taking male sexuality as the point of departure, the cultural influence on male sexuality, the sexual development of males, the meaning of masculinity and male reproductive health needs, knowledge, attitudes and practices, as well as reproductive health service delivery interventions that focus on men, will be discussed in this chapter.

2.2 CULTURE AND MALE SEXUALITY

The most powerful force shaping human sexuality is culture (Marilynn, 1996:2). Culture determines, moulds and shapes sexuality because cultural norms prescribe what is socially acceptable and what is prohibited. As such, culture describes the age at which boys can start dating and establish relationships with the opposite sex. Therefore, societal and cultural factors mainly determine sexuality, how it is expressed and what relationships are taboo (Thom, 1995:391).

Furthermore, all cultures have long-standing traditions about what is expected and is allowed regarding sexual and fertility regulation as well as well-defined ways of transmitting relevant sexual information and values (Kimane *et al.*, 1999; Maina-Alhberg, Fuglesang & Johansson, 1998). These traditional regulations are facilitated through institutional arrangements such as initiation and marriage rules mediated by elders.

Traditional gender roles and societal expectations can jeopardise the reproductive health of men as well as that of their partners. Some societies enforce cultural norms of masculinity by sanctioning men who do not conform to them (Lundgren, 2000:32). For instance, boys are expected to be sexually experienced before marriage. Similarly, in other societies it is not considered manly to participate in birthing nor to have responsibility for childcare or domestic activities.

Cultural factors also influence men's attitudes regarding use of the professional health care system. As such, Wallstam (1994:4) explains that some men do not practise contraception, as it is contrary to the teaching of their religion. Similarly, according to Raju and Leornard (2000:21) sexual matters may not be openly discussed in some societies, with the result that men feel uncomfortable about talking about their sexuality and their sexual concerns, not only with their partners but also with health care providers. This situation may lead to men not using the available health care when in need.

2.3 MALE SEXUALITY

There are many different definitions of the construct sexuality. According to Maina-Alhberg *et al.* (1998:4) the construction of sexuality, whether female or male, varies widely throughout the life cycle and between social and ethnic groups. Therefore, it is necessary to have a thorough understanding of sexuality for the development of efforts to improve the reproductive health of both men and women. However, Kumar (1997:2) states that sexuality refers to the total sexual make-up of an individual, including sexual knowledge, beliefs, attitudes, values and behaviour of individuals.

Both men and women use their sexual realm to affirm their masculinity. However, according to Cohen and Burger (2000:9) there are gaps in the general knowledge of sexuality, especially as regards male sexuality in the African context. Thus, according to Maina-Alhberg *et al.* (1998:4), to

understand sexuality and especially male sexuality, it is necessary to be knowledgeable about the social construction of masculinity in its cultural and social context as well as its influence on gender roles, sexual orientation and sexual development of males. Maina-Alhberg *et al.* (1998:4) further states that male sexuality influences and has an impact on the attitudes, knowledge and practices of males in their given cultural and social contexts.

▪ Male identify (masculinity)

The male identity (masculinity or manhood) is socially constructed as it is an expression of the social image a man has of himself in relation to women and other men (Cohen & Burger, 2000:15). Masculinity therefore consists of a set of characteristics and behaviours that are expected from men in a given culture. Cohen and Burger (2000:15) also state that the male identity in societies that rely heavily on the dominant status of males in the society may result in males controlling life in society. According to Barker (in Lundgren, 2000:28) in many cultures manhood is defined as a state of being – a state which must be earned rather than automatically conferred from society. The society expects from males that, during their development from adolescence, they (men) must prove their manhood and sexuality to their peers or elders. The result is that adolescent boys learn from their society's definition of masculinity from parents, peers and by observing adults. Thus the expression of masculinity is acquired through a process of socialisation leading to internalisation of a set pattern of male attitudes and values.

According to Lundgren (2000:28) manhood is defined on the basis of productivity or around the role of the financial provider. However, Cohen and Burger (2000:18) state that when the economic role that gives men status is taken away from them as a result of unemployment for an example, then males tend to express their sexuality by having multiple sexual partners and excessive alcohol intake as an alternative in the creation of their masculinity or male identity.

Another meaning in the social construct of masculinity is that males are expected to be sexually experienced and possess vast amounts of information on sexuality (Cohen & Burger, 2000:24). Thus, in some societies males are encouraged to develop their sexual skills through a collection of premarital sexual experiences. Therefore, if a boy has not had sexual intercourse with the opposite sex by a certain age, his friends and family may question his masculinity.

According to Clark (1996:499) the stereotyped view of the masculinity and gender roles pressurizes men socially to conform to this view. This view may conflict with their health (general and reproductive), which may lead some men sometimes to delay seeking health care and health information to enhance their own general and reproductive wellness. Another aspect to be kept in mind is the fact that men are socialized to view males as strong and invulnerable, with the result that many males may have difficulty in expressing their sexual feelings or even talking about sexual issues or admitting the general experience of health and reproductive health related concerns.

In the light of the above, Cohen and Burger (2000:15) stress the importance of the knowledge of masculinity in sexual and reproductive health programmes because masculinity is exercised within the context of the norms and values of the prevailing gender system and in particular the male gender.

▪ Gender roles

Gender roles are attributed to men and women based on the child's gender at conception. According to Lundgren (2000:36), in the traditional male role, the husband is responsible for the economic well-being of the family, while the woman is responsible for reproduction, home care and parenting children. Drennan (1998:19) explains that men are often called the gatekeepers of the

society because of the many powerful roles that men hold namely, husband, father, uncle, religious leader and national leader, while the function of health has been relegated by men to women. The result of this is that men are not actively involved in their own health, including their reproductive well-being.

Lundgren (2000:33) further stresses that another important factor to be borne in mind is the fact that traditional gender roles and the meaning given to masculinity or manhood, may jeopardise the health of men because of the physical and sexual risk-taking behaviour males adhere to. In many societies, like in Haiti and Thailand, it is acceptable that married men can have extramarital sexual relationships. In the African context this behaviour is also covertly accepted by both males and females.

▪ Sexual orientation

Sexual orientation entails the feeling of attraction a person has to members of either the same or opposite gender (Clark, 1996:466). According to Louw and Edwards (1998:466) there is a range of sexual orientations among individuals, namely, homosexuality, heterosexuality and bisexuality, with many persons (males and females) being neither exclusively homosexual, heterosexual or bisexual. Homosexuality is a sexual orientation in which attraction is to members of one's own gender rather than to those of the opposite gender (Davidson, 1998:18). Heterosexual orientation is when a person is attracted only to members of the opposite gender. A person is bisexual if he/she is attracted to both males and females (Hall & Kimura, 1994:1203-1206).

Lundgren (2000:37) argues that due to discriminatory attitudes of the society regarding sexual orientations, individuals may feel compelled to conceal their sexual orientation to such an extent that they do not maintain their reproductive and sexual well-being and do not try to get the necessary information and/or support they need. However, Hall and Kimura (1994:1203-1206) state that although all individuals have the right to accept,

acknowledge and live in accordance with their sexual orientation (be they homosexual, heterosexual or bisexual), many societies still do not accept this right as a universal human right as they ostracise homosexual persons and discriminate against bisexual persons.

▪ The physical (anatomical) and physiological sexual development of males

Physical and physiological development refers to the growth of the body and changes in the structure and functioning of the body (Meyer, 1995:10). For the purpose of this study, the sexual development of men will be traced from adolescence to old age.

▪ Adolescence

Adolescence, according to Thom (1995:377), is the developmental stage between childhood and adulthood. The age at which adolescence begins varies from 11 to 13 years and lasts to 17 to 21 years. The important primary physical changes that an adolescent boy experiences involves increases in the size of the penis, testes and scrotum. The primary physiological changes are characterized by a heightened libido, spontaneous erections and wet dreams, as a result of the effect of the male sex hormone, androgen (Thom, 1995:385). At the time primary gender characteristics develop (sexual organs), the secondary gender characteristics such as appearance of pubic hair, deepening and lowering of the voice, beard growth and broadening of the shoulders also begin to develop (Thom, Louw, Van Ede & Ferns, 1998:392).

According to Clark (1996:498) acceptance of the physical changes is not always easy for all adolescents. There are individual and cultural differences in adolescents' reactions to these changes. The lowering of voice, nocturnal seminal emissions and spontaneous penile erections cause embarrassment for many boys while other boys welcome the changes with pride. Similarly, Thom *et al.* (1998:393-395) state that the age at which adolescents reach physical maturity could affect their psychological development, especially when boys reach maturity – whether earlier or later than the average expected age. The adolescent boy could ask himself whether his development is inadequate or delayed and this could lead to emotional distress.

▪ Adulthood

Adulthood is described as a period between adolescence and old age (Louw & Edward, 1998:523). Adulthood is divided into three phases, namely early adulthood (20 to 40 years), middle adulthood (40 to 65 years) and late adulthood (from 65 years and older). Within these age divisions, however, sexual functioning is at its best from age 20 to 40 years and then it manifests a gradual decline.

➢ *Early adulthood*

Thom (1995:460) contends that during early adulthood many aspects of physical functioning are at their best from age 20 to 30 years and then gradually decline. Sexuality and emotional intimacy begin to converge during early adulthood, whereas those of adolescents may be more egocentric because the adolescent's identity, are not fully developed. The establishment of personal identity is therefore required for a mature adult relationship characterized by emotional intimacy and by caring and respect for other people.

➢ *Middle adulthood*

According to Eckard (1997:5) the middle adult years are characterized by decreased levels of the male sex hormone androgen, decreased sperm production, diminished sexual desire and loss of lean muscle mass. As such, middle-aged men older than 40 years may experience shrinkage of the testicles and have an increased risk of enlargement of the prostate by age 50 as well as cancer of the prostate.

➢ *Late adulthood*

Like earlier sexual developmental periods of adulthood, late adulthood is characterized by physical and physiological bodily changes. According to Raubenheimer (1995:567) aging implies biological, emotional and social changes. However, how an individual elderly man experiences and accepts these changes varies from individual to individual.

Among physical and physiological sexual changes, Bates (1991:372) states that the aging male experiences gradual modification of his sexual ability such as a prolonged excitement phase which creates a longer period before full erection is obtained, the erection is maintained for extended periods without ejaculation, and the erection is less firm. Similarly, according to Shell (1994:555), a decrease in size and firmness of the testes and a change in testicular elevation are also noted. Despite the above noted changes, however, Marilynn (1996:46) argues that there is no interruption in sexual needs, interest and capacity as all males continue to be interested in sex when older and like to have full and happy sexual relationships.

2.3.1 Male attitudes, knowledge, and practices regarding sexuality and reproductive health

Based on the construct of male sexuality, the attitudes, knowledge and practices of males will now be explored. It must be remembered, as discussed previously under culture and male sexuality, that the attitudes, knowledge and practices of males are culturally determined.

- **The attitudes of males towards their own sexuality**

According to Reilly and Oerman (1992:301) attitudes represent a feeling for or against a person, an object, a belief, a concept (for an example health and disease) or an event. These feelings or attitudes could be either positive or negative. Positive attitudes can be transferred into personal values while negative attitudes may reflect ignorance, fear or a need not fulfilled. Seen in this light, the attitudes of males regarding their own sexuality refer to the feelings that men have regarding their own bodies and gender which form part of their self-concept. These feelings maybe positive or negative.

Eckard (1997:3) explains that, according to the conservative male gender role, men are the primary decision makers regarding sexual activity and fertility in heterosexual relationships. The performance of household and child care/rearing responsibilities are not part of the male gender role, neither are taking responsibility for family planning and the use of contraceptives. Cohen and Burger (2000:26) found that men who held traditional views of manhood were more likely to report unsafe sexual practices. Following the example of older men, young men, in establishing their own masculinity, may have several sexual partners and not use condoms because they believe that condoms reduce male sexual pleasure.

Normal sexual developmental changes in males can elicit guilt feelings in them towards their own sexuality (Lundgren, 2000:21). In a study of sexual behaviour among Columbian high school students, young males admitted that masturbation, nocturnal emissions and spontaneous penile erections elicited feelings of guilt and embarrassment. Madaras (1995:19) also found that young males expressed anxious or fearful feelings regarding their first ejaculation. However, Louw and Edward (1998:505) argue that boys prepared for this experience expressed positive feelings because they see sexual development as a sign of their virility. Older men also may worry that the gradual changes in their physical and sexual capacity mean that something is wrong with their sexuality, and yet the changes they are experiencing are a normal part of aging.

Davidson (1998:17) indicates that, because men have been socialised not to talk openly about sexual matters, they may feel uncomfortable in expressing their feelings about their own sexuality. The author concludes that by talking about their own sexuality, men could understand more about their bodies, their relationships and their gender identity.

Based on the cultural construction of the perception of their male identity and sexuality, Singh (1997:8) found that male callers to a hotline on reproductive and sexual health in India did not consider sexually transmitted diseases as a risk to their reproductive health as they perceived themselves as givers during sexual intercourse (believing that semen must flow freely into the female body). Eckard (1997:2) also explains that men are more likely to conceal and suppress pain because they believe that sickness means weakness and weakness leads to sexual dysfunction which poses a threat to the male identity, and may predispose the man to risk self-destructive behaviour such as excessive consumption of alcohol or using drugs as a means to suppress or deny his feeling(s) of pain and an attempt to stay tough. Similarly, a man having a swelling on his groin may avoid having the groin examined because he fears the swelling may represent a threat to his sexuality.

▪ Knowledge of reproductive health

Walker (1999:6) states that to lead healthy lives men must understand their sexual and reproductive functioning. In view of this, according to Walker (1999:6), men must be knowledgeable about reproductive function, fertility and fertility control, sexually transmitted diseases (including acquired immune deficiency syndrome) as well as all factors that may have an impact on their reproductive functioning. Men should also be knowledgeable regarding where to seek help when experiencing reproductive health problems.

According to Davidson (1998:21) the knowledge of the anatomy and physiology of male reproduction is important to all men because this means men will understand how their bodies function and be able to cope with the physical and physiological changes at the different stages of their sexual development. Men who are knowledgeable regarding their anatomy and physiology will also be in a better position to notice anything unusual (such as lumps, sores or discharge) as soon as they occur on their reproductive organs and hence may seek care before complications arise.

Ndong, Berker, Haws and Wegner (1999:6) further state that men should be knowledgeable about fertility and fertility regulation to help them understand how pregnancy occurs and to be aware of the need of contraception in family planning. According to McCauley and Salter (1995:27) men who are knowledgeable regarding different contraceptive methods (male and female) are more likely to discuss contraception and family planning with their partners, are more co-operative in assessing and choosing a contraceptive method and are more supportive of their partners' use of the method. In support, Drennan (1998:15) contends that fears and misconceptions about contraceptives could be dispelled when men are knowledgeable about fertility control methods.

Also of significance, according to Gardner, Blackburn and Upadhyay (1991:1), is the fact that all sexually active men who are not monogamous, must know about sexually transmitted diseases (including acquired immune deficiency syndrome), their treatment and means of prevention, so as to avoid the risk of contracting the infection from or transmitting it to their partners. As such, men who are knowledgeable about sexually transmitted diseases can help prevent the transmission of infection to their partners by using condoms, limiting their sexual activity to one partner and seeking treatment for the current infection.

To promote sexual and reproductive health of men, Beare and Myers (1994:1963) argue that men need to be knowledgeable about factors that may have an impact on their reproductive health – for example the effect of illnesses, drugs, smoking and alcohol, which may eventually lead to impaired fertility and sexual functioning. Finally, according to the WHO[3] (2000:37), men have to be knowledgeable about the nature of services and how and where to obtain such services, as this is likely to increase acceptance of and access to reproductive and sexual health services.

▪ Reproductive health practices of males

To promote the reproductive health of males, all health care practitioners need to be aware of practices that can affect men's sexual functioning. As such, men's practices such as testicular self-examination, safer sex, circumcision, premarital and extramarital relationships will be addressed.

[3] WHO: World Health Organisation

▪ Testicular self-examination

Testicular self-examination is an intervention that facilitates early detection of testicular cancer, which is common among men aged 15 to 24 years (Clark, 1996:511). According to Best (1999:4), although testicular cancer may be easily detected by regular testicular self-examination, many men may not know how to perform the examination because few health providers teach testicular self-examination. Thus, according to Davidson (1998:31) it is important that every man learn how to do self-examination and be encouraged to check his testicles at least once a month for diagnosis of early changes such as lumps so that treatment can be sought in good time.

▪ Safer sex

The practice of safer sex entails any sexual activity that is pleasurable and avoids unwanted pregnancy and infection (Davidson, 1998:28). Safer sex activities include practising non-penetrative sex (stimulating your own or your partner's genitals through masturbation, thigh sex, massage or kissing), using a condom for vaginal or anal sex, or abstaining from sexual intercourse.

The major concern relative to the reproductive health of males who may engage in unprotected sex is that of sexually transmitted diseases and unwanted pregnancies, as well as infertility as a consequence of untreated sexually transmitted diseases (Clark, 1996:505). According to Best (1998:2) men having unprotected sex may become infected and transmit the infection to their partners.

▪ Premarital and extramarital relationships

Premarital sexual activity is common in many parts of the world and is reported to be on the increase (McCauley & Salter, 1995:6). In many societies young men are under strong social and peer pressure to engage in premarital sex. Many men face social expectations that they should be sexually experienced and knowledgeable (Maina-Alhberg *et al.*, 1998:5). Most societies encourage young men to experiment sexually before marriage through a collection of premarital sexual experiences. If a boy does not have sex by a certain age, his friends and family may question his male identity. Furthermore, Nkoli (2001:1) adds that premarital sex is tolerated in some societies for boys without any serious sanctions imposed on them, while sanctions exist for girls. In view of the above, Lundgren (2000:39) argues that such cultural norms can lead to the fact that male adolescents may impair their reproductive and sexual health by not protecting themselves.

According to McCauley and Salter (1995:7) the initiation of premarital sex is associated with several reproductive health consequences such as contracting sexually transmitted diseases. If sexually transmitted diseases are left untreated, they may progress to infertility. Furthermore, Cohen and Burger (2000:38) state that men who have two or more concurrent or consecutive sexual partners are more likely to become infected with sexually transmitted diseases. Most men generally have several sexual partners over their lifetime, especially prior to marriage. Kumar (1997:6) found that men reported several reasons for having extramarital relationships during the period that their wives are pregnant and are breastfeeding the baby. Men also indicated that they help woman who are not able to achieve pregnancy with their husbands because of the infertility of the husband. Nkoli (2001:2) argues that the persistence of the practice of extramarital relationships poses a grave threat to the attainment of sexual and reproductive health of men and their partners because when the men are infected with sexually transmitted diseases they may transmit the infection to their partners.

- **Circumcision**

Circumcision is the removal of the foreskin of the penis. Circumcision can be done traditionally or medically. Traditionally, male circumcision is practised as an important cultural ritual for coming of age. According to Muvundla (1997:16) circumcision is an important part of the initiation process of African males into adulthood. Medically, circumcision is done routinely as a health measure in case of a too tight foreskin. The authors also explain that circumcision does not affect the functioning of the penis during sexual intercourse.

Circumcision carries serious reproductive health risks if it is not performed with great care (Meintjes, 1998:68). If circumcision is not performed with a sterile instrument, the penis may become infected. In some cases the infection may become so serious that gangrene sets in resulting in the death of the male or amputation of the penis. Furthermore, if the same instrument is used and not properly cleaned after use, infection may be transmitted from one individual to another. In particular, transmission of such diseases such as syphilis, gonorrhoea and the immuno-deficiency virus can be transmitted in this way (Hull, 2001:10).

2.3.2 The sexual health of men

The sexual health of a person is important to the quality of life he or she lives as it enables the person to have a safe and satisfying sex life, which encompasses healthy psychosexual development from birth to death. Cohen and Burger (2000:10) state that a universal definition of sexual health is difficult to arrive at because human sexuality is varied, diverse and dynamic. However, the WHO (1999) defines sexual health as:

"The integration of the somatic, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love."

Wallstam (1997:9) argues that the concept of sexual health is broader than that of reproductive health as sexual health refers to a positive approach to human sexuality aiming at the enhancement of life and personal relationships, and not merely at the counselling and care related to procreation or treatment of sexually transmitted diseases. Cohen and Burger (2000:11) further state that the concept of sexual health also entails the complexity and multiple dimensions of self-identity and social interaction.

Reproductive health as such means that persons are able to have children, to regulate their fertility and engage in and enjoy their sexual relations while feeling secure. According to Cohen and Burger (2000:8), WHO described reproductive health, as follows (as derived from the definition of health as):

"A condition in which the reproductive process is complemented by a state of complete physical, mental and social well-being and not just the absence of disease or problems in the reproductive process."

- **Factors that may jeopardise the sexual health of males**

The sexual health of men can be threatened by environmental factors, lifestyle factors as well as by illnesses and drugs.

➢ *Environmental factors*

Barrett (1995:40) states that occupational exposure to physical agents such as heat and ionising radiation, and toxins such as lead and pesticides, can cause impaired fertility and sexual dysfunction.

➢ *Lifestyle factors*

A man's lifestyle may pose a threat to his sexual and reproductive health. In particular, Vine (2001:1) contends that cigarette smoke contains known mutagens and carcinogens that have adverse effects on male reproduction. Cigarette smoke has the potential to affect male reproductive capacity in several ways: it has cytoxic effects on the sperm cells thereby reducing their number or impairing their ability to function (Purvis, 1992:110).

According to Clark (1996:503) alcohol use and abuse is widely known for its negative effect on male sexual functioning. Impotence is widely associated with excessive alcohol consumption. Furthermore, according to Stanhope and Lancaster (1992:396), many males may also experience testicular atrophy with chronic alcohol abuse.

➢ *Diseases and treatment*

The reality of living with an acute and chronic disease may impact on the sexual health of many males. Pitts (in Serrant-Green, 2001:1040) cites that conditions such as diabetes mellitus, rheumatoid arthritis and vascular diseases may change a man's ability to express or maximise his sexual health. Serrant-Green (2001:1040) explains that diseases have an impact on male sexual functioning – directly or indirectly: that an illness may interfere with reflexes of sexual response while surgery on the other hand can result in sexual dysfunction. In addition, weakness, pain and fatigue resulting from the

disease may prohibit normal sexual functioning – many men recovering from a myocardial infarction reported that they reduced their sexual activity post-infarction for fear of further angina pain or another myocardial infarction. Alexander (in Serrant-Green, 2001:1041) also notes that medications such as beta-blockers and diuretics have the potential to cause impotence in some men.

2.3.3 Reproductive health needs of men

Like women, men have reproductive and sexual needs (including concerns) that vary and change as they (men) move through their life span. For this reason men's health programmes face the challenge of responding to men's reproductive and sexual health needs, as different groups of men have different needs.

According to Centerwall (1995:5) boys and young men have different needs from those of middle-aged married men. According to Davidson (1998:18) young boys may be curious about their bodies: they may be interested in issues such as penis size, maintaining erections, need for intimate relationships and prevention of sexually transmitted diseases among others. As such boys may need information that will help them to understand how their bodies function so as to cope with the changes they are confronted with. Similarly, older men may need information that will help them to cope with gradual changes in their physical and sexual capacities which affect older men in particular.

According to WHO (2000:37) there is also a need for greater attention to the sexual and reproductive health needs of men involved in commercial sex. Many men are likely to pay for sex with a sex worker (a woman or man who sells sexual services) when they are without their partners, when they are away from home or when their primary relationships are not satisfying. Mbogori and Barker (1993) reported the phenomena of sugar mommies cited

by young men interviewed in sub-Saharan Africa as an example of commercial sex. As such, according to Davidson (1998:19), men involved in sex work may need information and services that help them to learn about sex and safer sex practices.

The needs of an adolescent father are different from those of other adolescent boys. According to WHO (2000:38) the adolescent father may need information and services that will equip him with effective parenting skills and help him to cope with the stigma associated with adolescent fatherhood.

Men or male – only social institutions such as the military and detention facilities will also have different needs because they may engage in both forced and consensual sexual practices of homosexuality (Cohen & Burger, 2000:135). Greater attention has to be given to these men to promote their sexual and reproductive health, as they may be engaging in homosexuality as a way to cope with the stress of living away from home.

Homosexual men also have different needs from heterosexual men. Because these men face social stigma, they may fail to maintain their sexual health and may also not get the necessary information and support they need. According to Clark (1996:507) homosexual men may also experience a greater risk of contracting sexually transmitted diseases because of the nature of their sexual practices.

2.4 THE HEALTH CARE SYSTEM IN LESOTHO

The health care system in Lesotho generally operates within a biomedical model, which emphasizes science and technological innovation. Cohen and Burger (2000:52) argue that the biomedical model encourages dependency and submission and affects the inter-relationships between health professionals and other health workers in service provision and between

providers at all levels and the users of services. For instance doctors and nurses make decisions for patients without involving them, under the assumption that they know best.

According to the National Health Sector Plan (1995/6-2000) Lesotho has two distinct systems of health care, namely the western/professional health care system and the traditional health care system. There is such a lack of communication between the two systems such that patients hide from the western health care system the fact that they are receiving treatment from the traditional health system. However, the mission of the Lesotho health care system is to improve the physical, mental and social well-being of Basotho and to provide care and effective services through a primary health care approach, embracing curative, preventive and rehabilitative services.

However, according to Davidson (1998:11), when people have a health concern about sexual health, for example, they may have different perceptions and treatment preferences. For this reason, they may consult the formal (western) health care services such as hospitals or clinics or they may consult traditional healers. In view of the above, the formal health care system, the traditional health care system and the reproductive health service must deliver interventions that focus on men and address their needs.

2.4.1 Professional (formal) health care system

The formal health care system in Lesotho consists of three separate groups, namely the independent practitioner, the dependent practitioner and the support staff. According to Stanhope and Lancaster (1992:28) the independent practitioners are legally permitted to provide specific ranges of services without relying on supervision from any other provider such as medical doctors. The dependant practitioners, such as nurses, pharmacists, physiotherapists and social workers, must work under supervision. The

support staff comprises clerical, maintenance staff, housekeepers, technicians and food processing workers.

According to the Health and Social Welfare Plan (1995/6-1999/2000) the formal health care system is divided into four levels:

- **Referral hospitals**

Referral hospitals include Queen Elizabeth II Hospital, which acts as a national referral hospital and a health service area for the district of Maseru. Also located in Maseru are the leprosy hospital and mental health hospital which both serve as referral hospitals.

- **Health services areas**

The country is divided into 19 health service areas, 18 based around hospitals and the nineteenth being the Lesotho flying doctor services which serve remote clinics which are not easy to access by road. Besides providing clinical care, the health service areas also support the development of primary health care and supervise clinics within their catchment areas (www.lesotho.gov.ls/lsheath.htm).

- **Clinics and health centres**

Clinics and health centres are scattered throughout the country and are valuable for increasing coverage and accessibility to primary health care (Lesotho Review, 2000).

- **Community health workers**

These are voluntary workers trained to provide basic health care at the community level. They are supervised and assisted by the nursing staff at their local clinic. Community health workers encompass village health workers, traditional birth attendants as well as traditional healers (Health and Social Welfare Sector Plan, 1995/6-1999/2000:25). These health workers perform a vital role in many primary health care programmes, such as maternal and child health and family planning and health education.

Following the International Conference on Population and Development in 1994 and the Beijing Conference in 1995, the government of Lesotho, through the Ministry of Health, and like other countries world-wide, broadened family planning services to follow a more comprehensive approach, including reproductive health. Reproductive health falls under the family health division which is charged with the implementation of programmes and projects aimed at reducing maternal, child and infant morbidity and mortality (Health and Social Welfare Sector Plan, 1995/6-1999/2000:84). Maternal services which include family planning are integrated into primary health care at all levels of the health care system. Although both the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth Conference on Women in Beijing, provided a foundation for expanding family planning to move to a more comprehensive reproductive health approach to include men –no male reproductive health services as yet exist in Lesotho.

2.4.2 Traditional health system

The traditional health system is very important in the reproductive health of men because men have different treatment preferences (Mahlaba, 1992). Traditional medicine is reported to be both important and popular in that western medicine is largely unavailable to a sizeable portion of Lesotho's

population and its cost is unaffordable to many. Furthermore, the traditional health system also forms the backbone of the nation of the Basotho. It is frequently located in villages and addresses health issues (including male reproductive health issues such as sexually transmitted diseases and impotence immediately when the need arises (www.thabatours.de/english/molete.e.htm).

The composition of the traditional health system is characterized by different categories of traditional medical practitioners (traditional healers) who can be broadly categorized as diviners, herbalists, faith healers and traditional birth attendants (Mahlaba, 1992). The categories of practitioners are divided according to the methods that they use to diagnose and treat patients. The community in which they practise recognises them as competent practitioners who provide health care by using traditional medicine formulas prepared from various natural substances (derived from animals, minerals and vegetables). As such the traditional health practitioner has practised outside the professional health care system without any recognition but, according to Health and Social Welfare Sector Plan (1995/6-1999/2000:75), the Ministry of Health of the government of Lesotho has committed itself to the involvement of traditional healers in the professional health care system by training and mobilising traditional healers to support essential primary health care services.

The role of traditional healers in primary health care should not be under-estimated (Pretorius, 2001:1). In Lesotho traditional healers play an important role in the provision of health services, especially at the community level. Furthermore, they play a role in preventive, curative and rehabilitative care and also serve as allies in organising and implementing programmes to improve the health of communities. The treatment used by traditional healers varies greatly and depends on the healer's own knowledge and skills as well as the nature of the patient's health needs. Traditional health practitioners are able to diagnose and treat the health problems of all age groups. Other ailments they can diagnose and treat are sexually transmitted diseases

including AIDS, nose bleeding, hiccups, fits, mental disorders, hypertension and many others (www.thabatours.de/English/molete.e.htm). Traditional healers also refer patients to the professional health care system – however, it is still a one-way procedure.

2.5 FACTORS TO BE TAKEN INTO ACCOUNT IN DESIGNING PROGRAMMES FOR MALE REPRODUCTIVE HEALTH

Many factors must be observed when selecting a programme approach for male reproductive health (Senderowitz, 2000:5). These are briefly reviewed below:

▪ Developmentally appropriate interventions

According to Wells (1997:4) men themselves are the best sources of information about effective outreach and service delivery strategies. As such, a key way to design appropriate interventions is to involve men throughout programme design and implementation to ensure that services and information materials address their concerns and needs. Such involvement also supports a positive approach of viewing men as assets and not merely as embodiments of problems (Senderowitz, 2000:6). Furthermore, many programmes also utilize men to implement the programme as staff members, health educators and peer motivators to recruit participants.

Davidson (1998:18) emphasises that it is important to design programme interventions based on developmental stage. Thus age and physical development must be factored into project design (for example, many men were given no information about sexuality in their youth. Boys and young men need information specifically aimed at them while older men may need information about problems that affect older men such as prostate

enlargement and changes brought about by age that may affect their sexual capacity.

▪ Access to services

According to Lori and Landry (1997:2) access to services is of particular concern when designing programmes for men's services. For example, in many countries there may be cultural biases against allowing men into areas designed for provision of reproductive health services. In countries like Egypt and Pakistan, religion was cited as a reason for men not using contraceptives. In this case, Drennan (1998:27) suggests that a consideration as to how to change such attitudes must be taken into account. Countries like Jordan used religious leaders to advocate family planning as in line with the precepts of Islam because it improved the quality of family life.

▪ Service selection

One very important consideration in programme designing is determining which reproductive health services should be offered (Wells, 1997:4). This will depend upon available resources for each institution. WHO (1998:18) states that identifying men's needs in respect of reproductive health is the starting point in understanding the problem as the results will provide for the determination of priority goals and appropriate strategies to reach them, as well as help programme designers to decide on which elements to consider to include first in the programme.

▪ Sustainability

Sustainability of services should be an important element of programme design (Wells, 1997:5).. The author explains that programme designers should plan for future economic and technical sustainability of the programme from

the start of planning by tailoring the services to what the community wants and needs, by integrating services into existing programmes as well as by providing on-going training for different levels of staff so that if one professional leaves, the technical skill is not lost.

- **Developmental stage of community/country**

Senderowitz (2000:6) argues that a programme cannot be established into a setting without considering the community's developmental stage, its readiness to address sensitive issues such as male reproductive health and its potential to implement new activities. If the community has never addressed male reproductive health issues, a great deal of preparatory work is necessary. McCauley and Salter (1994:30) contend that programmes have won support from community leaders by forming alliances, by showing the importance of male reproductive health as well as involving them in programme design and implementation.

- **Evaluation**

According to Stanhope and Lancaster (1992:207) incorporating how the programme will be evaluated is needed to measure the impact of programme activities. The data obtained from evaluation will justify whether the programme is fulfilling its purpose or justify whether to expand or reduce the programme.

2.6 GUIDELINES FOR REPRODUCTIVE HEALTH SERVICE DELIVERY OF INTERVENTIONS THAT FOCUS ON MEN

Men cannot share responsibility for reproductive health and sexual health if services and information do not reach them. Lori and Landry (1997:1) contend that various strategies have been used in other parts of the world to

engage men as partners in improving women's reproductive health and extending services to men. The range of services provided and their delivery may vary according to local needs, cultural values and resources available. However, McCauley and Salter (1994:27) explain that knowledge about health programmes that have successfully served men should be shared with countries that may want to start or improve existing services for men. Many organisations have launched pilot programmes to try to involve men in different aspects of reproductive health. In view of the above, five main approaches to reach men in order to meet their needs as service clients will be addressed.

▪ Separate (male-only) clinics

Male-only clinics are one mode of service delivery targeting men, which have been popular and successful in attracting men to reproductive health services. According to McCauley and Salter (1994:27) separate male clinics have been successful in different parts of the world, including Columbia, Brazil, Guatemala and some African countries such as Kenya and Zambia. However, Cohen and Burger (2000:120) argue that male-only clinics have been viable only in urban areas, where client volume is high enough to sustain them. These clinics usually provide separate entrances and waiting rooms for men even though they may be connected to female clinics.

According to WHO (1998:18) starting with separate services for women and later integrating them with men's services have proved successful in some countries. Similarly, providing individualized care, a wide range of services (such as counselling on sexuality, information and instruction for fertility and fertility regulation, prevention and treatment of sexually transmitted diseases as well as sexual dysfunction), using male providers and a very attractive facility are reported as the most important criteria for success as this helps men to feel at case and ensures them privacy (Maina-Alhberg, 1998; Senderowitz, 2000; Lori & Landry, 1997). Cohen and Burger (2000:120)

conclude that, in some countries, custom and tradition may dictate the need for separate services for men.

▪ Better service for men at existing clinics

According to Wells (1997:4), while a few programmes have established successful clinics that serve men only, integrating men's services into existing services is likely to be easier and more cost-effective for most programmes. Given the high cost and difficulty of sustaining such services (reproductive health) sustainability of services should be an important element of programme design.

According to WHO (1998:14) it is possible to integrate skills and approaches into activities and services of different agencies that can complement or support one another. For example, counselling is important for both men and women to better understand how strengthening male involvement in reproductive health can be of benefit to both of them and their families. Furthermore, counselling is particularly important to young men, for it is an effective means of personalizing information and responding to concerns and fears and correcting misperceptions, and it can be incorporated into school activities and introduced into youth centres, as well as other places where young men tend to gather in the community.

▪ Outreach programmes

Information and education should reach potential clients wherever they are, be it at work, in schools, prisons, bars, military settings, sports clubs or youth clubs. According to Davidson (1998:15) outreach work involves taking services to where men congregate in large numbers. Because men may be reluctant to attend or utilise reproductive health services, they may be willing to use outreach services because they can stay in a familiar environment, and

the fact that they are with their friends may make them (men) feel comfortable to attend or use services.

According to Cohen and Burger (2000:133) offering reproductive health services and information at the workplace, for example, has many advantages: it is an effective way to reach large numbers of men who seldom visit health clinics because of inconvenient working hours and it is cost-effective because employers pay for or share the ongoing costs of the programme. Similarly, one of the largest employers of men is the army. Therefore, taking reproductive health services to the military presents a unique opportunity in which HIV/AIDS prevention, reproductive health education, promoting and distributing condoms can be provided to a large captive audience. Furthermore, schools and youth clubs could provide a safe place for boys to discuss reproductive health issues. However, according to Cohen and Burger (2000:150) such programmes (youth, school-based) may need the support of government and community leaders and parents to succeed.

- **Community-based services**

Community-based services are sometimes used as a demonstration that services such as reproductive health have a considerable value for men and the community as well (Senderowitz, 2000:33). According to Cohen and Burger (2000:131) careful consideration should be given to the recruitment, training and supervision of health workers since they play an important role in motivating men to establish healthier reproductive habits in the community. Using satisfied clients as reproductive health promoters in outreach activities can be a means of reaching other men. Incorporating male health workers has been effective in promoting the use of male contraceptive methods, educating men and in providing family planning information. For instance, community-based services have succeeded in distributing contraceptives and

giving reproductive health information in countries like Kenya and Zimbabwe (WHO, 1998:19).

➢ *Commercial and social marketing*

Social marketing is described as a strategy that combines principles of social and behavioural change with business operations (Senderowitz, 2000:34). The approach uses a combination of mass media and advertising to publicize the designated issues and products while identifying, through market research, promising outlets for selling commodities usually at a subsidized price.

According to Cohen and Burger (2000:130) social marketing is a powerful means of reaching men. By using mass media through many channels including print, radio, television and magazines, social marketing is more likely to reach men than will clinic-based education. Furthermore, marketing campaigns are useful tools for bringing men to clinics. For example, Profamilia in Colombia promotes its services in the mass media and through field workers. Similarly, the Social Marketing for Adolescent Sexual Health (SMASH) programme that took place in Botswana, Cameroon, Guinea and South Africa provides valuable lessons for improving social marketing programmes that target adolescents.

▪ Advocacy and social mobilisation

According to Cohen and Burger (2000:86) advocacy/social mobilisation strategies targeting traditional opinion leaders at the community level are central to generating change in social norms – traditional leaders are the guardians of customary law and as such have power to modify them. Senderowitz (2000:10) adds that building bridges with and involving members of the community (in particular, traditional and religious leaders in reproductive health programmes) can be a deciding factor that determines a

programme's success. In Senegal a network of religious leaders was created to inform men about sexuality and reproductive health. Similarly, programmes have won support from the community and religious leaders by forming alliances and by involving community leaders in programme design and implementation.

2.7 SUMMARY

Most reproductive health programmes in Lesotho are designed for women and children, and exclude men, and yet men, like women, face different reproductive health problems at different stages of development. Great emphasis has been placed on the importance of the sexual nature of men in the delivery of comprehensive sexual and reproductive health to men and their partners. Understanding male sexuality and cultural factors that may have an effect on sexuality (including their needs, knowledge, attitudes and practices) is important for the design of efficient sexual and reproductive health programmes. In view of the above it becomes clear that current reproductive health programme designers face the challenge to expand reproductive health programmes to incorporate men.

CHAPTER 3

The research methodology

3.1 INTRODUCTION

This study aims to explore the needs, knowledge, attitudes and practices of males in Lesotho regarding male reproductive health. Based on the findings, recommendations regarding relevant strategies for targeting men to utilize reproductive health services will be made. Therefore, in this chapter a description of the research design, the population and sample will be given. The data collection instruments and the data collection process, the validity and reliability of the whole study, as well as the data analysis process used, will also be described. Lastly, the ethical considerations, the problems encountered during the data collection process and the value of the study will be discussed.

3.2 THE RESEARCH DESIGN

The research design is defined as a blueprint for conducting the study that maximizes control over factors that could interfere with the validity of the findings (Burns & Grove, 1997:225). Thus, in the light of the aim and objectives of the study a non-experimental design of a descriptive nature was used. According to Burns and Grove (1997:55) a non-experimental design of a descriptive nature must be used when new knowledge is generated about topics that have been limited or not at all researched. As no previous studies have been conducted in Lesotho on male reproductive health needs, knowledge, attitudes and practices, the data obtained would be new, therefore the study is descriptive in nature. Since the descriptions (information) on men's reproductive health needs, knowledge, attitudes and

practices are real life situations (human experiences) no other design was applicable. Another reason for using the non-experimental design was that the needs, knowledge, attitudes and practices of men in Lesotho must be described to make possible the development of guidelines for establishing comprehensive male reproductive health programmes sensitive to the needs of all groups of men.

3.3 THE RESEARCH METHOD

A survey method was used to obtain the necessary data. The reasons for using this method were:

- Surveys can be used to collect information on men's actions, knowledge, intentions, opinions, attitudes and values.

- The method could accommodate all the age groups of the male population of Lesotho.

- Surveys can specifically focus on male reproductive health issues, and the information obtained could be used as guidelines to design reproductive health programmes sensitive to different groups of men.

3.4 POPULATION AND SAMPLE

Babbie and Mouton (2001:174) describe the population as an aggregation of elements from which the sample is actually selected. The sample on the other hand, according to Uys and Basson (1995:87), is the number of elements of the population being studied.

3.4.1 Population

The population of the study included all men in Lesotho in the following age groups: 15 to 19 years, 20 to 39 years, 40 to 59 years and 60 years and older. This total comes to 365,046 men and is based on the statistics of single and married men (Bureau of Statistics Lesotho, 1996:43).

The following inclusion criteria were used:

- All men between ages 15 to 60 years and older.
- All men living in the rural and urban areas of Lesotho.
- All men irrespective of occupation and schooling (literate/illiterate).
- All men who are single or married.
- All men who expressed willingness to participate in the study.

3.4.2 Sample

The proposed sample size was 1,000, but only 794 respondents eventually took part in the study. According to Leedy (1997:211) only a sample size of 384 for population sizes of 100,000 and more is adequate. Leedy further states that beyond a certain point (namely N=5,000) the population size is irrelevant and a sample size of 400 is adequate).

Males stratified by age, districts and dwellings (urban/rural) formed the unit of the sample. The following sampling procedures were used for the different levels of stratification:

3.4.2.1 Population level

This included all males from ages 15 to 60 years and older dwelling in the 10 districts of Lesotho.

3.4.2.2 Randomization level

The proportional stratification technique was used as the male population contained definite age strata, namely 15 to 19 years, 20 to 29 years, 30 to 39 years, 40 to 59 years and 60 years and older, as each age stratum has its own unique characteristics. Each age stratum was in proportional ratio in terms of the numbers of members to every strata (Leedy, 1997:212-216) as based on the proportional ratio of age stratum in the population per sé. As such the sample was distributed as follows (the figures of the proposed sample have changed as 794 respondents participated in the study):

		Proposed		**Actual**
➢	Adolescence (15 to 19 years)	30%	=	46%
➢	Young and middle adulthood (20 to 39 years)	50%	=	30%
➢	Late adulthood and middle age (40 to 59 years)	15%	=	18%
➢	Old age (60 and older)	5%	=	6%

The above calculations were based on the data provided by the World Population Data Sheet of 2001 (Saunders College Publication) including the mortality age of men in Africa (namely 51 years), Southern Africa 52 years and Lesotho 58 years.

Since the characteristics and needs of the population in the urban and rural areas differ, the proportional stratification in the proportion of 60% urban and 40% rural was used to stratify the sample further as described in Table 3.1 below.

TABLE 3.1: Distribution of sample per urban/rural dwelling

AGE STRATA	Proposed		Actual	
	Urban	Rural	Urban	Rural
Adolescence	180	120	217	145
Young and middle adulthood	300	200	142	95
Late adulthood and middle age	90	60	83	56
Old age	30	20	34	22

3.4.2.3 Data level

The simple random sampling technique was used to select the respondents proportionally (as indicated in Table 3.1) from 20 selected villages in the 10 districts of Lesotho, a list of which was obtained from the Bureau of Statistics. The table of random numbers was used to draw at random the male population until the desired sample size was obtained. Samples selected randomly in such a fashion are not subject to biases of the researcher (Polit & Hungler, 1993:181).

3.5 DATA COLLECTION PROTOCOL FOLLOWED

3.5.1 Permission to enter the field

Approval to conduct the study was first obtained from the Ethical Committee of the Faculty of Health Sciences at the University of the Free State as well as from the Ministry of Health in Lesotho. Approval was further obtained from the principal chiefs of the 10 districts in Lesotho as well as from local chiefs of the sampled villages. Consent from parents of all boys under age as well as from the participants themselves was also obtained (see Addendums D and E). At the end of the interviews participants were thanked for their participation as were the local chiefs for their approval to conduct the study and the parents of under age boys.

3.5.2 Research techniques

Since the research design of this study was of a descriptive nature, the following research techniques were used:

- Focus group discussions (semi-structured interviews)
- Structured interviews

3.5.2.1 Focus group interviews

These are interviews with groups of about five to 15 people whose opinions and experiences are requested simultaneously (Polit & Hungler, 1993:202; Brink, 1996:159; Greenbaum, 1997:1; Mayan, 2001:14-17). The focus group discussions were used for the following reasons:

- Focus group interviews allow participants to share their thoughts with one another (Barbour & Kitzinger, 1999:5; Hennink & Diamond, 1999:11-142). In this way, they trigger off new ideas and consider a range of views while answering the set question(s).

- Through use of focus group interviews deeper insights into men's needs, knowledge, attitudes and practices regarding reproductive health could be explored (Polit & Hungler, 1993:201). According to Denzin (1994:365) this allows for more information to be gathered.

- The focus groups were used to clarify the topics to be included in the structured interview guide.

Focus group interviews were held with the following age groups: 15 to 19 years, 20 to 39 years, 40 to 59 years and 60 years and older. Approximately eight focus groups were conducted including at least one from the rural and urban areas as demonstrated on the table below.

TABLE 3.2: Number of focus groups in terms of age and dwelling segment

AGE RANGE	Urban	Rural	Total
15 to 19 years	1	1	2
20 to 39 years	1	1	2
40 to 59 years	1	1	2
60 years and older	1	1	2
Total	**4**	**4**	**8**

Two focus group interview guides were developed, one to be used with the younger age group (15 to 19) and the other to be used with the three groups (20 to 60 years and older) (see Addendum H). In collaboration with the Ministry of Health, field workers were recruited and trained. Training of the four field workers (two moderators and two note takers) lasted a day. Two preliminary focus group discussions of five men in each category were conducted. The focus groups were held in two villages in Maseru; one urban (Khubetsoana) and one rural (Matukeng).

3.5.2.2 Validity and reliability of the focus group discussions

Validity and reliability of the focus group discussions was assured as follows:

- The questions were planned and piloted to ensure that they were clear, precise and free from bias and ambiguities while the questions were pilot tested by obtaining expert review of the content validity, questioning route and probes. Specific attention was given to the logical and sequential flow of questions and to the ability of probes to elicit desired information.

- Attention was given to the role of the researcher, field workers, physical setting, duration, the process itself and taking of field notes.

3.5.2.3 Data collection process

Eight focus group interviews were finally conducted by trained field workers including at least four from the urban and rural areas of two villages in the District of Berea, namely Lithabaneng (urban) and Sefikeng. A minimum of 10 men from each geographical area participated in the discussions in the age

category of 15 to 24 years and 25 to 60 years and older. These men were not included in the study.

The discussions were held in a pleasant atmosphere to ensure that respondents were comfortable. The purpose of the discussion and the importance of the study were explained. Before the commencement of the discussion, the following measures were taken into account to gain the co-operation of participants and clear up any uncertainties:

- Although participants had volunteered to participate they could withdraw whenever they wished without any repercussions.

- Participants were assured that the interview would not last longer than one hour, but more time could be spent if necessary.

- Everyone's ideas and opinions were equally important.

- There were no right or wrong answers to the questions they would discuss.

- Anything they said would be treated as confidential and would not be disclosed.

Questions were asked in the order on the discussion guide. At the end, the participants were thanked for their support and willingness to participate in the study.

3.5.3 Structured interviews

Burns and Grove (1997:358) state that a structured interview can be used to gather data on beliefs, attitudes, opinions and knowledge. As such, the structured interview was used to collect data regarding the beliefs, attitudes, opinions and levels of knowledge of men in Lesotho. The structured interview was also used because most males in Lesotho could be reached and because it was the most convenient technique to ensure anonymity, which is critical in obtaining information about unspoken cultural and human life subjects such as reproductive health issues.

The structured interview guide (see Addendum H – English H1 and Sesotho H2) was constructed after focus group discussions were held. The reason for this was that the results obtained in the focus group interviews clarified the topics that had to be included in the interview guide. The questions in the structured interview guide included both open-ended and close-ended questions on the needs, knowledge, attitudes and practices of males in Lesotho. Also included in the schedule were questions on the bio-social history of the respondents.

3.5.3.1 Validity and reliability of the structured interview guide

Validity and reliability of the structured interview guide were assured by:

- Evaluation of the structured interview guide by domain experts at the University of the Free State and in Lesotho regarding the content validity, the logical and sequential flow of questions and the wording.

- The structured interview guide was pre-tested in two places (one school and one workplace) in Maseru with about 10 respondents sampled randomly in each case. The field workers were included in the pre-testing in order to give them a clearer understanding of the study objectives and to prepare them for the data collection process.

- Constructing the instrument in English and then translating the English instrument into Sesotho and then back into English, increased the validity and reliability of the questionnaire. This was also done to ensure that the meanings of questions remained the same.

3.5.3.2 Data collection process

The structured interviews were only held after the guide was evaluated by domain experts. The pilot study was done after the chiefs of the concerned districts and villages had granted permission. The respondents were randomly selected and then requested if they would participate in the study through the informed consent process (see Addendums C, D, E and F). The interviews were done by 10 field workers, two in each of the 10 districts of Lesotho for the period of two weeks. The study participants were recruited from 20 villages from the urban and rural setting of the 10 districts of Lesotho, as demonstrated on Table 3.3 below.

TABLE 3.3: Breakdown of villages by district and dwelling

DISTRICT	Villages	
	Urban	Rural
Berea	Ha Motjoka	Mohatlane
Leribe	Lisemeng	Mahobong
Butha Buthe	Ha Mopeli	Qalo
Maseru	Thetsane	Ha Hlalele
Mafeteng	Ramokhele	Ha Motanyane
Mohale's Hoek	Qalaheng	Mekaling
Quthing	Theoheli	Thaba-Ntšo
Thaba-Tseka	Ha Ntaote	Ha Phaila
Qacha's Nek	Ha Manteko	White Hill
Mokhotlong	Ntlholohetsane	Mapholaneng

The field workers had to recruit the study participants from house to house until the required sample size was obtained. The interviews were conducted in privacy after all respondents were read an informed consent form that explained the nature of the study and sought the agreement of the respondents to be interviewed. Data was collected for two weeks. Seven hundred and ninety-four men out of the sample size of 1,000 participated in the study. Two hundred and six structured interview guides were disqualified as they were not fully completed. The number of questionnaires received is demonstrated in Table 3.4.

TABLE 3.4: Number of received questionnaires

DISTRICT	Frequency	Percentage
Maseru	95	12
Berea	100	13
Leribe	65	8
Butha-Buthe	45	6
Mokhotlong	49	6
Thabe-Tseka	90	11
Qacha's nek	90	13
Quthing	53	7
Mohale's hoek	99	12
Mafeteng	97	12
Total	**794**	**100**

3.6 VALIDITY AND RELIABILITY OF THE STUDY

Validity and reliability of the whole study were assured through:

▶ Data triangulation

According to Burns and Grove (1997:241) data triangulation refers to the collection of data from multiple sources, with similar foci to obtain diverse views from participants about the topic under study. In this study data was obtained from individual men using the structured interview and groups of men using focus group discussion in the 10 districts of Lesotho.

▶ Theoretical triangulation

Through literature review of books, articles, discussion with domain experts as well as by consultation with males (not included in study) regarding clarity of the structured interview guide, theoretical triangulation was ensured.

▶ Methodological triangulation

According to Burns and Grove (1997:243) method triangulation is the use of two or more research methods in a single study. In this study, a literature study was done, and, based on it, the focus group interviews were held after which the structured interviews were done to collect the necessary data. In this way methodological triangulation was ensured and maximized by using the topics discussed in the focus group interviews to facilitate the formulation of the structured interview guide.

Validity and reliability of the study were further assured through monitoring of the data collection process by the researcher, establishing equivalence by defining the sampling criteria, training field workers, using only male subjects (homogeneity) and heterogeneity (subjects were drawn from all 10 districts of Lesotho according to age stratum, districts and dwellings).

3.7 DATA ANALYSIS

The analysis of all data obtained was done on the nominal descriptive level. The Department of Statistics at the University of Lesotho conducted the analysis while the Biostatistics Department of the University of the Free State served as consultational agent.

The data analysis was done as follows:

- The data obtained through focus group interviews was analysed using the method described by Tesch (in Creswell, 1994:144-155). This method will be fully discussed in Chapter 4.

The data obtained through the structured interviews was analysed as follows:

- Close-ended questions were analysed and described on a descriptive ordinal level.

- Open-ended questions were analysed using the method described by Tesch (in Creswell, 1994:144-155).

3.8 ETHICAL CONSIDERATIONS ADHERED TO

Conducting nursing research requires not only expertise and diligence but also honesty and integrity (Burns & Grove, 1997:194) as well as protection of the human rights of respondents as described in the ethical standards of nurse researcher principles of the Democratic Nurses Association of South Africa (1998:1-7). In view of this the following ethical actions were adhered to in this study:

▶ Protection of human rights

The human rights that required protection in this study included the following:

(i) The right to self-determination

The prospective respondents were treated as autonomous agents by being informed about the nature of the proposed study and allowing them to voluntarily choose to participate or not to participate, as well as to withdraw from the study at any time without any penalty.

(ii) The right to privacy, anonymity and confidentiality

The respondents' privacy was protected by informing them that data collected would not be made accessible to people other than those involved in the research. In addition, respondents were assured that their identity would not be linked with their responses by the researcher.

▶ Obtaining informed consent

Written permission to participate in the study was obtained from participants as well as from parents of young boys following explanations regarding the purpose of the study, method of obtaining information and how information would be used. Furthermore, both the structured interview and semi-structured interview guides were provided with instructions assuring anonymity and voluntary participation.

▶ Permission granted by the necessary institutions/ persons

The research protocol was submitted to both the expert and evaluation committees of the School of Nursing and then to the Ethical Committee of the Faculty of Health Sciences of the University of the Free State as well as to the Ministry of Health in Lesotho so as to obtain permission prior to the data collection process.

3.9 PROBLEMS ENCOUNTERED

During the conduct of focus group interviews the following problems were encountered:

- Some men were reluctant to talk about their own sexuality whether it concerned knowledge, attitudes, practices or needs.

- In one village some men thought that those who participated were going to be given something as a reward. The result was that all the males present wanted to join the discussion (which was not possible as a group too large was going to be difficult to control). Although they were told that those who participated were going to represent them, they were ensured that they would be considered as respondents in the structured interviews.

During the conduct of structured interviews the following problems were encountered:

- Some respondents were reluctant to talk openly about sexual and reproductive health matters and this resulted in some questionnaires being not fully completed.

- Some parents were hesitant to give permission for their adolescents to be interviewed. In some cases persuasive reasoning about anonymity, confidentiality and the overall importance of the study helped to resolve the problems.

- The fieldworkers had to move from one household to another, in some cases the occupants of the household were not at home, and this therefore affected the return rate of questionnaires.

- In some places fieldworkers failed to interview the required number of respondents because of rain.

3.10 VALUE OF THE STUDY

The results will serve as a basis for policy makers and programme managers of the Ministry of Health in Lesotho to design comprehensive reproductive health programmes and services that are responsive to the needs of different groups of men. The study will not only help Lesotho but also may benefit other African countries which need to develop male reproductive health programmes.

3.11 SUMMARY

A non-experimental design of a descriptive nature was used. The focus group discussions and structured interview were used as research techniques to collect the necessary data. Validity and reliability of the study as a whole as well as of data collection tools were ensured. The protection of the human rights of the respondents was strictly adhered to. The results of the data analysis process will be discussed in Chapter 4.

CHAPTER 4

Analysis of the collected data

4.1 INTRODUCTION

Data analysis entails categorising, ordering, manipulating and summarising the data and describing it in meaningful terms (Brink, 1996:178). Data analysis involves three activities, namely data reduction, categorisation and interpretation. The data obtained from the research was analysed according to the theoretical basis and the results were described on the descriptive nominal level.

4.2 THE REDUCTION AND CATEGORISATION OF DATA

Data reduction is the process of selecting, focusing, simplifying and transforming the data in the transcriptions (Lundgren, 2000:19). Therefore, because of the volumes of data acquired in a non-experimental design of a descriptive nature, initial efforts at analysis focused on reducing the data to facilitate examination. During the data reduction phase of the qualitative data obtained from the focus group interviews, the following steps were adhered to as described by Tesch (in Creswell, 1994:145-155):

- To form an idea of the completeness of the data, the coders first worked through all the data from focus group interviews.

- The principal encoder and the co-encoder (working separately) then categorized the data by placing the inferences to the words, the statements and phrases which were used in the content, into categories.

- The coding system was accepted and the preliminary categorization of responses was done.

- The responses to the focus group discussion questions were taken back to the concerned groups (men in the age categories 15 to 24 years, 25 to 39 years, 40 to 59 years and 60 years and older) to confirm whether the categorized responses were theirs. The control sessions lasted about one hour per group.

- After confirmation, the final framework was drawn and all data was analysed and categorized according to this perspective (see Addendum G for transcription of focus group discussions).

The data obtained from all open-ended questions in the structured interview guide, was also reduced and analysed according to the steps described by Tesch (see previous paragraph). For the exact phrases and words from statements of respondents (see Addendum H).

The data from close-ended questions in the structured interview guide was categorised as follows:

- Section A: Biographical data
- Section B: Knowledge of male reproductive health
- Section C: Men's attitudes towards reproductive health
- Section D: Men's practises regarding reproductive health
- Section E: Reproductive health services

4.3 ANALYSIS OF THE DATA COLLECTED

4.3.1 The results of data obtained through the focus group interviews

The results of the data acquired through the focus group or semi-structured interview will be discussed under the following headings:

- Male's knowledge of reproductive health
- Male attitudes regarding reproductive health
- Male reproductive practises
- Male reproductive health services

4.3.1.1 Male's knowledge of reproductive health

Regarding men's knowledge of reproductive health, the respondents discussed the following topics: Understanding of male reproductive health; knowledge related to the anatomy and physiology of male reproduction; knowledge of male sexual development; knowledge of fertility and fertility control; knowledge of male infertility; and knowledge of sexually transmitted diseases (including acquired immune deficiency syndrome). Table 4.1 represents the topics discussed by the respondents. Based on the responses in Table 4.1 the above-mentioned topics were incorporated into the structured interview guide.

TABLE 4.1: Topics discussed as important regarding reproductive health by age and dwelling (urban/rural)

TOPIC	URBAN		RURAL	
	Young Important	Older Important	Young Important	Older Important
Meaning of male reproductive health	70%	70%	40%	50%
Anatomy and physiology	80%	80%	80%	80%
Male sexual development	90%	90%	90%	90%
Male infertility				
Pregnancy and childbirth	60%	70%	50%	70%
Male contraceptives	60%	70%	40%	40%
Female contraceptives	20%	30%	40%	30%
Sources of contraceptives	30%	40%	30%	50%
Meaning of sexually transmitted diseases	40%	50%	25%	60%
Who can contract sexually transmitted diseases	80%	70%	70%	60%
Mode of transmission of sexually transmitted diseases	80%	70%	60%	60%
Signs and symptoms of sexually transmitted diseases	80%	80%	80%	80%
Where to seek help	80%	80%	80%	80%
Prevention of sexually transmitted diseases	70%	60%	60%	60%
Risk behaviour of sexually transmitted diseases including acquired immuno-deficiency syndrome	60%	50%	60%	60%

4.3.1.2 Attitudes towards male reproductive health

The following topics were discussed by respondents: Feelings about their own sexuality; feelings about development of sexual desire; reaction if they could not father a child; attitude about premarital sex and extramarital relationships; feelings about a man being allowed in the delivery room at the birth of his child; feelings about male participation in child rearing; attitudes towards people infected with sexually transmitted diseases; feelings towards male reproductive health and sexual orientation; and homosexuality. Table 4.2 represents the responses given by the respondents. Based on the men's responses the above topics were incorporated in the structured interview guide.

TABLE 4.2: Topics discussed as important regarding attitudes towards reproductive health by age and dwelling

STATEMENT	URBAN		RURAL	
	Young Important	Older Important	Young Important	Older Important
Feeling about development of sexual desire	80%	50%	80%	50%
Feeling about own sexuality	60%	60%	60%	60%
Ever had a feeling for other men	-	70%	-	70%
Reaction if could not father a child	-	50%	-	50%
Feeling about premarital sex	60%	90%	70%	90%
Feeling about extramarital relationships	-	50%	-	50%
Feeling about participation in child rearing	-	20%	-	80%
Feeling about entrance into delivery room	-	60%	-	80%
Feeling towards people infected with sexuality transmitted diseases	-	80%	-	80%
Feeling towards male reproductive health services	20%	20%	20%	20%
Feeling towards homosexuality	-	90%	-	90%
Feeling towards traditional circumcision	60%	40%	50%	30%

4.3.1.3 Male reproductive practises

The respondents discussed the following topics: Alternative practises/ways of realizing sexual desire other than sexual intercourse and whether these ways were culturally acceptable; whether men practised safe sex, in their community, and whether traditional circumcision was safe. The results are presented in Table 4.3. Based on the findings the above-mentioned topics were included in the structured interview guide.

TABLE 4.3: Topics discussed as important regarding reproductive health practises by age and dwelling

TOPIC	URBAN		RURAL	
	Young Important	Older Important	Young Important	Older Important
Ways of realising sexual desire	70%	50%	60%	40%
Whether the ways were acceptable	80%	80%	80%	80%
Whether men practise safe sex	80%	80%	80%	80%
Whether traditional circumcision was acceptable	70%	70%	50%	60%

4.3.1.4 Male reproductive health services

The respondents discussed the following topics: Attendance of reproductive health services (if they existed); gender of the preferred service provider; the type of services preferred; the type of setting preferred as well as the preferred hours of services. The findings are presented in Table 4.4. Based on the responses given by the respondents the above topics were included in the structured interview guide.

TABLE 4.4: Topics discussed as important regarding reproductive health services by age and dwelling

TOPIC	URBAN		RURAL	
	Young Important	Older Important	Young Important	Older Important
Whether men would attend reproductive health services (if existed)	80%	70%	50%	60%
Gender of preferred service provider	50%	80%	40%	70%
Type of setting preferred	80%	90%	80%	90%
Preferred hours of services	80%	70%	80%	70%
Barriers against using reproductive health services	70%	70%	70%	70%

4.3.2 The results of data obtained through the structured interviews

The results of the data obtained through the structured interviews will be discussed under the following headings:

- Biographical data
- Knowledge of male reproductive health
- Men's attitudes towards reproductive health
- Men's reproductive practises
- Reproductive health services

4.3.2.1 The biographical data obtained

The biographical data will be discussed as follows: Geographical location, name of district, age, religious affiliation and the highest level of education attained.

4.3.2.1.1 Origin of respondents by geographical location

The respondents came from the 10 districts of Lesotho, namely Maseru, Berea, Leribe, Butha-Buthe, Mokhotlong, Thaba-Tseka, Quthing, Qacha's Nek, Mohale's Hoek and Mafeteng.

4.3.2.1.2 Age, religion and education of the respondents

The age, religious affiliation and educational attainment of the respondents are reflected in Table 4.5.

TABLE 4.5: Age, religion and education of men (N=794)

AGE	Frequency	Percentage (%)
15 to 24 years	362	46
25 to 39 years	237	30
40 to 59 years	139	18
60 years and older	56	6
RELIGION	**Frequency**	**Percentage (%)**
Anglican	169	22
Roman Catholic	214	27
Lesotho Evangelical	246	31
Other	155	20
EDUCATION	**Frequency**	**Percentage (%)**
Primary	260	33
Secondary	337	43
College	75	10
University	42	5
Illiterate	74	9

The results in Table 4.5 reveal that young men (15 to 24 years) constituted 46% of the respondents, followed by 30% of men in the age group 25 to 39 years. This finding correlates with the demographical distribution of the population. Regarding the religious affiliation, 73% of men belonged to the Protestant and other Christian churches, while the Roman Catholic religion constituted 27%. Most men (91%) were literate while 9% were not. The aspect of illiteracy must therefore be taken into account when planning male reproductive health programmes.

4.3.2.2 Male's knowledge of reproductive health

As this section contains several subheadings, each subheading will be discussed separately.

(1) Understanding of male reproductive health

Men constructed the concept *"male reproductive health"* as reflected in Figure 4.1.

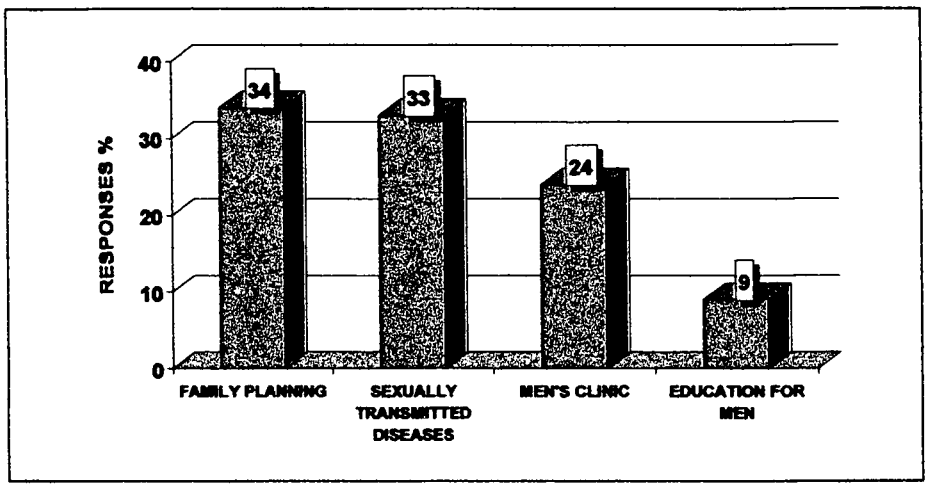

FIGURE 4.1: Men's understanding of male reproductive health

According to Figure 4.1, 34% of males constructed male reproductive health as family planning, while 66% referred to male reproductive health as the services rendered to males for the treatment of sexually transmitted diseases and for education.

(2) General reproductive health concerns

The general reproductive health concerns males have are set out in Figure 4.2.

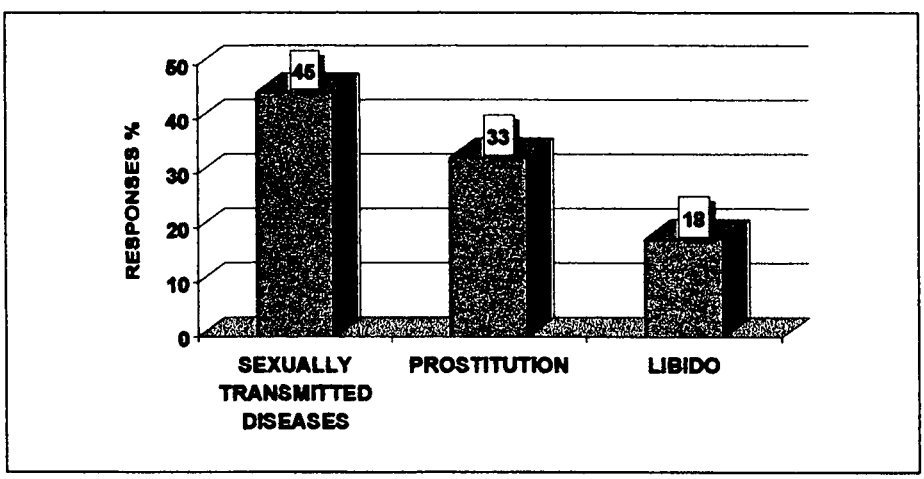

FIGURE 4.2: General reproductive health concerns of men

From Figure 4.2, it is evident that most men (45%) are concerned about sexually transmitted diseases and then about prostitution (33%) and libido (18%).

(3) Individual reproductive health concerns

According to the results, most men (60%) expressed sexually transmitted diseases as their primary individual reproductive health concern followed by 25% of men having concerns about low sexual performance, while 15% of men mentioned infertility and hydrocele as problematic.

(4) Persons men consult when experiencing reproductive health problems

The preferred source of consultation by men experiencing reproductive health problems is shown in Table 4.6.

TABLE 4.6: The person men preferred to consult when experiencing reproductive health problems

SOURCE	Frequency	Percentage (%)
Traditional healer	183	24
Nurse	249	33
Doctor	209	28
Other	117	15
Total	**758**	**100**

It is apparent from Table 4.6 that most men (76%) preferred to see a professional health practitioner when experiencing reproductive health problems, while 24% of men would rather consult the traditional healer – a fact to be borne in mind when planning services for men.

4.3.2.2.1 Anatomy and physiology

(1) Knowledge of the structure of the male reproductive organs

The knowledge of men regarding the structure of the male reproductive organs is illustrated in Figure 4.3.

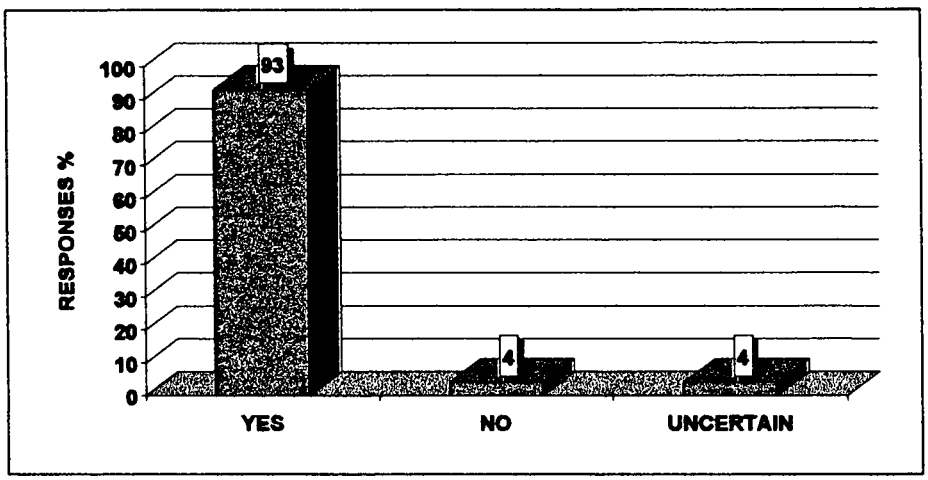

FIGURE 4.3: Knowledge of the structure of male reproductive organs

According to Figure 4.3, 93% of men accentuated the fact that they should know about the structure of the male reproductive organs.

The reasons given why men should be knowledgeable are:

- They should understand their bodies: 52%
- They should be able to notice disorders: 25%
- They should know how to care for themselves: 23%

(2) Knowledge of the function of the male reproductive organs

The knowledge of men regarding the function of male reproductive organs is represented in Figure 4.4.

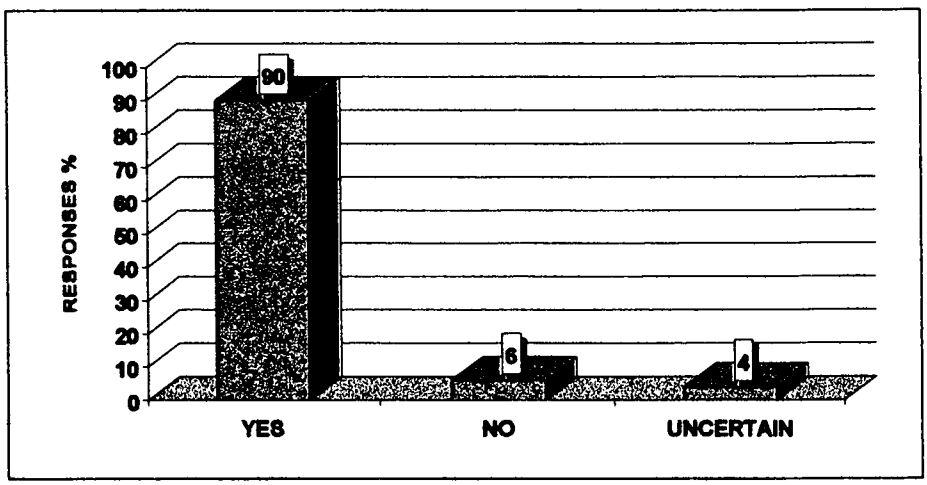

FIGURE 4.4: Knowledge of the function of the male reproductive organs

Figure 4.4 shows that 90% of men were eager to know how male reproductive organs functions.

The reasons stated why they need this knowledge include:

- They need to know to perceive that they are sick: 60%
- They need to know to be able to care for themselves: 40%

(3) Knowledge of physical changes in boys during puberty

Knowledge related to the physical reproductive changes in boys during puberty is depicted in Figure 4.5.

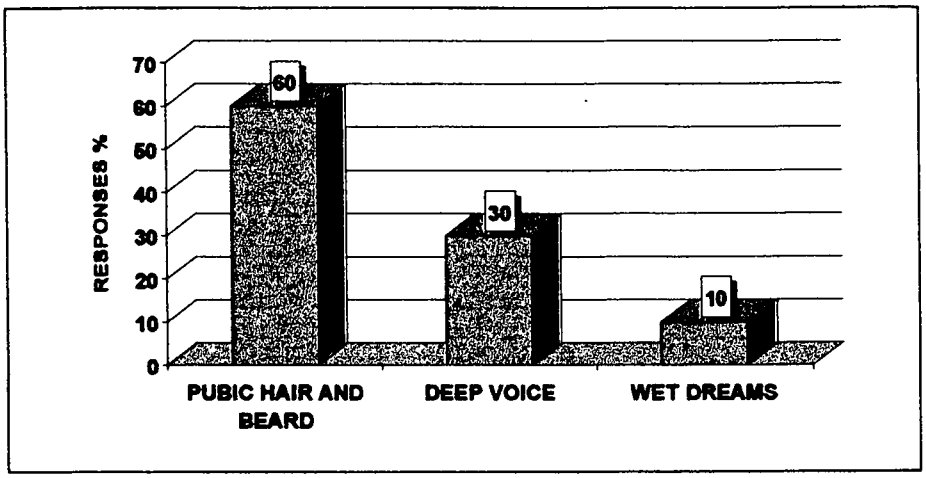

FIGURE 4.5: Knowledge of reproductive physical changes at puberty

According to Figure 4.5, 90% of males indicated that beard and pubic hear and deeping of voice are the first physical changes to occur during puberty. Ten percent of men referred to wet dreams as the completion of adolescence.

(4) Knowledge of physiological changes that occur in adolescents

Knowledge regarding physiological changes during adolescence is represented in Figure 4.6.

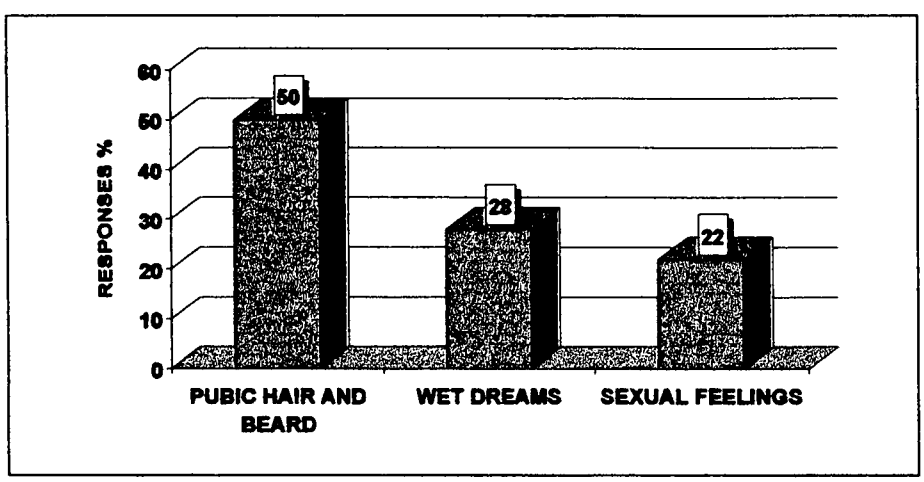

FIGURE 4.6: Knowledge of reproductive physiological changes at puberty

The findings in Figure 4.6, reveal that 50% of men were knowledgeable about the physiological changes of adolescents as were able to identify wet dreams and sexual feelings as the changes they knew about, while 50% mistakenly identified beard and pubic hair.

(5) Knowledge of reproductive physical changes in adulthood

Knowledge of reproductive physical changes during adulthood is shown in Table 4.7.

TABLE 4.7: Knowledge of reproductive physical changes in adulthood

RESPONSE	Frequency	Percentage (%)
Genitals reached maximum size	118	15
Greying of hair	165	21
Deep voice	140	18
Wet dreams	200	26
Sexual feelings	152	20
Total	**771**	**100**

The results in Table 4.7 show that men are not knowledgeable concerning the reproductive physical changes that occur during adulthood – 64% of men mistakenly identified wet dreams, deep voice and sexual feelings as physical reproductive changes while only 37% knew that by adulthood genitals have already reached their maximum size and that greying of pubic hair begins.

(6) Knowledge of reproductive physiological changes that occur in men during adulthood

Knowledge of reproductive physiological changes that occur in men during adulthood is depicted in Table 4.8.

TABLE 4.8: Knowledge of reproductive physiological changes in men during adulthood

Deepening voice	229	30
Pubic hair	164	21
Wet dreams	110	14
Declining sexual performance	80	10
Do not know	189	25
Total	**769**	**100**

According to Table 4.8, the results reveal that 65% of men are not knowledgeable about the physiological changes that occur in men during adulthood, as they mention physical changes that occur among adolescents as physiological changes in adulthood. Only 10% of men knew that sexual performance declines in adulthood while 25% of men knew nothing about the physical changes they are/will be experiencing.

(7) Knowledge of whether it is normal to experience wet dreams

The views of men regarding whether it is normal for a man to experience wet dreams are depicted in Figure 4.7 below.

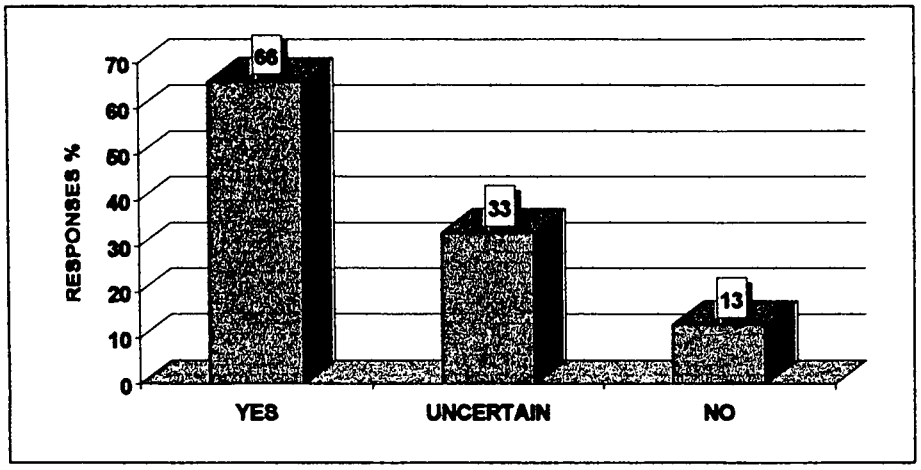

FIGURE 4.7: Knowledge of whether the experience of wet dreams is normal (N=786)

According to Figure 4.7, it is apparent that only 66% of men know that the experience of wet dreams is a normal phenomenon, while 33% do not know or are uncertain. The men who knew that the experience is a normal process, gave the following reasons:

- It is an indication that a men can reproduce: 27%
- It is a sign that one is a man: 20%
- It shows maturation: 35%
- Wet dreams are a natural process: 18%

(8) Knowing that undescended testicles lead to infertility

Men's knowledge regarding undescended testicles leading to infertility is represented in Figure 4.8 below.

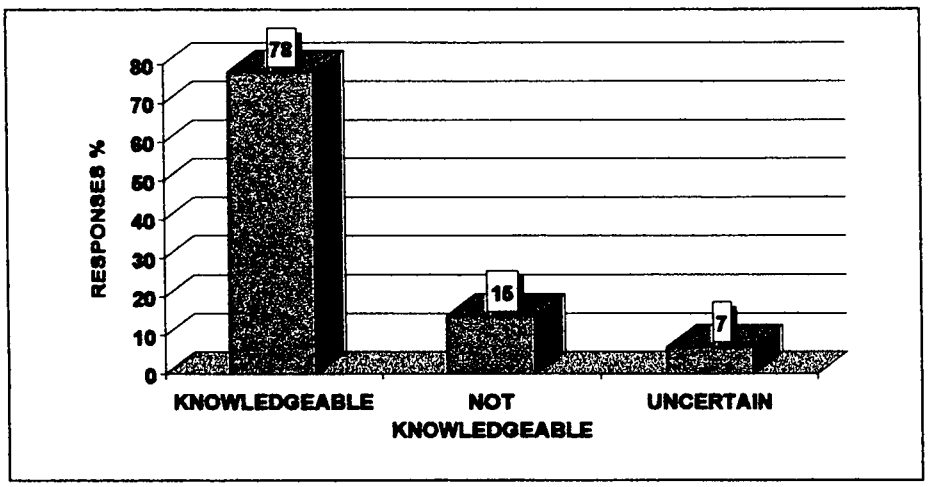

FIGURE 4.8: Men's knowledge of that undescended testicles lead to infertility (N=788)

Figure 4.8 shows that most men (78%) know that undescended testicles may lead to infertility.

(9) Persons who taught men about reproductive physical changes

Persons who taught the respondents about the physical and physiological changes that occur in men are indicated in Table 4.9.

TABLE 4.9: Persons who taught respondents about physical and physiological changes

SOURCE	Frequency	Percentage (%)
Father	192	24.6
Mother	16	2
Grandfather	38	4.9
Friends	319	40.8
School	118	15
Nurses	10	1.3
Initiation school	20	2.6
Doctors	9	1.2
Village health worker	9	1.2
Traditional healer	4	0.5
Other	47	6
Total	**782**	**100**

It is evident from Table 4.9 that friends (40.8%) were the primary source of information regarding physical and physiological changes in men, followed by schools (15%) and then fathers (24%). Health care practitioners (37%) and traditional practitioners (3.1%) are not important sexual health educators.

4.3.2.2.2 Reproductive health and birth control

(1) Knowledge of pregnancy

The knowledge that men have regarding pregnancy is depicted in Figure 4.9.

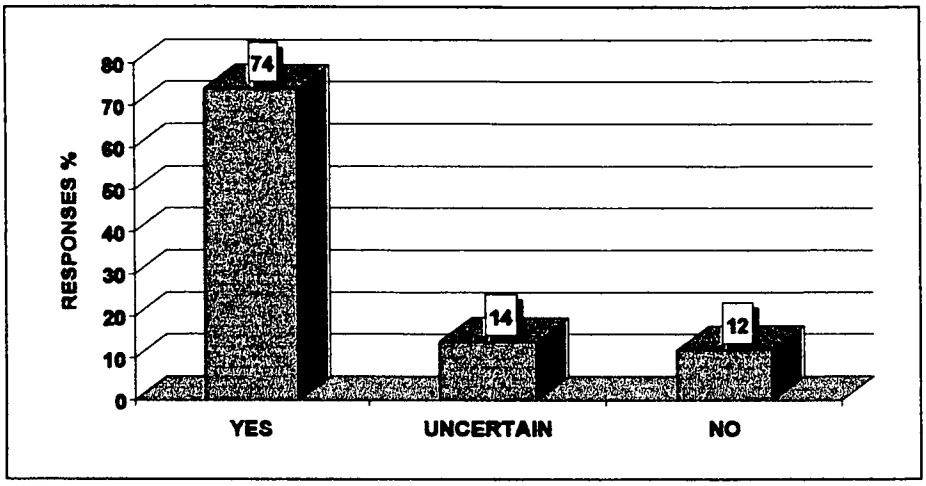

FIGURE 4.9: Knowledge of pregnancy

According to Figure 4.9, 74% of men indicated that it is necessary for men to be knowledgeable about pregnancy, while 26% were uncertain or saw no need for it.

Men who expressed the need to know about pregnancy, cited the following reasons:

- They need to know how conception occurs: 21%
- They have to know so that they can help their wives during pregnancy: 31%
- Being fathers of the expected children prompted a need to know: 29%
- They need to know about related problems: 19%

(2) Knowledge of whether pregnancy can occur without vaginal penetration

The knowledge that men have regarding whether pregnancy can occur without vaginal penetration is reflected in Figure 4.10.

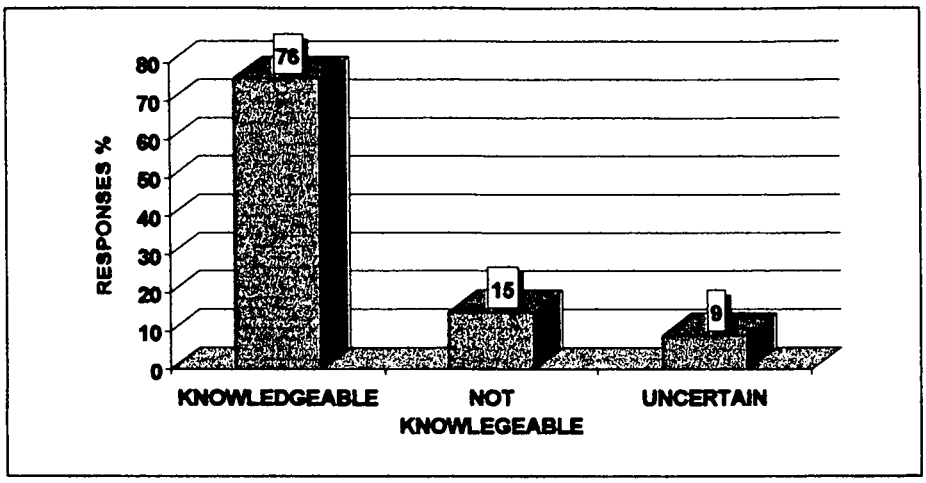

FIGURE 4.10: Men's knowledge of whether pregnancy can occur without vaginal penetration (N=785)

According to Figure 4.10, 76% of men knew that pregnancy cannot occur without vaginal penetration.

(3) Knowledge of the age at which males can impregnate women

Men's knowledge regarding the age at which males are capable of impregnating women is reflected in Table 4.10.

TABLE 4.10: Knowledge of the age at which males can impregnate women (N=775)

AGE	Frequency	Percentage (%)
12 years	126	16
13 years	61	7.8
14 years	211	27
15 years	136	17.5
16 years	82	10.5
17 years	61	7.8
Do not know	98	12.6
Total	**775**	**100**

According to Table 4.10, the respondents indicated that the age at which a male is capable of impregnating women varies from 12 to 17 years. However, it could be said that most men (87%) were knowledgeable.

(4) Knowledge of family planning

The men's responses regarding being knowledgeable about family planning are depicted in Table 4.11.

TABLE 4.11: Knowledge of family planning (N=779)

RESPONSE	Frequency	Percentage (%)
Accentuated	626	80
Not important	59	8
Uncertain	94	12
Total	**779**	**100**

According to Table 4.9, 80% of men expressed that men should know about family planning.

The reasons cited why men should be knowledgeable included the following:

- They should be able to choose which contraceptive method to use: 42%
- They should know which different contraceptive methods existed: 58%

(5) Understanding of the concept "contraception"

How men conceptualised the term "contraception" is presented in Table 4.12.

TABLE 4.12: Conceptualisation of the term contraception by men (N=761)

RESPONSE	Frequency	Percentage (%)
Birth control device	425	56
Contraceptives	76	10
Family planning	167	22
Avoiding unwanted	93	12
Pregnancy		
Total	**761**	**100**

According to Table 4.10, most men (66%) saw contraception as birth control devices or contraceptives, while 22% thought it was family planning.

(6) Knowledge of male and female contraceptive methods

The knowledge men have regarding different male and female contraceptives is reflected in Table 4.13.

TABLE 4.13: Knowledge of male and female contraceptive methods (N=763)

CONTRACEPTIVE METHOD	Frequency	Percentage (%)
Injection	95	12
Loop	57	7
Pill	355	46.5
Condom	206	27
Other	30	4
No response	30	4
Total	**763**	**100**

According to Table 4.11, most men (96%) know about different male and female contraceptive methods: condoms (46.5%) are the most widely known, followed by the pill (27%).

(7) Knowledge of male contraceptive devices

The knowledge men have of male contraceptive devices is depicted in Table 4.14.

TABLE 4.14: Knowledge of male contraceptive devices (N=773)

CONTRACEPTIVE	Frequency	Percentage (%)
Condoms	688	89
Pill	34	4
Injection	39	5
Vasectomy	10	1
Withdrawal	2	0.17
Total	**773**	**100**

The results in Table 4.12 show that the condom (89%) was the best known male contraceptive device.

(8) Whether partners should decide together to use birth control methods

The views of males as to whether they should decide together with their partners whether to use birth control methods is illustrated in Figure 4.11.

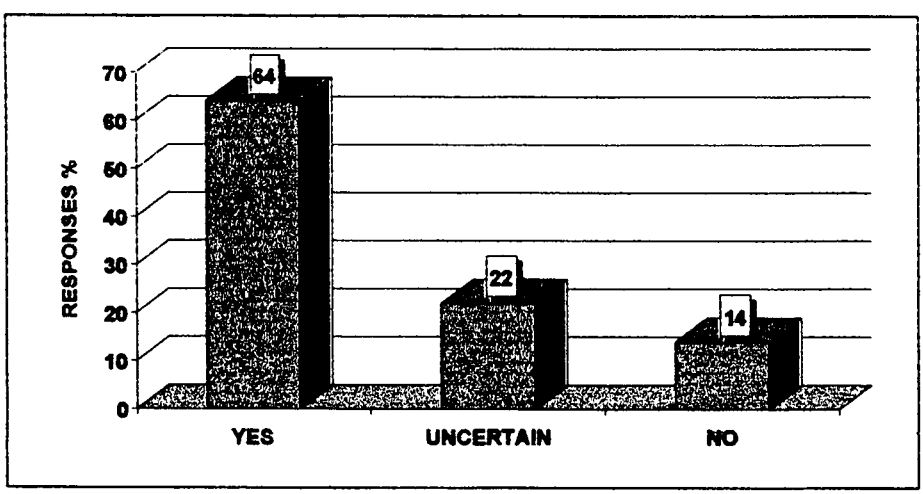

FIGURE 4.11: Views of men regarding whether to decide together with their partners about using birth control methods (N=789)

According to Figure 4.11, 64% of men expressed the view that it was necessary for sexual partners to decide together whether to use birth control methods, while 22% were uncertain and 14% indicated that they would not consult their partners.

The following reasons were expressed as to why it was necessary for partners to decide together:

- So that the best method to use can be decided on: 42%
- Men and females are equally responsible for planning pregnancies: 35%
- Partners should decide together to avoid conflict: 27%

(9) Source of information regarding contraception

The persons consulted for information on contraception is reflected in Table 4.15.

TABLE 4.15: Source of knowledge regarding contraception

SOURCE	Frequency	Percentage (%)
Nurses	306	39
Doctors	88	11
Friend	245	31
Mother	13	2
Father	7	1
Grandfather	12	2
Traditional healer	15	2
Village health worker	38	5
Other	60	8
Total	**784**	**100**

Table 4.15 reveals that the professional nurse (39%) was the most preferred source of information, followed by friends (31%).

(10) Information men would like to receive regarding contraception

Table 4.16 reflects topics on contraception that men prefer.

TABLE 4.16: Preferred topics regarding contraception

TOPIC	Frequency	Percentage (%)
Pregnancy	374	48
Birth control methods	164	21
Benefits of birth control methods	99	13
Side effects of birth control methods	77	10
Male contraceptives	40	5
Female contraceptives	15	2
Other	12	2
Total	**782**	**100**

According to Table 4.16, nearly half of the respondents (48%) would like more information on pregnancy and birth control methods (5%).

(11) How men would like information on contraception to be conveyed to them

Men's views regarding how information on contraception should be conveyed is represented in Table 4.17.

TABLE 4.17: Men's preferences regarding how information on contraception should be conveyed

PREFERENCE	Frequency	Percentage (%)
Radio	270	35
Television	156	20
Lectures	230	29
Brochures	86	11
Other	40	5
Total	**782**	**100**

According to Table 4.17, the radio (35%) was the most preferred medium for conveying information on contraception to men, followed by lectures (29%).

4.3.2.2.3 Sexually transmitted diseases

(1) Understanding of the term sexually transmitted diseases

The views of men regarding their understanding of the term sexually transmitted diseases are represented in Table 4.18.

TABLE 4.18: Men's understanding of the term sexually transmitted diseases

RESPONSE	Frequency	Percentage (%)
Diseases transmitted through sexual intercourse	170	22
Diseases like acquired immune deficiency syndrome	150	20
Diseases that affect sexual partners	192	25
Diseases that affect genitals	92	12
Total	769	100

The results in Table 4.18 reveal that all men knew what sexually transmitted diseases means.

(2) Knowledge of different sexually transmitted diseases

The knowledge of men regarding the different sexually transmitted diseases is reflected in Figure 4.12.

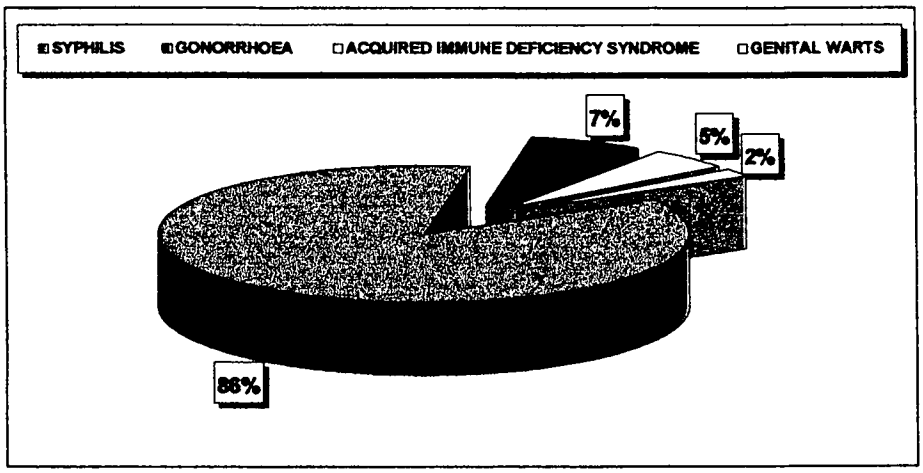

FIGURE 4.12: Knowledge of different sexually transmitted diseases (N=785)

According to Figure 4.12 all men knew about the different sexually transmitted diseases as they could identify at least one type of sexually transmitted disease. Overall, syphilis (86%) was the most widely known sexually transmitted disease.

(3) Knowing of how sexually transmitted diseases can be transmitted

The knowledge that men have concerning the transmission of sexually transmitted diseases is depicted in Figure 4.13.

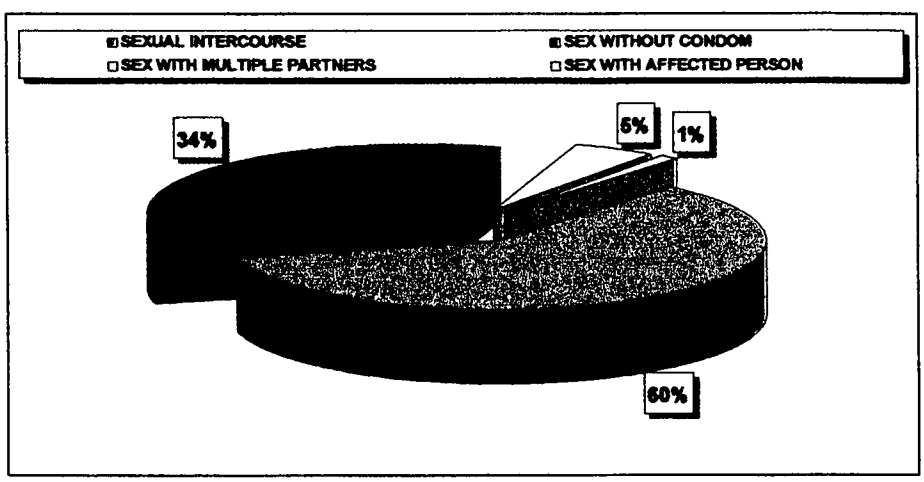

FIGURE 4.13: Knowledge of transmission of sexually transmitted diseases (N=771)

From Figure 4.13, it can be seen that all men knew that sexually transmitted diseases were transmitted through sexual intercourse. Sixty percent indicated that sexual intercourse is the main route of transmission, followed by 34% indicating that sexual intercourse without a condom can also lead to transmission.

(4) Knowledge of persons who could contract sexually transmitted diseases

The respondents' view regarding the persons who could contract sexually transmitted diseases is represented in Figure 4.14.

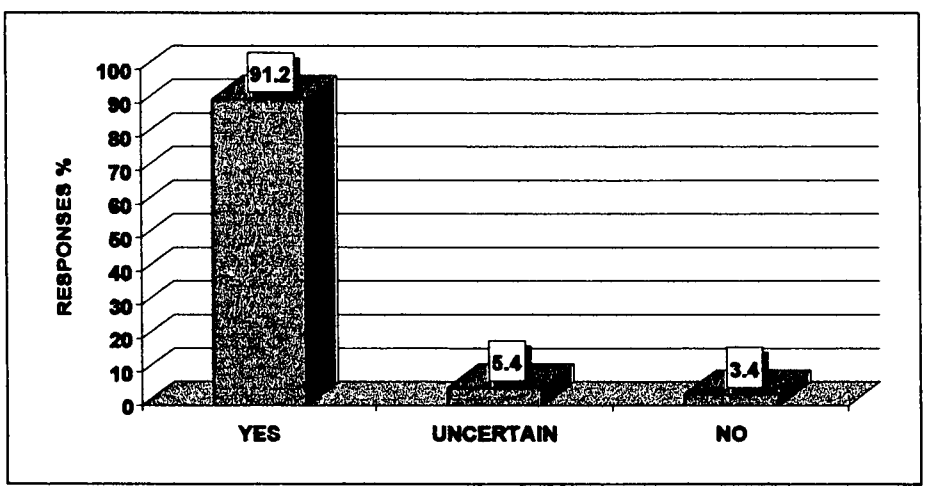

FIGURE 4.14: Knowing about who could contract sexually transmitted diseases (N=775)

According to Figure 4.14, most men (91.2%) knew that any person could contract sexually transmitted diseases.

(5) Knowledge of signs and symptoms of sexually transmitted diseases

Men's knowledge of signs and symptoms of sexually transmitted diseases is represented in Figure 4.15.

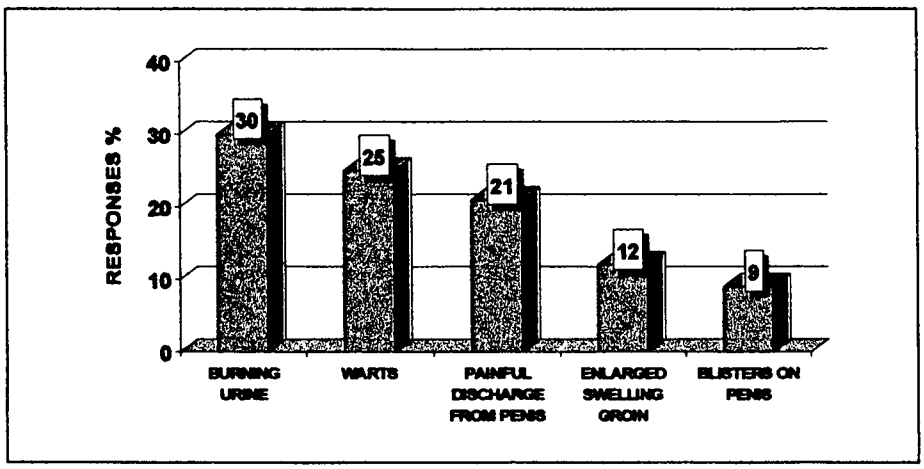

FIGURE 4.15: Knowledge of signs and symptoms of sexually transmitted diseases

The findings in Figure 4.15 reveal that burning urine (30%) was the best known sign and symptom, followed by warts (25%) and painful discharge from the penis (21%). Overall, all men were knowledgeable about signs and symptoms of sexually transmitted diseases as they were able to identify at least one sign and symptom.

(6) Knowledge of how sexually transmitted diseases are prevented

The respondents indicated the following ways in which sexually transmitted diseases could be prevented, as reflected in Table 4.19.

TABLE 4.19: Knowledge of prevention of sexually transmitted diseases

RESPONSE	Frequency	Percentage (%)
Using condoms	250	33
Abstaining	150	20
Monogamy	90	12
Health education	100	13
Taking traditional herbs	100	13
Avoid premarital sex	70	9
Total	**760**	**100**

According to Table 4.19, most men (33%) indicated that using condoms is a preventive measure against sexually transmitted diseases.

(7) Knowledge that sexually transmitted diseases influence fertility

Men's knowledge regarding the influence of sexually transmitted diseases on a person's fertility is depicted in Figure 4.16.

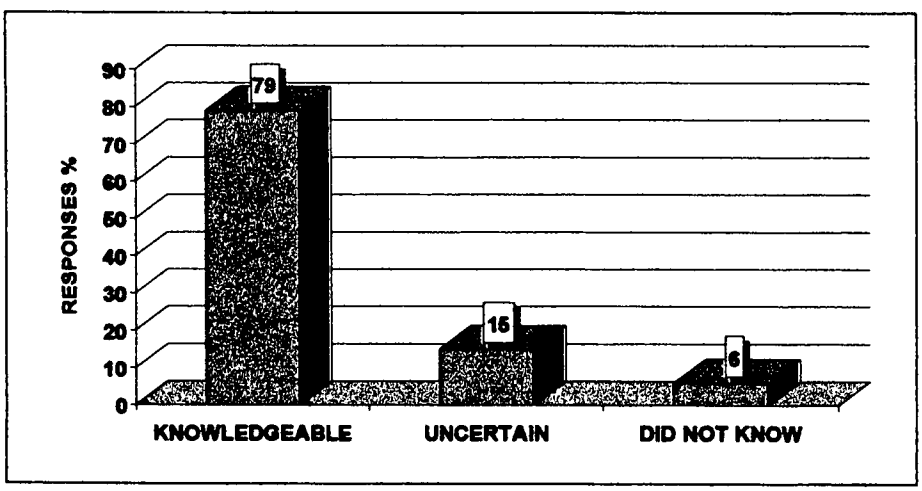

FIGURE 4.16: Knowledge that sexually transmitted diseases influence fertility (N=780)

The results in Figure 4.16 reveal that 79% of men knew that sexually transmitted diseases can influence their fertility, while 21% did not know.

4.3.2.2.4 Factors that may have an impact on men's reproductive health

(1) Knowing that illnesses can affect men's reproductive health

Men's knowledge that illnesses can affect their reproductive health is depicted in Figure 4.17.

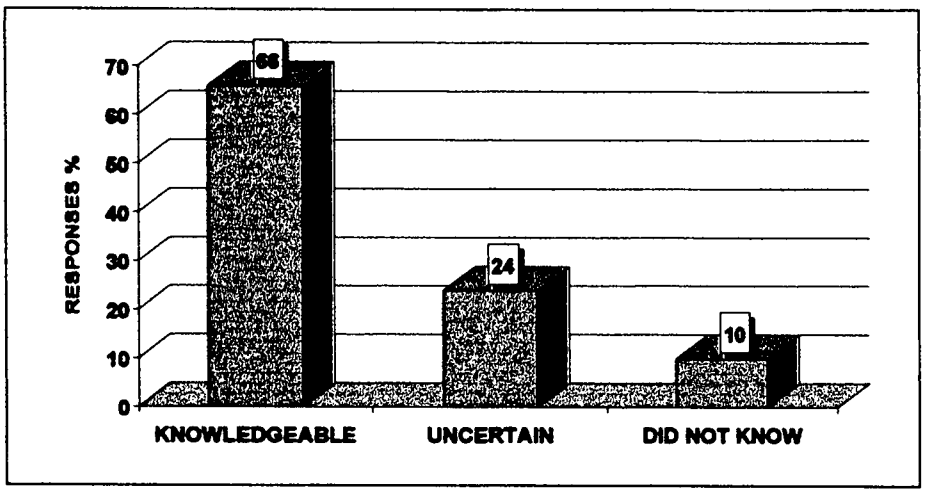

FIGURE 4.17: Knowledge of effect of illnesses on men's reproductive health

According to Figure 4.17, 66% of men know that illnesses may affect their reproductive health.

The reasons cited by men as to why they should know that illnesses affect their fertility are:

- Some illnesses can inhibit sexual feelings: 55%
- Some illnesses affect men's fertility: 45%

(2) Knowing that drugs have an effect on men's reproductive health

The knowledge of men regarding the effect of drugs on men's reproductive health is depicted in Figure 4.18.

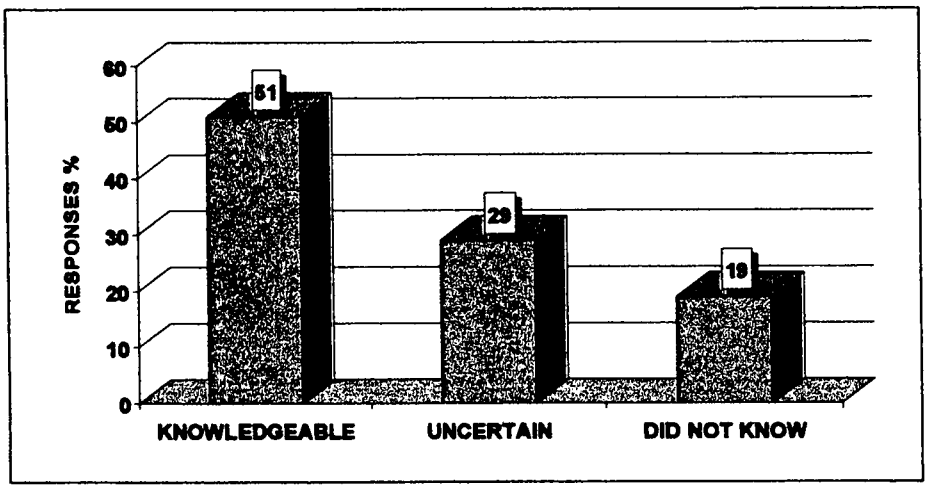

FIGURE 4.18: Knowledge of effect of drugs on men's reproductive health (N=785)

The results on Figure 4.18 show that 51% of men were aware that drugs can have an effect on their reproductive health while 48% did not know this.

The reasons given as to why men should know that drugs can have an effect on their reproductive health were:

- Diabetes drugs inhibit the libido: 41%
- Some drugs increase libido (dagga): 59%

(3) Knowledge that alcohol and smoking affect men's reproductive health

The knowledge of men regarding the effect of smoking and alcohol on reproductive health is represented in Figure 4.19.

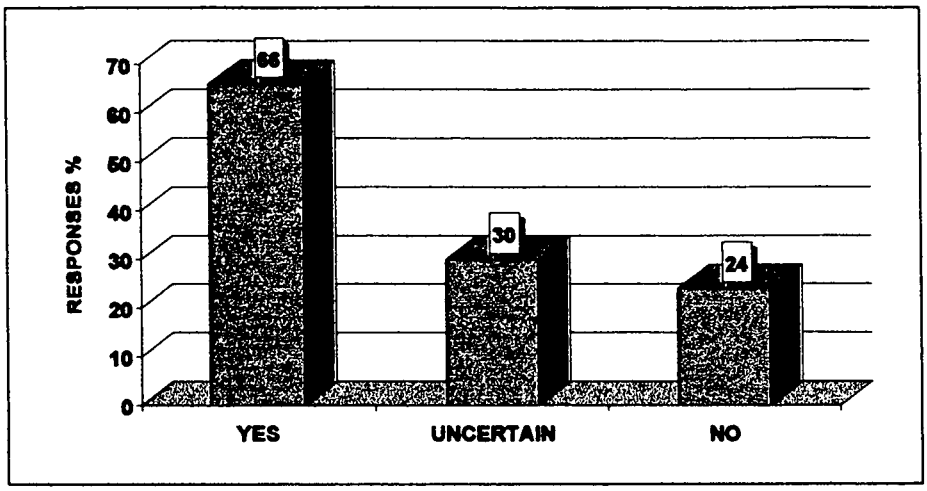

FIGURE 4.19: Knowledge of effects of smoking and alcohol on men's reproductive health (N=770)

According to Figure 4.19, 66% of men know that smoking and alcohol affect their reproductive health.

Reasons expressed for awareness that smoking and alcohol affect men's reproductive health were:

- Heavy smoking affects sexual performance: 41%
- Heavy consumption of alcohol reduces libido: 34%
- Excessive intake of alcohol can lead to rape: 25%

4.3.2.3 Men's attitudes towards reproductive health

(1) Attitudes about premarital sex

Men's opinions about premarital sex are depicted in Figure 4.20.

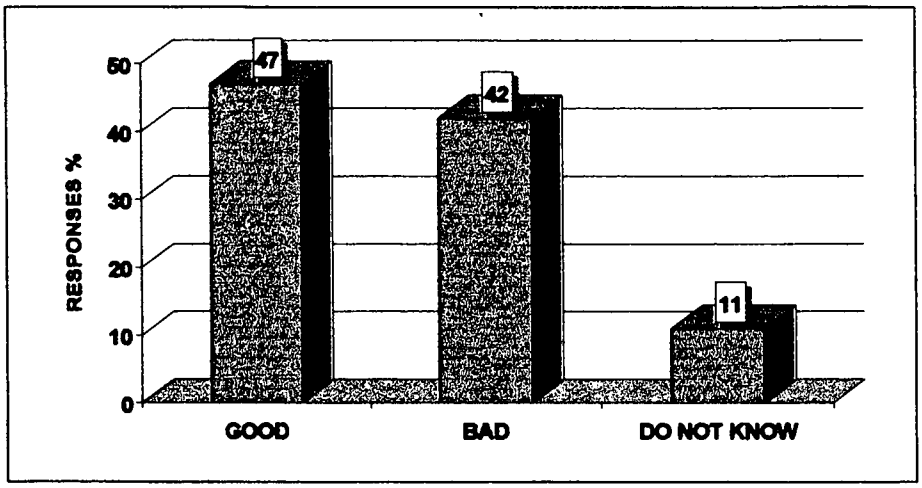

FIGURE 4.20: Opinions of men about premarital sex

According to Figure 4.20, most men (47%) hold a view that premarital sex is good, while 42% feel it is undesirable.

The main reasons for considering premarital sex to be bad include:

- *"It is a sin before God."*
- *"Premarital sex may lead to unwanted pregnancy."*
- *"Premarital sex may predispose a person to infection with sexually transmitted diseases."*

Statements supporting premarital sex include:

- *"It is good as boys/girls need to learn how to have sex."*
- *"Premarital sex prepares one for marriage."*

(2) Men's views about extramarital relationships

The views men hold regarding extramarital relationships are reflected in Figure 4.21.

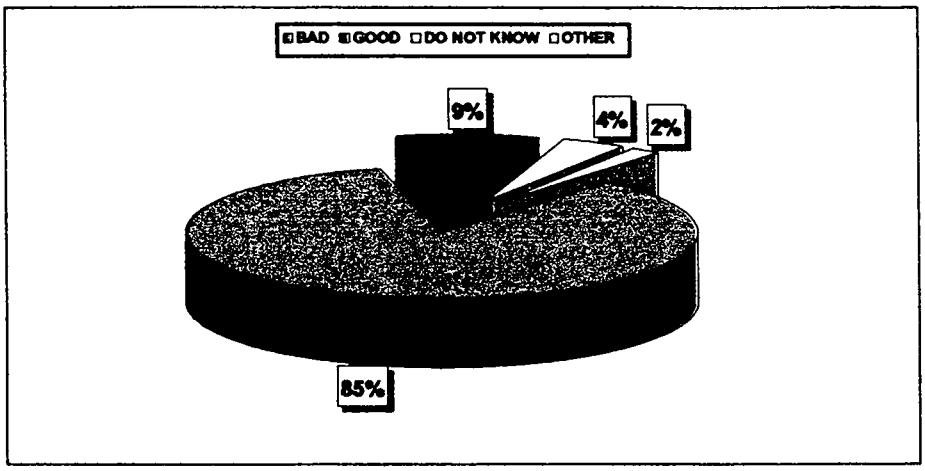

FIGURE 4.21: Opinions of men about extramarital relationships

According to Figure 4.21 it is evident that most men (85%) felt extramarital relationships were bad.

The reasons expressed by men for regarding extramarital relationships to be bad are:

- *"Extramarital relationships break families."*
- *"The practise is a sin before God."*
- *"They expose the man to sexually transmitted diseases."*

The following statements were expressed by men who supported extramarital relationships:

- *"A man is for many women."*
- *"Extramarital relationships help men to satisfy their sexual feelings when their partners/wives are away or pregnant."*

(3) Opinions that childlessness can result from male infertility

The respondents' views regarding the fact that childlessness can result from male infertility is depicted in Figure 4.22.

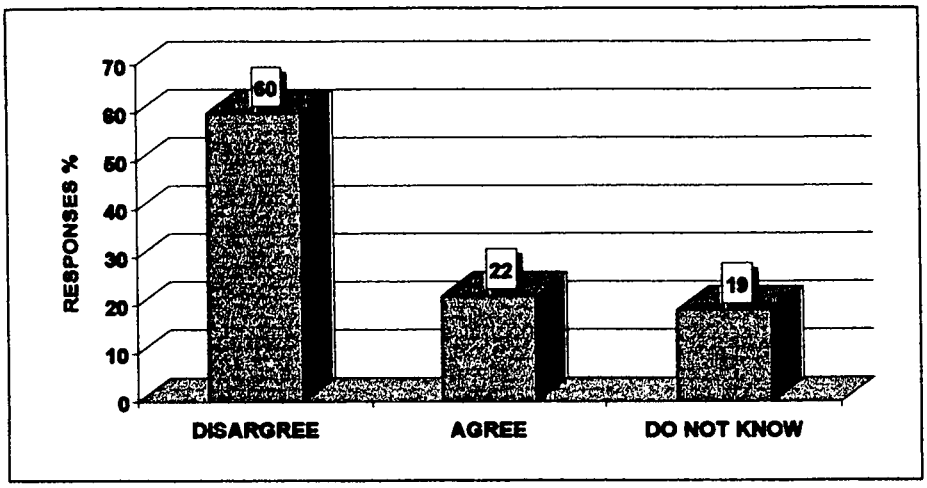

FIGURE 4.22: Opinions of men about childlessness resulting from male infertility

The findings in Figure 4.22 reveal that most men (60%) do not believe that childlessness can result from male infertility.

The reasons for not believing that childlessness can be due to male infertility are:

- *"Infertility is a female problem only."*
- *"Males are the ones to make kids."*
- *"A man never gets old."*

(4) Father's presence during birth of his child

The responses of males concerning the presence of a father during the birth of his child are represented in Figure 4.23.

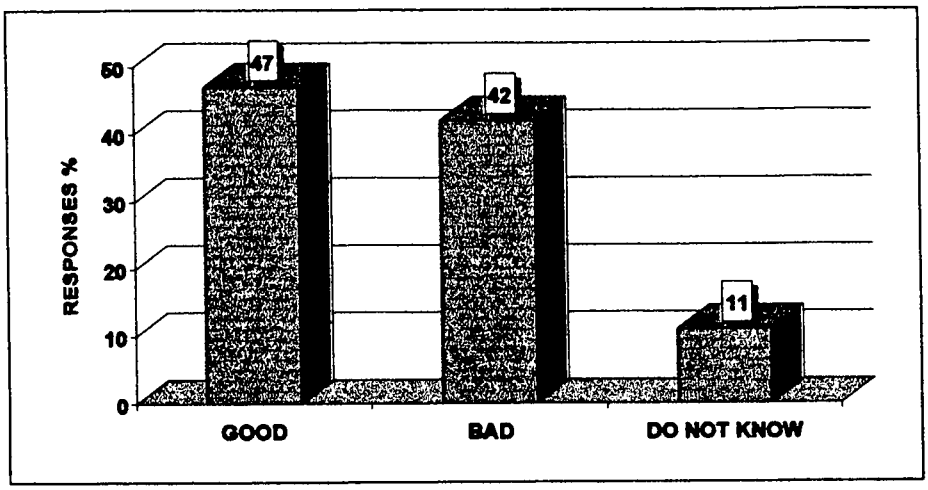

FIGURE 4.23: Father's presence during the birth of his child

As depicted in Figure 4.23 most men (47%) support the idea that a father should be present during the birth of his child.

The reasons expressed by men who agree that a father should be present during the birth of his child were:

- *"A man has to be present because the child is his."*
- *"A man has to be allowed to enter to support his wife."*

Among men who were against the idea that a father should be present at birth of his child, the following statements were cited:

- *"Childbirth is a female secret."*
- *"It is against our tradition."*

(5) Participation of males in child rearing

The views of men regarding their participation in child rearing are represented in Figure 4.24.

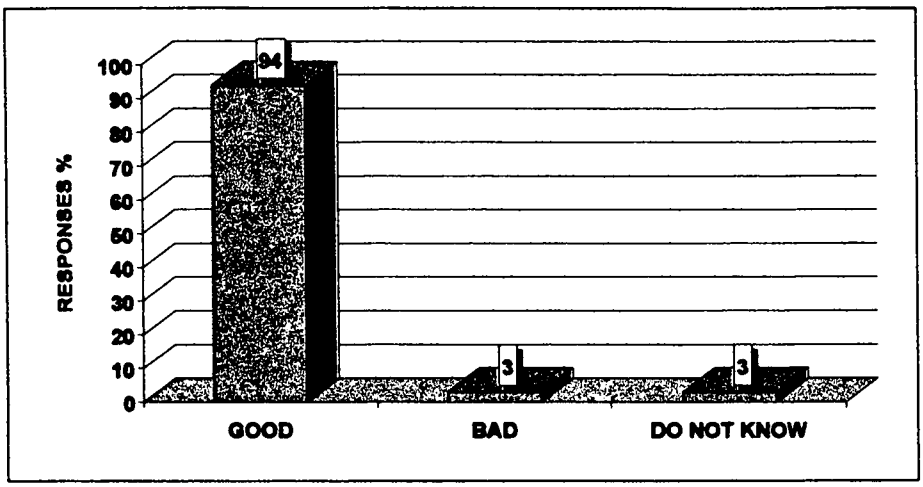

FIGURE 4.24: Views of men about participation in child rearing

The results of Figure 4.24 show that most men (94%) felt it was good for men to participate in child rearing.

The main reasons for considering their (men's) participation in child rearing to be good include:

- *"Men are equally responsible for the upbringing of a child."*
- *"A child is for both a woman and a man."*
- *"A man must participate to be able to look after children when his wife is away."*

(6) Discussion of reproductive health issues with their partners

How men felt about discussing reproductive health issues with their partners is represented in Figure 4.25.

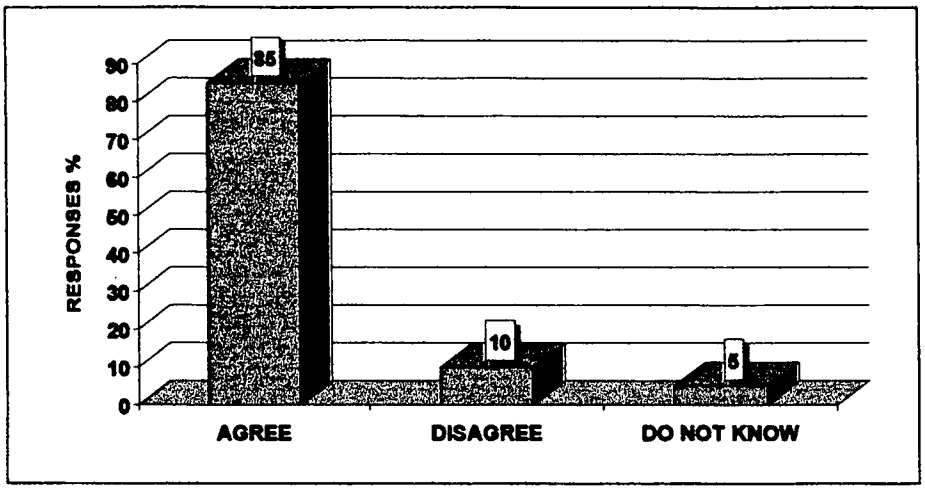

FIGURE 4.25: Discussion of reproductive health issues with partners

According to the findings in Figure 4.25, most respondents (85%) indicated that men should discuss reproductive health issues with their partners.

Men indicated the following reasons for the necessity to discuss reproductive health with their partners:

- *"They have to discuss to share each others' opinions."*
- *"They need to discuss reproductive health to advise each other when there is a problem."*

(7) Attitudes regarding homosexuality

The attitudes of men about homosexuality are set out in Figure 4.26.

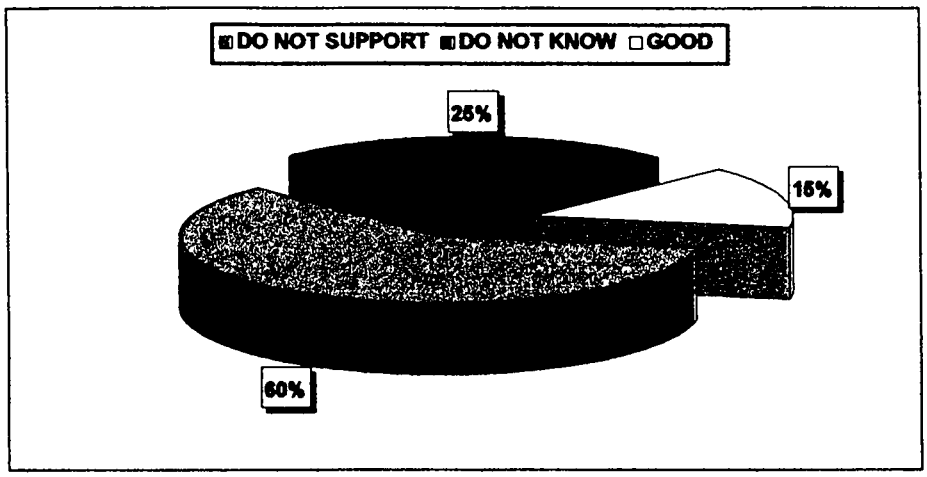

FIGURE 4.26: Attitudes of men about homosexuality

According to Figure 4.26, most men (60%) do not support a homosexual orientation while 15% felt it was acceptable.

Reasons given by those men who do not support homosexuality include the following:

- *"It is culturally immoral."*
- *"A man does not have to have sex with another because women are plentiful."*
- *"Homosexuality gives high risk to sexually transmitted diseases."*

The reasons given by men who said homosexuality was acceptable are:

- *"Homosexuality is a way to satisfy feelings."*
- *"Homosexuality is natural."*
- *"If they enjoy it, it is good because each person has the choice to do what he likes."*

4.3.2.4 *Reproductive health practises*

(1) Alternative ways of realising sexual desire

The alternative ways of realising sexual desire used by men are depicted in Figure 4.27.

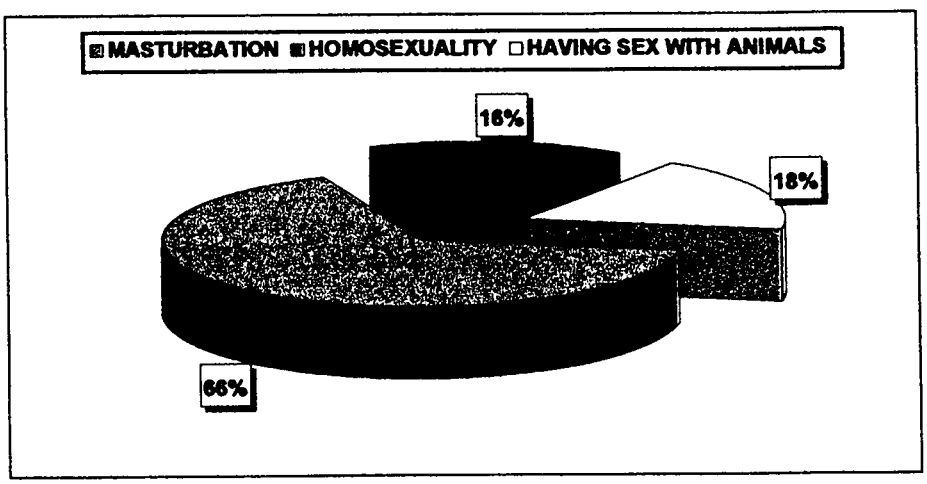

FIGURE 4.27: Alternative ways used by men to satisfy sexual desire other than sexual intercourse

According to the results in Figure 4.27 most men (66%) identified masturbation as an alternative way they can use to realise sexual desire other than sexual intercourse. Disturbing is the 18% of men indicating that beastiality is a good way of realising their sexual desire.

(2) Practise of safe sex

Whether men practise safe sex or not is depicted in Figure 4.28.

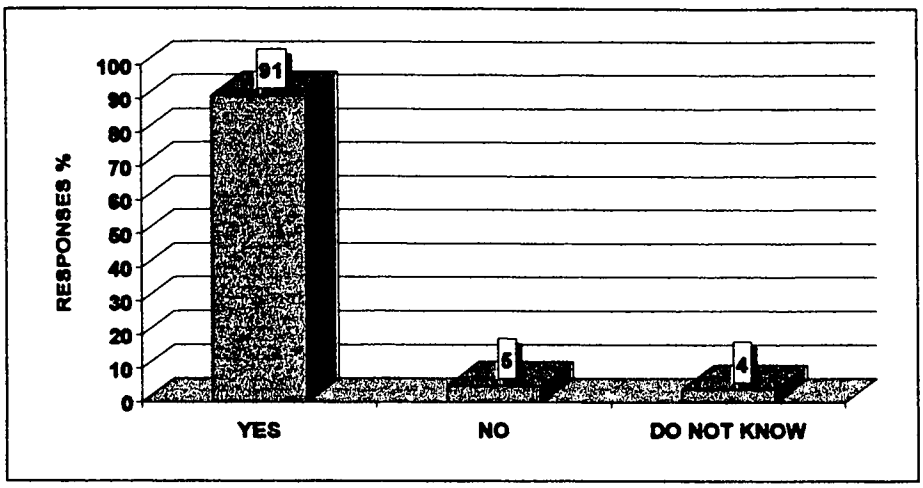

FIGURE 4.28: Practise of safe sex by men

According to the findings presented in Figure 4.28, most men (91%) indicated that they practised safe sex.

Reasons given by men for practising safe sex were:

- *"We practise safe sex to protect ourselves from contracting sexually transmitted diseases."*
- *"We practise safe sex to avoid unwanted pregnancy."*
- *"We practise safe sex by sticking to one sexual partner."*

(4) Support for the practise of traditional circumcision

The views of men as to whether they support traditional circumcision are shown in Figure 4.29.

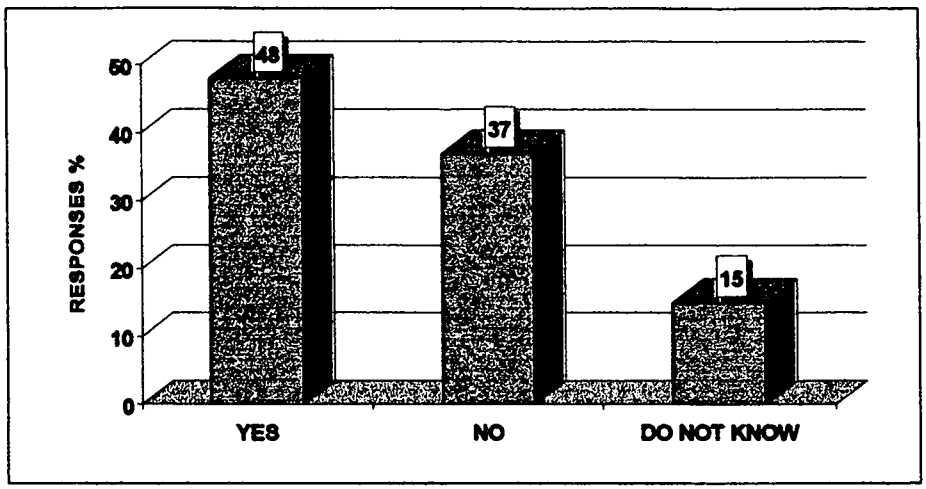

FIGURE 4.29: Support of men regarding the practise of traditional circumcision

According to the findings in Figure 4.29, 48% of men indicated that they supported the practise of traditional circumcision, while 37% of men did not support it at all.

The main reasons given by men who said they supported traditional circumcision were:

- *"Traditional circumcision is the tradition of Basotho."*
- *"It is where boys are taught the Sesotho culture."*
- *"Traditional circumcision is good because boys who are circumcised are real men."*

4.3.2.5 Reproductive health services

(1) Use of reproductive health services

Men's use of any reproductive health facility is represented in Figure 4.30.

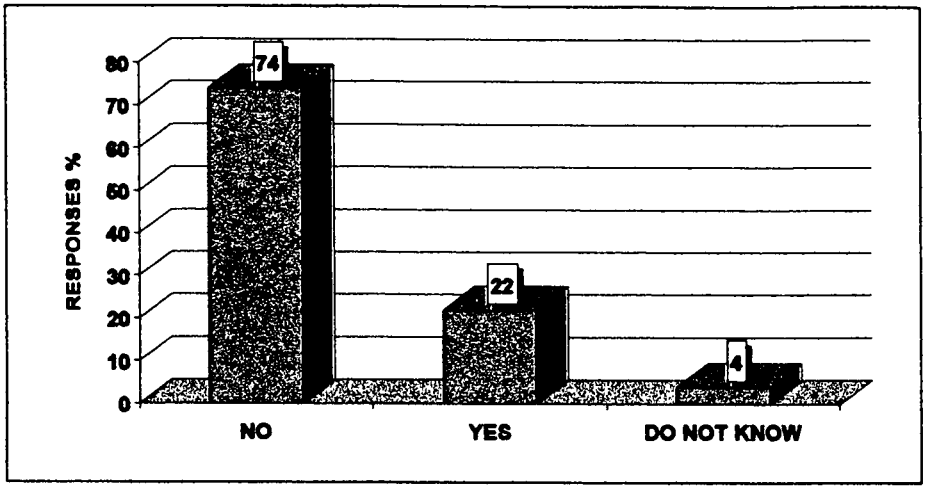

FIGURE 4.30: Men' use of reproductive health services

According to the findings in Figure 4.30 most men (74%) indicated that they do not use any reproductive health facility.

The main reasons men gave for not using reproductive health facilities are:

- *"We do not have such services."*
- *"We have not heard about the existence of such services."*
- *"I have never found it necessary to visit."*

(2) Use of reproductive health services in the future

Men's views regarding whether they would use reproductive health services in the future, if such services exist, is depicted in Figure 4.31.

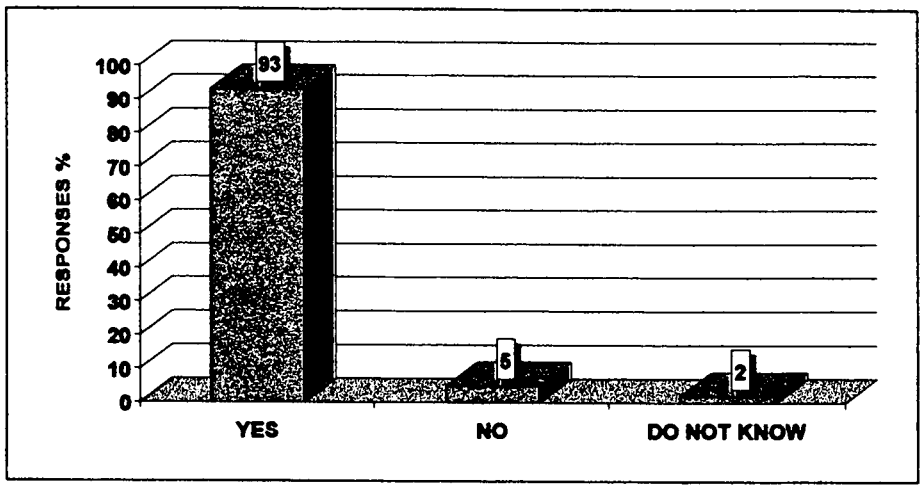

FIGURE 4.31: Men's use of reproductive health services in the future, if such services exist

According to the findings in Figure 4.31 most men (93%) stated that they would use reproductive health services in the future while 5% of men indicated that they would not.

The reasons given by men who said they would use reproductive health services are:

- *"We would go there to get advice on sexually transmitted diseases."*
- *"We would go to know more about the services."*

(3) Preferred type of services

The type of reproductive services men prefer is depicted in Table 4.20.

TABLE 4.20: Preferred type of services by men

SERVICE	Frequency	Percentage (%)
Information on prevention of sexually transmitted diseases (including acquired immune deficiency syndrome	310	40
Information on family planning	60	8
Counselling and treatment of infertility	80	10
Counselling and treatment of sexual dysfunction	160	21
Information on child rearing	80	10
Information on drug and alcohol abuse	85	11
Total	769	100

According to the findings on Table 4.20, most men (40%) would like the services to provide information on prevention of sexually transmitted diseases, followed by counselling and treatment of sexual dysfunctions (21%).

(4) Preferred service provider

Men's preferences regarding the gender of the service provider are shown in Table 4.21.

TABLE 4.21: Gender of service provider preferred by men

SERVICE PROVIDER	Frequency	Percentage (%)
Male provider	325	43
Female provider	31	4
Doctors	252	33
Nurses	75	10
Village health workers	25	3
Lesotho planned parenthood	38	5
Association		
Traditional healer	8	1
Other	8	1
Total		

The findings in Table 4.21 show that 43% of men prefer to be served by a male provider while 33% preferred doctors.

(5) Type of setting preferred

The type of setting that men prefer is depicted in Table 4.22.

TABLE 4.22: type of setting preferred by men

SETTING	Frequency	Percentage (%)
Men only clinic	548	71
Men/women	106	14
Workplaces	68	9
Sporting events	23	3
Social clubs	15	2
Other	9	1
Total	**769**	**100**

According to the findings in Table 4.22 it is evident that most men (71%) need a *"men only"* type of setting; 14% prefer a setting open to men and women, while 9% prefer the services to be rendered at their place of work.

(6) Service times preferred

The times of services men prefer are shown in Table 4.23.

TABLE 4.23: Hours of services preferred by men

TIME	Frequency	Percentage (%)
Morning hours	185	24
Lunch time	37	5
Afternoons	66	9
Evenings	463	60
Throughout the day	20	3
Total	**771**	**100**

According to the findings on Table 4.23 evenings (60%) were the most preferred service times, while 24% of men preferred morning hours.

(7) Designing of services

The respondents expressed the following views regarding the design of services:

- *"Male reproductive health should be rendered throughout the country."*
- *"Male reproductive health services should be brought to the people (villages, schools and workplaces)."*

- *"The services should focus on young men as well."*
- *"Male health providers should provide services."*
- *"Services should be rendered day and night."*

4.4 CONCLUSION

In this chapter the data obtained by focus group discussions and reduction of data obtained through the structured interview were discus The responses given by the respondents were reduced and categorised then presented graphically on a nominal descriptive level. The reasons g for the responses were described in narrative statements. The findings of study will be discussed in Chapter 5.

CHAPTER 5

5.1 INTRODUCTION

This chapter addresses the findings of the study, the discussion of the conclusions reached and the recommendations made.

5.2 THE FINDINGS OF THE STUDY

Based on the data analysis the following findings were made:

5.2.1 More knowledge regarding male reproductive health is needed

Generally, the findings revealed that men lacked knowledge related to: what constitutes male reproductive health; the anatomy and physiology of male reproduction; the fact that infertility can result from undescended testis; illnesses that may affect male reproductive health; other options regarding male contraceptive methods; and the transmission of sexually transmitted diseases.

5.2.2 The attitudes of males differ regarding reproductive health

The participants held different opinions regarding reproductive health issues, including resistance to reveal their feelings related to their own sexuality. They also held different views regarding sexual maturity. Homosexuality was not acceptable to some men, and some also believed male infertility affects men's sexual identity. Many men opposed premarital sex, extramarital

relationships, men's participation in child rearing, entering the delivery room during birth of their children and the use of condoms. Participants also held negative opinions towards people infected with STDs[4] including HIV[5]/AIDS[6], indicating that those infected were largely promiscuous.

5.2.3 Inadequate information related to safe reproductive health practices

The findings revealed that young men aged 15 to 24 years were not familiar with alternative ways of realising sexual desire other than sexual intercourse. Furthermore, some men were not aware of dangers involved in unsafe traditional circumcision.

5.2.4 Lack of male reproductive health services

The findings revealed that most men were interested to utilize male reproductive health services provided such services existed, however they expressed different preferences related to the type of services preferred. The type of service provider preferred, the type of setting, service hours, as well as barriers against utilizing services.

[4] STD's = Sexually transmitted diseases
[5] HIV = Human immunodeficiency virus
[6] AIDS = Acquired immunodeficiency syndrome

5.3 DISCUSSION OF FINDINGS

5.3.1 Lack of knowledge regarding male reproductive health

- **Lack of knowledge related to what constitutes male reproductive health**

From the results it can be seen that most men suggested that they should know more about family planning and sexually transmitted diseases as male reproductive health issues. It could be assumed that men's limited knowledge could be attributed to the fact that family planning and reproductive health services have not addressed a large number of issues concerning men, such as sexual dysfunction, infertility and urologic conditions. However, the findings correlate with those of Drennan (1998:24) who found that many men in countries like Kenya, Mexico and Pakistan wanted more information on sexually transmitted diseases and family planning.

- **Lack of knowledge related to the anatomy and physiology of male reproductive health**

The respondents expressed a lack of knowledge regarding the anatomy and physiology of the male reproductive system as well as the bodily changes they experience during their life cycle (sexual maturation). This finding is similar to those of (WHO, 2000:33; Davidson, 1998:18) who found that many men lack knowledge related to their sexuality because, from their early years of development, they are rarely provided with information about the physiology of male reproduction and physical changes accompanying sexual development. This lack of information may affect the ability of men to make informed decisions about risk behaviour and sexual health.

- **Lack of knowledge about infertility resulting from undescended testes**

Most young and old Basotho[7] men were not aware that undescended testes could lead to male infertility. This finding is in line with findings of the study by Tortora and Grabowski (1993:925) who stated that if men are not aware of how their bodies are structured and function they may not be able to make informed decisions related to their sexuality.

- **Lack of knowledge about illnesses that may affect male reproductive health**

According to Laura-Serrant (2000:1041) illnesses can affect male sexuality both directly and indirectly. An illness may interfere with the reflexes of sexual response while medications may have side-effects. Based on the findings that the majority of men were not aware of any illnesses that may affect their reproductive health, it may be assumed that most men in Lesotho do not know of any illnesses that can impact on male reproductive health.

- **Limited knowledge about the choice of male contraceptive methods**

The results revealed that the condom was the only known male contraceptive method. However, many expressed negative opinions and fears about using them (concerns that include decreased sexual pleasure, unreliability and loss of sensation). This finding is in line with that of Cohen and Burger (2000:41) who found that in all 15 African countries surveyed by the Demographic

[7] Basotho = People of Lesotho are called Basotho

Health Survey, the majority of men knew of at least one male contraceptive method.

- **Misinformation regarding transmission of sexually transmitted diseases**

The central issue underlying the transmission of sexually transmitted diseases was sexual intercourse, toilet seats and mosquito bites. This finding is similar to those of Lundgren (2000:38) and (Temin, 1999:188) who found that some men had knowledge of the modes of transmission of sexually transmitted diseases while others mistakenly mentioned mosquito bites, sharing eating utensils and using bathrooms of the infected person as modes of transmission.

5.3.2 Different opinions related to reproductive health issues

- **Men's Resistance towards revealing their feelings regarding their own sexuality**

Most men were uncomfortable to talk about how they felt about their own sexuality. This finding is similar to those of Mturi (2000:19), Kimane *et al.* (1999:105), Clark (1996:514) and Raju and Leornard (2000:21) that many men may have difficulty in expressing their feelings, particularly if the feelings are contrary to masculine roles. Similarly, in many cultures, men rarely discuss sexual issues openly as sex is regarded as a taboo, and thus the discussion of sexual topics is highly embarrassing.

▪ Men hold different attitudes to sexual maturity

The results revealed mixed feelings: half of the men aged 25 to 60 years held positive feelings toward development of sexual desire, stating that it was an indication that one has reached manhood, while young men aged 15 to 24 years were still insecure and conservative about the changes. These findings are in line with those of Lundgren (2000:20) who found that it was not always easy for boys and some men to accept the changes they experience during their development.

▪ Homosexuality not acceptable to some men

Most men aged 25 to 60 years regarded homosexuality as bad and unacceptable to them as they are heterosexually oriented. However, few men (whether homosexually and/or bisexually oriented) felt it was not wrong to feel sexually attracted to other men. This finding correlates with that of Clark (1996:507) who found that homosexual men live in a social environment that often considers their sexual orientation unacceptable and overtly and covertly discriminates against them. As a result of discrimination homosexual males may find themselves unable to access the usual support systems heterosexual men use to cope with health and sexual concerns.

▪ Male infertility affects men's sexual identity

Most men held negative attitudes regarding male infertility, expressing feelings of being incomplete, ashamed and not being a real man. This finding corresponds with that of Davidson (1998:41) that male infertility is strongly linked with sexual performance and a sense of manhood. For this reason, a man who is infertile may fear losing his identity within the community especially where the culture emphasizes the fathering of children as a central activity in a man's life.

- **Premarital sex unacceptable to some men**

Overall, premarital sex is not accepted by some men aged 25 to 60 years while those aged 15 to 19 years were in favour of the practice. This finding is in line with those of Kimane *et al.* (1999:86) and Motlomelo and Sebatane (1999:73) who found some participants were against premarital sex while some supported the practice. Furthermore, Nkoli (2001:1) found that while sanctions exist for girls who indulge in premarital sex, the practice was generally tolerated amongst boys who had no sanctions imposed on them.

- **Extramarital relationships unacceptable to some men**

Half of the men actively opposed the practice of extramarital relationships while the other half supported the practice. This finding correlates with those of Kumar (1997:14), Kimane *et al.* (1999:86), Nkoli (2001:1) and Mbizvo (1997:177) who found that society in general disapproves of the practice of extramarital relationships among both men and women; however, the practice is tolerated more among men than among women.

- **Men's participation in child rearing and views regarding entrance into the delivery room**

The results revealed mixed feelings: most men in the rural settings opposed the idea of men being allowed into the delivery room during the birth of their children while those in the urban generally supported the idea. This finding correlates with those of Ndong and Finger (1998:6), Pile (1999:10) and Blaney (1997:3) who found that in some cultures men are forbidden from entering the delivery room at the birth of their children while in some places, including the United States of America, a man's presence is encouraged as a way to enhance his appreciation of this important event.

Most men held positive opinions regarding the participation of men in child rearing. This finding is supported by Clark's (1996:501-502) view that men may have an interest in participation in childcare but have little or no experience because of male cultural socialization (not socialized to nurture or care for young children or work in related conditions).

- **Stigma attached to people infected with STDs including HIV/AIDS**

The results revealed that most men regarded people infected with STDs, including HIV/AIDS, as promiscuous, and as such they are avoided for fear that they may transmit the infection to them. This finding is in line with those of Kimane *et al.* (1999:93) and Kgosidintsi and Mugabe (1994:73) who found that infection with STDs, including HIV/AIDS, carries the social stigma of being identified with promiscuity. As a result, this may block efforts at STD, HIV prevention and prevent infected people from getting the care and support they need.

5.3.3 Inadequate information about safe reproductive health practices

- **Inadequate information among men aged 15 to 24 years about alternative ways of realizing sexual desire other than sexual intercourse**

Males aged 25 to 60 years and older were able to identify alternative ways of realizing sexual desire other than sexual intercourse but reported that those ways were practiced privately by individuals. Based on the findings that alternative ways of realizing sex other than sexual intercourse were done privately, it could be assumed that young unmarried men may know of them

but were uncomfortable to talk openly about them, especially because in some cultures the practice of masturbation is regarded as shameful or believed to cause blindness. However, the findings correlate with those of Kimane *et al.* (1999:89) that practices such as rubbing or pressing the penis between the thighs was done to avoid vaginal penetration with the intention of avoiding ejaculation of sperms into the vagina, while boys in their puberty stage used masturbation for sexual enjoyment.

- **Health dangers involved in traditional circumcision**

Most men opposed traditional circumcision stating that it was no longer safe and not serving the purpose (of socializing boys into manhood). As such they suggested that those who perform the practice should be trained so that healthier ways could be adopted. This finding correlates with that of Meintjies (1998:71), Mturi (2001:30) and Shaw (1997:2-3) who found that the practice of traditional circumcision posed serious health risks including traumatic penile amputation and death caused by sepsis.

5.3.4 Lack of male reproductive health services

- **Lack of access to reproductive health services**

Most men expressed interest in utilising male reproductive health services if they existed. This finding is similar to that of Drennan (1998:1, 24), who found that men are very interested in family planning and more willing to participate in reproductive health.

- **Preferred type of services**

More than half of men preferred services on family planning while a few were interested in health education pertaining to sexually transmitted diseases. This finding correlates with that found in Population Council Frontiers in reproductive health (www.popcouncil.org/frontiers, 2001) that men identified services on family planning and STDs as their preferences.

- **Different preferences related to type of service provider**

Preferences of men related to type of service provider varied depending on geographical setting: most men in the urban areas preferred to be served by the male health provider compared to those in the rural areas who said that they would accept services from either a female or male provider. This finding correlates with that of Drennan (1998:31) who found that men will accept services and information from either male or female health providers as long as they were knowledgeable about their work and respectful. Similarly, Cohen and Burger (2000:120) found that men in places like Kenya and Bangladesh were uncomfortable to visit reproductive health facilities that are served by women.

- **Service hours preferences**

Most men preferred to be served during working hours while some preferred afternoons. This finding is supported by Lori and Landry's (2001:2) view that hours of service delivery should be appropriate to all groups of men.

- **Barriers against utilizing services**

Most men referred to a number of barriers related to not utilizing reproductive health services, including ignorance of the type of services provided, fear and shyness, services provided by females, and the feeling that services were exclusively for females. This finding correlates with that found by the Population Council Frontiers in reproductive health (www.popcouncil.org/ frontiers, 2001) that men interviewed in Kenya, Tanzania and Zambia listed a number of difficulties they encountered when accessing reproductive health services; amongst others, inconvenient service hours and services seen as being for women only.

5.4 RECOMMENDATIONS

Based on the discussion of the findings and conclusions, the following recommendations are made:

5.4.1 Programme design

The following aspects need to be addressed:

- Intervention programmes to increase men's level of knowledge and raise their awareness about male reproductive health issues therefore need to be designed. These intervention programmes should:

  - Increase men's knowledge regarding what constitutes male reproductive health, the anatomy and physiology of male reproduction, sexual maturation, fertility and fertility control, sexually transmitted diseases including HIV/AIDS, and their treatment and prevention.

- ↪ Increase men's knowledge of illnesses and lifestyles that may affect their reproductive health.

- ↪ Increase knowledge that promotes chastity, abstinence and postponement of sexual intercourse among young unmarried men.

- ➤ Programmes that target different groups of men should be designed (outreach and workplace programmes).

- ➤ Programme designers should identify opinion leaders and traditional leaders who could participate in programme designing, implementation and as advocates to increase male reproductive health awareness in their communities.

- ➤ Programme planners should formulate and support male-friendly policies that will promote male participation in reproductive health programmes.

- ➤ Programmes should be linked with non-governmental organizations to enhance male reproductive health.

- ➤ Programme evaluation should be incorporated into programme designing to monitor the impact of the programmes.

5.4.2 Services design

One very important consideration in programme design is determining what reproductive health services should be offered. Reproductive health services include more than family planning and sexually transmitted disease. For this reason, when planning reproductive health services for men, the following health aspects should be included:

- Establish male-friendly services to increase access:
  - Provide comprehensive education that will include the anatomy and physiology of male reproduction, sexual maturity, pregnancy and birth control, sexually transmitted diseases including HIV/AIDS, and sexual dysfunction.
  - Offer separate services for men.
  - Offer services hours that are convenient to all groups of men, with short waiting times.
  - Provide services based on a sliding scale.
  - Expand availability of male contraceptive methods.
  - Involve men in planning and implementing services.
  - Ensure that men have privacy and that clinic policies emphasize confidentiality.
- Train peer educators to provide information and education to men (young and old).
- Teach men testicular self-examination.
- Offer guidance on effective parenting skills.
- A complete physical exam including sexual and reproductive history should also be part of service delivery.

- To attract male client to services, male – specific information and materials must be provided.

- To reach a large audience and to stimulate awareness and change attitudes, mass media can be used.

5.4.3 Education of health providers

- Health providers should be trained in men's reproductive health service delivery. Training should be on-going to up-date staff on developments in men's reproductive health service delivery.

- Training institutions should incorporate male reproductive health into curricula of health providers' training.

5.4.4 Implications for research

Based on the findings of the study, there is a need for further research to develop appropriate programme interventions:

- Studies are needed to identify the most effective interventions to increase male utilisation of reproductive health services.

- Further research is needed to determine the extent of male involvement in reproductive health.

- There is a need to determine the attitudes of service providers towards the provision of male reproductive health services.

5.5 SUMMARY

In this chapter the findings of the study were presented and the conclusions were discussed. Recommendations regarding health care programme management and education of health care providers were made to promote the provision and design of men friendly programmes and services. The need for further research regarding male reproductive health was also highlighted. In the next chapter a proposed male reproductive health programme is outlined.

CHAPTER 6

A proposed male reproductive health programme

6.1 INTRODUCTION

Although reproductive health information and service delivery have been identified as a necessity for females for decades, the availability of such programmes for men has only been recently endorsed, according to Wegner, Landry, Wilkinson and Tzanis (1998:1). This endorsement is instrumental in making both the public and reproductive health professionals aware of the need of developing and delivering creative strategies to reach all categories of men – a need that has become urgent in the face of changing attitudes towards male reproductive health and because of the growing worldwide spread of sexually transmitted diseases (including acquired immuno-deficiency syndrome). Therefore this chapter presents a proposed male reproductive health programme that will meet the needs of different groups of men – outlining the aims and objectives, strategies for achieving the aims and evaluation of the programme.

6.2 THE AIM AND OBJECTIVES OF THE PROGRAMME

Based on the findings of the study, the programme aims at:

- Promoting male sexual and reproductive health taking into account the needs, attitudes, knowledges and practices of males in Lesotho.

- Fostering an enabling environment to improve men's access to reproductive health services.

6.2.1 Objectives

Based on the aims of the programme the following objectives must be pursued:

- Designing a national male reproductive health policy to serve as a guideline for programme decision-making.
- Raising awareness and increasing the knowledge of all men and the community leaders at district level about male reproductive health.
- Establishing male-friendly services in all districts of Lesotho.
- Developing a training curriculum and manuals for lay educators.
- Developing a training curriculum for health providers.

6.3 A DISCUSSION OF THE AIMS AND OBJECTIVES OF THE PROGRAMME

6.3.1 Designing a national male reproductive health policy to serve as a guideline for programme decision-making

A policy is a written guideline to direct decision-making during execution of a specific responsibility (Muller, 1998:159). The formulation of the national policy for male reproductive health is clearly a multisectoral process involving the government, non-governmental organisations and religious organisations with the help of United Nations agencies (World Health Organisation, 1999:46).

The formulation of a national reproductive health policy may bring about several advantages regarding male reproductive health, such as:

- A coherent national policy can lead to the mobilization of financial, administrative and human resources needed to ensure that activities for promoting and safeguarding male reproductive health are widely implemented by public, private and non-governmental organisations.

- A national policy with strong government commitment to male reproductive health will also help to ensure direction, funding and operational support from other public sectors such as education, labour and social welfare.

- A well documented national policy which advocates for male reproductive health can permeate governmental, private and public sectors by raising awareness of male reproductive health issues and needs.

- The development of a national policy for male reproductive health will provide an opportunity for professionals from various sectors (government and private) to review jointly, with men, their perceived needs and priorities and to introduce a plan of action which is mutually owned and accepted (Lori & Landry, 2001:1-6). Thus, collaboration of the government, the private and non-governmental sectors is crucial for successful implementation of a national programme.

- A national policy for male reproductive health will endorse the delivery of the necessary services as well as remove legislature and policy barriers that hinder access to reproductive health information and services especially for young males. This is an important aspect of

ensuring that men have the opportunities and services they need to promote and protect their health.

6.3.2 Raising awareness and increasing knowledge of all men and the community leaders at district level about male reproductive health

According to Barker (1997:1-3) in order to raise and increase men's knowledge regarding male reproductive health, men need to be provided with basic information related to male reproductive anatomy and physiology, male sexual development, pregnancy and child rearing, sexually transmitted diseases (prevention, transmission, signs and symptoms and treatment) and where to seek help if problems occur. McCauley and Salter (1995:26) accentuate that sexuality education and services for men are controversial issues. Therefore, health professionals must meet the reproductive health needs of men by helping the community to understand male reproductive health and promote the need for the programme and its goals and approaches. All male reproductive programmes must win the support of community leaders (men, opinion leaders, teachers) – thus, alliances with them must be formed and they must also be involved in all programme designing and implementation. The purpose of involving the community leaders is to ensure that they will promote male sexual and reproductive health in their respective communities.

6.3.3 Establishing male-friendly services in all districts of Lesotho

Male-friendly reproductive health services are those services to which men feel welcome to come for information and counselling for family planning, prevention and treatment of sexually transmitted diseases and treatment of male reproductive diseases (Lori & Landry, 1997:3). Such information and

counselling should include all their (males) reproductive health needs – aspects such as male sexuality and identity. Male-friendly services are imperative to safeguard both men and their partners' sexual and reproductive health.

Barnett (2000:83) argues that provision of male-friendly services does not necessarily mean building a new clinic. The existing services can be used by adding men-only hours or offering services where men congregate, such as at schools, work places or during sporting events. Furthermore, the existing services could establish new programmes or work within a referral network by linking up with other programmes in governmental departments such as the Departments of Education and Social Welfare and non-governmental organisations.

6.3.4 Developing a training curriculum and materials for lay educators

Developing a training curriculum for lay educators is necessary to educate the lay educators regarding male reproductive health as well as to standardize the practice of lay educators (World Health Organisation, 1999:160). Lay educators are men who interact with other men and as such need to be knowledgeable about male reproductive health so that they can transfer their knowledge and capacity to their local communities. Therefore, the training of lay educators should be an important component of the programme from the beginning to ensure acceptability and sustainability.

According to the World Health Organisation (1999:177) written materials and training guides for each level of training, as well as plans for selecting lay educators, are essential features of a training programme. Barker (1997:1-3) also explains that the development and the production of materials such as leaflets, brochures, bulletins and newsletters (as support materials) must not only target men but also inform men about the availability of services. As

such, the value of these materials rests in their ability to dispel myths prevalent in countries where free discussion of sexuality and other sensitive reproductive health issues is forbidden. To obtain the best results, the consumers (men) of reproductive health services must participate actively in the designing of these materials or assume responsibility for their production and dissemination.

6.3.5 Developing a training curriculum for health providers (professional and traditional)

Lori and Landry (1997:1) reproductive health outlook (2000:www.rho.org) state that most professional and traditional reproductive health workers are trained in women's health, but few receive formal training in male reproductive health including male anatomy and physiology – only few health care providers are trained to work with men or trained on how to counsel male clients. In the light of this, there is a need to incorporate men's reproductive health into the training curriculum of both professional and traditional health care providers to equip them with the knowledge and skills of rendering quality care to men. Toure (1996:11) also stresses that there is a special need for programmes to train programme managers as well as service providers to enable them to advocate and propagate male reproductive health to the public.

6.4 STRATEGIES THAT MUST BE USED TO ACHIEVE PROGRAMME GOALS

Various service delivery strategies to meet the needs of different groups of men must be used (Toure, 1996:1). However, according to Cohen and Burger (2000:117), the range of services provided for men and their delivery may vary significantly according to local needs, cultural values and available

resources. Therefore, for the proposed programme the following strategies are suggested based on the findings of the study:

- **Separate (male-only) clinics**

A male-only clinic is one strategy that can be used to target men to make use of reproductive health services. McCauley and Salter (1994:27) explain that a male – exclusive environment helps to create an environment for sharing concerns and discussing male issues as it puts men at ease. Furthermore, a male – exclusive environment is an efficient channel to reach some of the vulnerable groups in the population, such as male adolescents from the remote areas and middle age men.

- **Better service for men at existing clinics**

Integrating men's services into existing services is another powerful mode of service delivery that could be used to serve men. According to Wells (1997:4) integrating services into existing services is likely to be easier and more cost-effective for most programmes and that programme experience show that men are more likely to use existing health services when such services are made attractive to them – activities that take into account their full range of interests and needs (discussions about sexuality, including sexual health concerns). A male environment has to be created as men will not attend clinics where women and children are serviced. Couples should be handled differently according to their needs.

▪ Outreach programmes

Outreach work involves taking services to where men congregate in large numbers (Davidson, 1998:5). Offering reproductive health services and information where men congregate has many advantages such as; men will be more comfortable because the environment is familiar and therefore more receptive for information and services as well as an effecive way to reach large numbers of men who seldom visit health clinics (Cohen & Burger, 2000:133). According to Cohen and Burger (2000:150) workplace, schools, social clubs, sporting events, local fairs, bars, street corners, factories, military institutions are some of the outreach sites that can be used to reach men with reproductive health information and services.

▪ Community-based services

Community-based services are sometimes used as a demonstration that services such as reproductive health have a considerable value for men and the community as well (Senderowitz, 2000:33). According to Cohen and Burger (2000:131) careful consideration should be given to the recruitment, training and supervision of health workers, since they play an important role in motivating men to establish healthier reproductive habits in the community. By using satisfied clients as reproductive health promoters in outreach activities can be a means of reaching other men. Incorporating male health workers has been effective in promoting use of the male methods, in educating men and in providing family planning information. For instance, community-based services have succeeded in distributing contraceptives and giving reproductive health information in countries like Kenya and Zimbabwe (WHO, 1998:19).

➢ *Commercial and social marketing*

Social marketing is described as a strategy that combines principles of social and behavioural change with business operations (Senderowitz, 2000:34). The approach uses a combination of mass media and advertising to publicize the designated issues and products while identifying, through market research, promising outlets for selling commodities usually at a subsidized price.

According to Cohen and Burger (2000:130) social marketing is a powerful means of reaching men. By using mass media through many channels including print, radio, television and magazines, social marketing is more likely to reach men than clinic-based education is. Furthermore, marketing campaigns are useful tools for bringing men to clinics. For example, Profamilia in Colombia promotes its services in the mass media and through field workers. Similarly, the Social Marketing for Adolescent Sexual Health (SMASH) programme that took place in Botswana, Cameroon, Guinea and South Africa provides valuable lessons for improving social marketing programmes that target adolescents.

▪ Advocacy and social mobilisation

According to Cohen and Burger (2000:86) advocacy/social mobilisation strategies targeting traditional opinion leaders at the community level are central to generating change in social norms – traditional leaders are the guardians of customary law and as such have power to modify them. Senderowitz (2000:10) adds that building bridges with and involving members of the community (in particular traditional and religious leaders in reproductive health programmes) can be a deciding factor that determines a programme's success. In Senegal a network of religious leaders was created to inform men about sexuality and reproductive health. Similarly, programmes have won support from the community and religious leaders by forming

alliances and by involving community leaders in programme design and implementation.

6.5 PROGRAMME EVALUATION

Evaluation is defined as a process during which a value determination of the standard and outcome of a programme is made (Carl, 2000:178). According to Stanhope and Lancaster (1992:202) programme evaluation is an ongoing process beginning with the beginning of the planning phase of the programme and procedure until the programme is terminated. The major aim of the programme evaluation are to determine the relevance, progress, efficiency, effectiveness and impact of programme activities to the clients served. Evaluation data may be used to justify expanding the programme, reducing the programme or even terminating it.

The following three aspects of the programme must be evaluated on a regular basis:

- **Structure**

According to the World Health Organisation (1999:189) the focus of structure evaluation of a programme is to assess the physical facilities, equipment, availability of policies and procedures, services that are provided, and credentials for administrative and staff positions. As such, guidelines or policies describing the required equipment, services that must be provided, administrative structure and the required employees should be incorporated into programme planning.

■ Process

This aspect of evaluation refers to the monitoring of all programme activities, such as hours of services, number of service providers used, number of referrals made and the amount of money spent to meet programme objectives (Stanhope & Lancaster, 1992:208). This type of evaluation is an example of formative evaluation and occurs as an ongoing monitoring while the programme is in existence. Furthermore the efficiency of the male reproductive health programme(s) may be determined in order to assess whether one programme provides better benefits to men at a lower cost than a similar programme, as well as whether to establish whether the numbers of men served justify the cost of the programme.

■ Outcome

Outcome evaluation, according to Stanhope and Lancaster (1992:208), is undertaken to discover whether the aims and objectives of the programme have been/are being achieved. As outcome evaluations are focused on determining changes in behaviour or health status, such evaluation is therefore a meaningful way to judge the effectiveness of the planned strategies. Outcome evaluation helps programme managers to evaluate men's level of satisfaction regarding the reproductive health of service delivery, establishes whether men have acquired the necessary skills, whether an occurred increased level of reproductive health knowledge has occurred and whether changes in attitudes and practices regarding reproductive health have occurred.

The World Health Organisation (1999:194) stresses that the type of measurement techniques to be used to evaluate the programme goals must be incorporated into the programme design at the commencement of planning. The most common measurement techniques that can be used included surveys, interviews, observations and indicators. Surveys in the form

of questionnaires could be used to evaluate the client's satisfaction regarding service rendered. Information about the programme could also be obtained through auditing of clinical records, and the existence of policies that support male reproductive health could be noted.

Health indicators could also be used to evaluate the programme. According to Yinger and Murphy (1999:8) and Matalama (1998:10-21) indicators are descriptors of projected outcomes, products or changes that are used as observable evidence to measure the impact of strategies used in a programme. Indicators are facts, opinions and events that describe the standard of performance or what should be attained in order to obtain the planned results. Thus, to facilitate systematic monitoring and evaluation, according to Bertrand and Tsui (1995:25), it is necessary to make indicators part of programme design from its inception and planning phase. Indicators are a critical part of programme design and their specification should flow from the objectives and activities planned, paying attention to how they will be measured. As such Bertrand and Tsui (1995:25) suggest that the following criteria must be adhered to when using indicators limited numbers of indicators that are consistent with objectives must be used, the indicators must be prioritized by order of importance, and the type(s) of data collection for each indicator must be identified. In the light of the above the following male reproductive health indicators must be assessed:

- Existence of government policies favourable to male reproductive health.

- Male reproductive health knowledge.

- Percentage of men who use or do not use male reproductive health services.

- Percentage of lay educators competent in communicating male reproductive health issues.

- Percentage of service providers trained in male reproductive health counselling.

Like women, men have different reproductive health concerns and needs in their life cycle. Thus it is crucial to establish male reproductive health programmes. Both the 1994 International Conference on Population in Cairo and the Fourth World Conference on Women in Beijing have endorsed that innovative reproductive health programmes must be developed and be accessible to all men, young and old. Therefore it is imperative that the creative male reproductive health programme that uses a multisectoral approach to expand its reach and encompasses a variety of strategies to address the needs of different groups of men, is designed and delivered.

6.6 SUMMARY

In this chapter a proposed male reproductive health programme is outlined. However, more could still be added to address the needs of different groups of men. Developing a programme and services for men is part of the larger effort to translate the goals of Cairo into real changes at the service delivery level by increasing the number of men who are served, the quality of care they receive and the likehood that services will be sustainable. Therefore, one of the most important commitments a country can make for future economic and social progress and stability is to address the reproductive health needs of all its citizens of both sexes. In the last chapter the conclusion of the study will be highlighted.

CHAPTER 7

The conclusion of the study

Most reproductive health programmes in Lesotho are designated for women only, such as the family planning programmes, which focus only on women and children and excluded men. Male reproductive health programmes do not exist in Lesotho. Yet men like women, have different reproductive health needs and problems at different stages of their development.

The purpose of this study was to determine men's needs, knowledge, attitudes and practices regarding reproductive health. A non-experimental design of a descriptive nature was used. The survey method was used to gather data. Probability sampling techniques were used to select the sample size of about 794 male respondents from the 10 districts of Lesotho. Ethnical principles as relevant to the conduct of research involving human subjects was adhered to, such as obtaining the necessary permission and complying with the human rights of the respondents. Focus group and structured interviews were used to collect data from the respondents aged 15 to 60 years and older, living in the rural and urban areas of Lesotho. All data was analysed on a nominal descriptive level.

The results of the study showed that men needed more knowledge and information related to male reproductive health; their attitudes towards their own reproductive health and the services to be delivered varied; they did not possess adequate information related to safe reproductive health practices and indicated that they (men) would utilise male reproductive health services provided they existed. Based on the above, recommendations were made that health care programme managers in Lesotho should design men-friendly programmes and services. The education of health care providers should be modified to include male reproductive health and health care providers should

be trained to render quality male reproductive health care. Furthermore the need for further research on male-friendly reproductive health was emphasized. Lastly, a proposed male reproductive health programme has been outlined as a guideline for health care managers.

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ADDENDUM A

Letter requesting permission to conduct the study to the Ministry of Health

P.O. Box 8890
Maseru
100
LESOTHO

15th November, 2001

The Director of Health Services
Ministry of Health
P.O. Box 514
Maseru
100
LESOTHO

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I kindly request for permission to conduct research on *"Male reproductive health in Lesotho: Needs knowledge, attitudes and practices"*, in selected villages in the 10 districts of Lesotho as reflected on Table 3.3 as annexed. The study will be conducted to fulfill the requirements of the Masters degree in Nursing Science at the University of the Free State. It is hoped data collection will be carried out during the month of December.

Find enclosed a copy of the research protocol as approved by the Research Ethics Committee of the Faculty of Health Sciences at the University of the Free State.

Thank you.

Yours sincerely

.....

Agnes Moelo Phoofolo
M.SOC.SC. STUDENT

ADDENDUM B

Letter of approval to conduct study from the Ministry of Health

MINISTRY OF HEALTH AND
SOCIAL WELFARE
P.O. BOX 514
MASERU 100

H/PROJ/38

6th December 2001

The Dean,
Faculty Of Health Sciences.
University of the Free State.
Bloemfontein.

Dear Sir' Madam.

RE : REQUISITION TO UNDERTAKE A STUDY ON MALE REPRODUCTIVE HEALTH IN LESOTHO BY 'MOELO PHOOFOLO.

The Ministry of Health and Social Welfare (MOHSW) wishes to acknowledge receipt of a requisition to undertake a study titled **Male Reproductive Health in Lesotho : Needs, Knowledge Attitudes and Practices** by Mrs. 'Moelo Phoofolo in accordance with the requirements for her Masters degree in Social Sciences(Nursing).

The Ministry therefore has allowed the student to proceed with the research as the topic already addresses the pertinent research needs of the RH Programme of the Primary health Care Department.

In delaying to respond to the request, the MOHSW would like to extend its sincere apology.

Regards.

Dr. T. Ramatlapeng.
Director General Of Health Services

ADDENDUM C

Letter requesting permission to enter the field to the principal and local chiefs of target villages

University of the Free State
P.O. Box 339
BLOEMFONTEIN
9300

10th December, 2001

Principal chiefs
District Administrators
Village Chiefs

RE: REQUEST TO CONDUCT A STUDY

I am herein requesting permission to pursue a research study entitled: *Male reproductive health in Lesotho: Needs, knowledge, attitudes and practices.*

This study seeks to determine men's needs, knowledge, attitudes and practices regarding their (men) reproductive health. The sample of the study will be drawn from men aged 15 years to old age.

The study is conducted in accordance with the requirements of Master of Social Science (Nursing) at the University of the Free State. This study has already been approved by the Ethical Committee. Your co-operation will be highly appreciated.

Yours sincerely

.....

A.M. Phoofolo
STUDENT M.SOC.SC. (NURSING)

ADDENDUM D

Consent to parents

University of the Free State
Faculty of Health Sciences

20th February 2001

CONSENT FROM PARENT

You are kindly requested to allow your son to participate in the study on: *Male reproductive health in Lesotho: Needs, knowledge, attitudes and practices*. The study will benefit your son directly as the information obtained will help policy makers and programme managers to design comprehensive reproductive health programmes sensitive to the needs of all groups of men. There will be no risks involved.

The study and its procedures have been approved by the Ethical Committee of the Faculty of Health Sciences of the University of the Free State. Participation in this study will take approximately 30 minutes. You are free to ask questions about the study or about being a respondent.

Participation of your son in this study is totally voluntary. Your son has the right to withdraw at any time from the study. All data regarding your son will be anonymous. I need your consent to interview your son. Please sign the necessary form.

I, hereby give permission that my son can participate in the study. I, hereby take cognisance that my son can withdraw without my consent at any time.

....

SIGNATURE OF PARENT **DATE**

EXPLANATION OF THE STUDY TO THE PARENT BY THE RESEARCHER

I have explained this study to the parent and have sought his/her understanding for informed consent.

....

SIGNATURE OF RESEARCHER **DATE**

ADDENDUM E

Consent to respondents

University of the Free State
Faculty of Health Sciences

20th February 2001

CONSENT FROM RESPONDENTS

I am herewith inviting you to participate in a research study on *Male reproductive health in Lesotho: Needs, knowledge, attitudes and practices.* The study will benefit you directly as the information obtained will help policy makers and programme managers to design comprehensive reproductive health programmes sensitive to the needs of all groups of men. There will be no risks involved.

The study and its procedures have been approved by the Ethical Committee of the Faculty of Health Sciences of the University of the Free State. Participation in this study will take approximately 30 minutes. You are free to ask questions about the study or about being a respondent.

Your participation in this study is totally voluntary. You have the right to withdraw at any time. Your anonymity will be ensured at all times. I need your informed consent to do the study. Would you please sign the necessary form.

I, hereby give permission that my participation is voluntary and that I may withdraw my consent at any time.

....

SIGNATURE OF RESPONDENT **DATE**

EXPLANATION OF THE STUDY TO THE PARENT BY THE RESEARCHER

I have explained this study to the parent and have sought his/her understanding for informed consent.

....

SIGNATURE OF RESEARCHER **DATE**

ADDENDUM F

Letter of permission to conduct the study from the Ethical Committee of the Faculty of Health Sciences of the University of the Free State

UNIVERSITY OF THE FREE STATE

Office of the Director: Administration
Faculty of Health Sciences

P/ 339 BLOEMFONTEIN 9300
☎ (051) 405-3013 / 401-2847
REPUBLIC OF SOUTH AFRICA
TELEFAX (051) 444-3103 SA

Enquiries Mrs G Niemand Tel 4053004 22nd August 2001

MS A PHOOFOLO
C/O DR RH VAN DEN BERG
SCHOOL OF NURSING
UNIVERSITY OF THE FREE STATE

Dear Ms A Phoofolo

ETOVS NR 171/01
RESEARCHER: MS A PHOOFOLO
PROJECT TITLE: MALE REPRODUCTIVE HEALTH IN LESOTHO: NEEDS, KNOWLEDGE, ATTITUDES AND PRACTICES.

You are hereby informed that during their meeting held on the 21st August 2001 the Ethics Committee approved the abovementioned study.

Your attention is kindly drawn to the following:

a) A progress report be presented not later than one year after approval of the project
b) That all extentions, amendments, serious adverse events, termination of a study etc have to be reported to the Ethics Committee

Will you please quote the Etovs number as indicated above in subsequent correspondence, reports and enquiries

Yours faithfully

For DIRECTOR: MEDICINE ADMINISTRATION

ADDENDUM G

Focus group guides

FOCUS GROUP GUIDE

(15-24 year)

INTRODUCTION

Welcome the group and briefly give the purpose of the discussion

We are going to talk today about topics related to your reproductive health. The purpose of this discussion is for you to share your ideas and experiences with me so that we can design programmes that are responsive to your needs. We would appreciate if you could spare some few minutes so that we can discuss and ask questions on issues related to male reproductive health.

Ground rules for group discussion

Everyone's ideas and opinions are important. There are no right or wrong answers to questions I will be asking you. Please feel free to answer exactly as you feel. Anything you say here will be private and confidential.

A. Knowledge of male reproductive health

1. What knowledge do you think boys of your age should have regarding reproductive health?

   Probe for:

- Male reproductive anatomy and physiology.
- Bodily changes that boys experience during puberty. What do they know about the changes they are experiencing?

- Where do boys of your age learn about their body and how to care for it? Where do they learn about sex? (Probe for mass media, parents, teachers, friends. Probe for type of information they receive and their opinion of the information.)
- What concerns boys like you about their physical development and sexuality? (Probe for penis size, wet dreams, spontaneous erections, masturbation.) Did any one tell you about the changes? What information do you need?
- Do boys your age have sexual desires? How do they satisfy them? (Probe for coitus, masturbation, touching, kissing).

2. In your opinion should boys be knowledgeable of pregnancy and childbirth.

   Probe for:

   - Understanding of contraception.
   - Contraceptives used by males and how they feel about them.
   - Contraceptives used by females and how they feel about them.
   - Benefits of using contraceptives.
   - Where they would go if they wanted contraceptives? Why?

3. What do you understand about sexually transmitted diseases?

   Probe for:

   - Who can contract sexually transmitted diseases?
   - How sexually transmitted diseases can be contracted?
   - Signs and symptoms of sexually transmitted diseases.
   - Where they seek consultation if they experience symptoms of sexually transmitted diseases?
   - How sexually transmitted diseases can be prevented?
   - Knowledge on HIV/AIDS.
   - Signs and symptoms of HIV/AIDS.
   - How HIV/AIDS can be prevented?

- Behaviours that can put them at risk of sexually transmitted diseases including HIV/AIDS.

B. Attitudes towards male reproductive health

1. How do you feel about your sexuality?
   Probe for:
   - How do you feel about the development of sexual desire?
   - What do you do to satisfy sexual feelings? (Probe for masturbation) How do you feel about what you did?
   - If ever had feelings for other men? How did this make you feel?

2. How do you feel about premarital sex and extra marital sex? Why?

3. What are your feelings about use of condoms? Why?

4. What are your attitudes towards people infected with sexually transmitted diseases, HIV/AIDS in this community?

C. Male reproductive health practices

1. What alternative ways of realising sexual desire other than sexual intercourse can boys use? Please name them. (Probe for masturbation, touching and kissing.) Are these ways acceptable?

2. Is the practice safe sex part of this community? How? When? Is it helpful?

3. Is traditional circumcision a safe practice? Why?

4. Do you have access and use reproductive health services in this community? Why and why not?

D. Reproductive health services

1. Do you know of anywhere that offers reproductive health services for young men?

   Probe for:

   - What are the common reproductive health problems among young people of your age in this community?
   - Would they consult any health facility when experiencing reproductive health problem? Why

2. If male reproductive health services of boys of your age existed would you use such services?

   Probe for:

   - What type of services they would like?
   - Who should provide such services? Why?
   - What type of setting they prefer? Why?
   - Would these services be different from those for girls and adults? Why? In what ways?
   - At what time of the day should services be provided? Why?

   Probe:

   - What would be some barriers of not using such services?

E. Wrap Up: Explore feelings during the discussion and determine interest and need for more information

- How did you feel during our discussion today? Have you ever talked with anyone about the subjects we discussed today? (Probe for father, mother, friends.) How did you feel talking about them? What did you talk about?

- Would you like more information on anything we discussed today? What would you like to learn about? (Probe to prioritise information needs.) How would you like to receive information on these topics? (Probe for mass media, friends, religious leaders.) Who would you like to discuss them with?

- Are there any suggestions that you wish to communicate in relation to men and reproductive health services?

Thank you for sharing your thoughts and experiences.

FOCUS GROUP GUIDE

(25-60 years and above)

INTRODUCTION

Welcome the group and briefly give the purpose of the discussion

We are going to talk today about topics related to your reproductive health. The purpose of this discussion is for you to share your ideas and experiences with me so that we can design programmes that are responsive to your needs. We would appreciate if you could spare some few minutes so that we can discuss and ask questions on issues related to male reproductive health.

Ground rules for group discussion

Everyone's ideas and opinions are important. There are no right or wrong answers to questions I will be asking you. Please feel free to answer exactly as you feel. Anything you say here will be private and confidential.

A. Knowledge of male reproductive health

1. What knowledge do you think men should have regarding reproductive health?

   Probe for:

   - Male reproductive anatomy and physiology.
   - Bodily changes that young men and older men experience during their life cycle (first ejaculation, wet dreams, spontaneous erections, sexual performance).

- Undescended testicles leading to infertility.
- Illness and effect on reproductive health.
- Drugs, alcohol and smoking and effect on reproductive health.
- What information do they need?

2. In your opinion should men be knowledgeable of pregnancy and childbirth?

   Probe for:

   - Understanding of contraception.
   - Contraceptives used by males and how they feel about them.
   - Contraceptives used by females and how they feel about them.
   - Benefits of using contraceptives.
   - Decision-maker regarding use of contraceptives.
   - Where they would go if they wanted contraceptives and why?

3. What do you understand about sexually transmitted diseases?

   Probe for:

   - Who can contract sexually transmitted diseases?
   - How sexually transmitted diseases can be contracted?
   - Signs and symptoms of STD's.
   - Where men seek consultation if they experience symptoms of sexually transmitted diseases?
   - How STD's can be prevented?
   - Knowledge on HIV/AIDS.
   - Signs and symptoms of HIV/AIDS.
   - How HIV/AIDS can be prevented?
   - Behaviours that can put men at risk of HIV/AIDS.

B. Attitudes towards male reproductive health

1. How do you feel about your own sexuality?

   Probe for:

   - How do they feel about the development of sexual desire?
   - What do they do to satisfy sexual feelings? How do they feel about what they did?
   - If ever had feelings for other men? How did this make you feel?

2. How would you react if you cannot father a child? (Probe for infertility) Why?

3. How do you feel about premarital sex and extramarital sex? Why?

4. How do you feel about extramarital sex? Why?

5. What are your feelings about males being allowed into the delivery room?

   Probe for:

   - Men participation in child rearing.
   - Men discussing reproductive health issues with their partners?

6. What are your feelings about homosexuality?

7. What are your attitudes towards people with sexually transmitted diseases and HIV/AIDS infection in this community?

8. If male reproductive health services could exist, what would be your feelings about them?

C. Male reproductive health practices

1. What alternative ways of realising sexual desire other than sexual intercourse can men use?
   Probe for:
   - Are these ways acceptable in your community and why?

2. Is the practice safe sex part of this community? How? When? Is it helpful?

3. Is traditional circumcision a safe practice? Why? If yes, why? If no, why?

4. How can traditional circumcision be made safe?

5. Do men in this community have access and use reproductive health services in this community? Why and why not?

D. Reproductive health services

1. Do you know anywhere that offers male reproductive health services in your community?
   Probe for:
   - What problems do males in this community have regarding reproductive health?
   - Would you consult any health facility when experiencing reproductive health problem? Why?

2. If male reproductive health services existed would you use such services?

   Probe for:

   - What type of services they would like?
   - Who should provide such services? Why?
   - What type of setting they prefer? Why?
   - Would these services be different from those for women? Why? In what ways?
   - At what time of the day should services be provided? Why?
   - What would be some barriers of not using such services?

E. Wrap Up: Explore feelings during the discussion and determine interest and need for more information

- Explore feelings during the discussions and determine interest and need for more information.

- How did you feel during our discussion today? Have you ever talked with anyone about the subjects we discussed today? How did you feel talking about them? What did you talk about?

- Would you like more information on anything we discussed today? What would you like to learn about? (Probe to prioritise information needs.) How would you like to learn about this topic? Who would you like to discuss them with?

- Are there any suggestions that you wish to communicate in relation to men and reproductive health services?

Thank you for sharing your thoughts and experiences.

ADDENDUM H

Structured interview guides

ADDENDUM H1

English guide

MALE REPRODUCTIVE HEALTH IN LESOTHO: NEEDS, KNOWLEDGE, ATTITUDES AND PRACTICES

The researcher wishes to express her appreciation for your willingness to participate in this study. The information obtained from you will assist in policy making and planning so that appropriate interventions can be designed. You need not fill your name as the gathered information will be treated confidentially.

SECTION A: Biographical data

FOR OFFICE USE ONLY

☐☐☐ 1-3

1. Name the district where you stay:

_____ ☐ 4

2. Geographical location

Urban	1
Rural	2

☐ 5

3. What is your age?

15-19	1
20-29	2
30-39	3
40-49	4
50-59	5
60 and older	6

☐ 6

4. What is your religion?

Anglican church	1
Lesotho evangelic church	2
Roman catholic	3
Other (specify):	4

☐ 7

5. What is the highest level of education you attained?

FOR OFFICE USE ONLY

Primary	1
Secondary	2
College	3
University	4
Illiterate	5

☐ 8

SECTION B: Knowledge of male reproductive health

6. What do you understand by the term "male reproductive health"?

_____

_____

_____ ☐☐ 9-10

7. What reproductive health concerns do males in general have?

_____

_____ ☐☐ 11-12

8. What reproductive health concerns do you have?

_____

_____ ☐☐ 13-14

9. Whom do you usually consult when you experience a reproductive health problem?

Traditional healer	1
Nurse	2
Doctor	3
Other (specify):	4

☐ 15

• Anatomy and physiology

FOR OFFICE USE ONLY

10. Should males know the structure of the male reproductive organs?

Yes	1
No	2
Do not know	3

☐ 16

10.1 Please motivate your response:

_____

_____ ☐☐ 17-18

11. Should males know the function of the male reproductive organs?

Yes	1
No	2
Do not know	3

☐ 19

11.1 Please motivate your response:

_____

_____ ☐☐ 20-21

12. What reproductive physical changes occur in boys during puberty?

_____

_____ ☐☐ 22-23

13. What reproductive physiological changes occur in boys during puberty?

_____

_____ ☐☐ 24-25

14. What reproductive physical changes occur in men when they get older?

FOR OFFICE USE ONLY

[ ][ ] 26-27

15. What reproductive physiological changes occur in men when they get older?

[ ][ ] 28-29

15.1 How do you feel about these changes?

[ ][ ] 30-31

16. Who taught you about the reproductive physical and physiological changes? (Mark all that apply in brackets)

Father	1	[ ] 32
Mother	2	[ ] 33
Grandfather	3	[ ] 34
Friends	4	[ ] 35
School	5	[ ] 36
Nurses	6	[ ] 37
Initiation school	7	[ ] 38
Doctors	8	[ ] 39
Village health worker	9	[ ] 40
Traditional healer	10	[ ] 41
Other (specify):	11	[ ] 42

17. What information would you like to receive regarding reproductive physical changes?

[ ][ ] 43-44

18. What information would you like to receive regarding reproductive physiological changes?

FOR OFFICE USE ONLY

_____ ☐☐ 45-46

_____

19. How would you like to receive information regarding reproductive physical and physiological changes?

Radio	1	☐ 47
Television	2	☐ 45
Lectures	3	☐ 46
Brochures	4	☐ 47
Other (specify):	9	☐ 48

20. Is it normal for a man to experience wet dreams?

Yes	1
No	2
Do not know	3

☐ 50

20.1 Motivate your response:

_____ ☐☐ 51-52

_____

21. Does undescended testicles lead to infertility?

Yes	1
No	2
Do not know	3

☐ 53

- **Birth control**

22. Should men be knowledgeable of pregnancy?

Yes	1
No	2
Do not know	3

☐ 54

22.1 Please motivate your response:

FOR OFFICE USE ONLY

_____ ☐☐ 55-56

23. Can pregnancy occur when vaginal penetration has not taken place?

Yes	1
No	2
Do not know	3

☐ 57

24. When do you think is a boy old enough to get a girl pregnant?

_____ ☐☐ 58-59

25. Should men be knowledgeable of contraception?

Yes	1
No	2
Do not know	3

☐ 60

25.1 Please motivate your response:

_____ ☐☐ 61-62

26 What do you understand about the term "contraception" (family planning)?

_____ ☐☐ 63-64

27. What different male contraceptive methods do you know?

_____ ☐☐ 65-66

28. What different femmale contraceptive methods do you know?

FOR OFFICE USE ONLY

_____ ☐☐ 67-68

_____

29. Who should decide whether to use birth control methods?

The male	1
The female	2
Both the male and the female	2
Do not know	3

☐ 69

29.1 Please motivate your response:

_____ ☐☐ 70-71

_____

30. Who taught you regarding contraception? (Mark all that apply in brackets)

Nurses	1	☐ 72
Doctors	2	☐ 73
Friend	3	☐ 74
Mother	4	☐ 75
Father	5	☐ 76
Grandfather	6	☐ 77
Traditional healer	7	☐ 78
Village health worker	8	☐ 79
Other (specify):	9	☐ 80

FOR OFFICE USE ONLY

[ ][ ][ ] 1-3

31. What information would you like to receive regarding contraception? (Mark all that apply in brackets)

Pregnancy	1	[ ] 4
Birth control methods	2	[ ] 5
Benefits of birth control methods	3	[ ] 6
Side-effects of birth control methods	4	[ ] 7
Male contraceptives	5	[ ] 8
Female contraceptives	6	[ ] 9
Other (specify):	9	[ ] 10

32. How would you like to receive information regarding contraception?

Radio	1	[ ] 11
Television	2	[ ] 12
Lectures	3	[ ] 13
Brochures	4	[ ] 14
Other (specify):	9	[ ] 15

- **Sexually transmitted diseases**

33. What do you understand about the term sexually transmitted diseases?

_____

_____ [ ][ ] 16-17

34. What sexually transmitted diseases are you familiar with? (Mark all that apply in brackets)

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Syphilis	1	18
Gonorrhoea	2	19
Acquire immuno deficiency syndrome	3	20
Clamydia	4	21
Genital warts	5	22
Thrush	6	23
Trichomoniasis	7	24
Genital herpes	8	25

35. How can a person contract sexually transmitted diseases?

_____ 26-27

_____

36. Can all men (unmarried and married) contract sexually transmitted diseases?

Yes	1	
No	2	
Do not know	3	28

37. What are the common signs and symptoms of sexually transmitted diseases? (Mark all that apply in brackets)

Painful discharge from penis	1	29
Enlarged swelling in the groin	2	30
Burning urine	3	31
Painful blisters on the penis	4	32
Small, fleshy and soft lumps on the inside of penis (warts)	5	33
Painful ulcer on penis	6	34
Painless ulcer on penis	7	35
Other (specify):	8	36

38. How are sexually transmitted diseases prevented?

FOR OFFICE USE ONLY

_____ ☐☐ 37-38

_____

39. Is the human immuno deficiency virus and acquired immuno deficiency syndrome sexually transmitted?

Yes	1
No	2
Do not know	3

☐ 39

40 Does sexually transmitted diseases influence the fertility of men?

Yes	1
No	2
Do not know	3

☐ 40

41. What information would you like to have regarding sexually transmitted diseases?

_____ ☐☐ 41-42

_____

41.1 How would you like to receive this information?

Radio	1	☐ 43
Television	2	☐ 44
Lectures	3	☐ 45
Brochures	4	☐ 46
Other (specify):	9	☐ 47

- **Other factors that have an impact on male reproductive health**

FOR OFFICE USE ONLY

42. Do illnesses have an effect on men's reproductive health?

Yes	1
No	2
Do not know	3

☐ 48

42.1 Please motivate your response:

_____

_____

☐☐ 49-50

43. Can drugs have an effect on men's reproductive health?

Yes	1
No	2
Do not know	3

☐ 51

43.1 Motivate your response:

_____

_____

☐☐ 52-53

44. Can smoking affect men's reproductive health?

Yes	1
No	2
Do not know	3

☐ 54

44.1 Please motivate your response:

_____

_____

☐☐ 55-56

45. Can alcohol consumption affect men's reproductive health?

Yes	1
No	2
Do not know	3

FOR OFFICE USE ONLY

☐ 57

45.1 Please motivate your response:

_____

_____

☐☐ 58-59

46. What information would you like to receive regarding the effect of alcohol consumption on men's reproductive health?

_____

_____

☐☐ 60-61

47. What information would you like to receive regarding the effect of smoking consumption on men's reproductive health?

_____

_____

☐☐ 62-63

48. How would you like to receive this information?

Radio	1	☐ 64
Television	2	☐ 65
Lectures	3	☐ 66
Brochures	4	☐ 67
Other (specify):	9	☐ 68

SECTION C: Men's attitudes towards reproductive health

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49. What is your feeling about sex before marriage?

It is bad	1
It should not be done	2
It is acceptable as long as people use contraceptives	3
Other (specify):	4

☐ 69

49.1 Motivate your response:

_____

_____ ☐☐ 70-71

50. What is your feeling about the practice of extra marital relationships among men?

Bad	1
Good	2
Do not know	3
Other (specify):	4

☐ 72

50.1 Motivate your response:

_____

_____ ☐☐ 73-74

51. In your opinion, can childlessness be due to male infertility?

Yes	1
No	2
Do not know	3

☐ 75

51.1 Motivate your response:

_____

_____ ☐☐ 76-77

FOR OFFICE USE ONLY

52. What is your feeling about a man being allowed into the delivery room during birth of his child?

Good	1
Do not support the idea	2
Do not know	3

☐ 78

53.1 Motivate your response:

_____

_____

☐☐ 79-80

☐☐☐ 1-3

54. What is your feeling about men's participation in childrearing?

Good	1
Do not support the idea	2
Do not know	3

☐ 4

54.1 Motivate your response:

_____

_____

☐☐ 5-6

55. In your opinion, should men discuss reproductive health issues with their partners?

Agree	1
Disagree	2
Do not know	3

☐ 7

55.1 Motivate your response:

_____

_____

☐☐ 9-10

56. What is your feeling about the practice of homosexuality?

Good	1
Do not support the idea	2
Do not know	3

FOR OFFICE USE ONLY

☐ 11

56.1 Motivate your response:

_____

☐☐ 12-13

SECTION D: Men's practices regarding reproductive health

57. What alternative ways of realising sexual desire other than sexual intercourse can men use?

_____

_____

☐☐ 14-15

58. What ways can a man use to promote safe sex?

_____

_____

☐☐ 16-17

58.1 Motivate your response:

_____

_____

☐☐ 18-19

59. Do you support the practice of traditional circumcision?

Yes	1
No	2
Do not know	3

☐ 20

59.1 Give reasons for your response:

_____

_____

☐☐ 21-22

SECTION E: Reproductive health services

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60. Have you ever visited any reproductive health facility?

Yes	1
No	1
Do not know	2

☐ 23

60.1 Motivate your response:

_____

_____

☐☐ 24-25

61. If male reproductive health services existed, would you attend?

Yes	1
No	1
Do not know	2

☐ 26

61.1 Motivate your response:

_____

_____

☐☐ 27-28

62. In your opinion, what should men's reproductive health services offer? (Mark all that apply in brackets)

Information on prevention of sexually transmitted diseases including acquired immuno deficiency syndrome	1	☐ 29
Giving information on family planning	2	☐ 30
Counselling and treatment of infertility	3	☐ 31
Counselling and treatment of sexual dysfunction	4	☐ 32
Screening and treatment of testicular and prostate cancer	5	☐ 33
Information on childrearing	6	☐ 34
Information on drug and alcohol abuse as well as sexual health	7	☐ 35
Other (specify):	8	☐ 36

63. Who should provide these services? (Mark all that apply in brackets)

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Male providers	1		37
Female providers	2		38
Doctors	3		39
Nurses	4		40
Village health workers	5		41
Lesotho Planned Parenthood Association	6		42
Traditional healers	7		43
Religious leaders	8		44
Other (specify):	9		45

64. In what settings should services be offered? (Mark all that apply in brackets)

Men's only clinic	1		46
Men and women clinic	2		47
Work places	3		48
Sporting events	4		49
Social clubs	5		50
Other (specify):	6		51

65. At what time of the day do you think services should be provided?

Morning hours	1		52
Lunch time	2		53
Afternoons	3		54
Evenings	4		55
Throughout the day	5		56
Other (specify):	6		57

66. How would you like to see male reproductive health services delivered?

58-59

Thank you for responding to this questionnaire!

ADDENDUM H2

Sesotho guide

LITSEBELETSO TSA BOPHELO TSE AMANANG LE BOTONA BA BANNA LESOTHO: LITLHOKO, TSEBO, MAIKUTLO LE LITLOAELO

Ke leboha ha u lumetse ho nka karolo liphuphutsong tsena. Litaba tse fumanoeng li tla thusa ba boholong ho etsa meralo e nepahetseng e amanang le litsebeletso tsa bophelo tsa bo-ntate. Ha ho hlokahale hore u fane ka lebitso ha o araba lipotso, me litaba tseo u li faneng li tla nkuoa e le lekunutu

SECTION A

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☐☐☐ 1-3

1. Lebitso la setere sa heno:

_____ ☐ 4

2. Tikoloho eo u tsoang ho eona e oela kae?

Mabalane	1
Mahaeng	2

☐ 5

3. Lilemo tsa hao li kae?

15-19	1
20-29	2
30-39	3
40-49	4
50-59	5
60 ho ea holimo	6

☐ 6

4. U kena kereke efe?

Chache	1
Fora	2
Roma	3
Tse ling:	4

☐ 7

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5. U tsoile sekolong u bala sehlopha sefe?

Sehlopha sa mathomo	1
Sehlopha se mahareng	2
Coleche	3
Sekolo se seholo	4
Ha kea kena sekolo ho hang	5

☐ 8

SECTION B: Tsebo ka litsebeletso tsa bophelo tse amanang le bo-ntate

6. U utloisisang eng ka litsebeletso tsa bophelo tse amanang le botona ba bo-ntate?

_____

_____

_____ ☐☐ 9-10

7. Ke mathata afe a bophelo ka kararetso a ka amang botona ba banna?

_____

_____ ☐☐ 11-12

8. U na le mathata a fe a bophelo a amanang le botona ba hao?

_____

_____ ☐☐ 13-14

9. U e u batle thuso ho mang ha o na le mathata a bophelo a amanang le botona?

Ngaka ea setho	1
Nese	2
Ngaka	3
Tse ling:	4

☐ 15

- **Litho tsa botona le tsebetso ea tsona**

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10. Na banna ba lokela ho tseba ka litho tsa botona?

Ee	1
Che	2
Ha ke tsebe	3

☐ 16

10.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 17-18

11. Na banna ba lokela ho tseba tšebetso ea hore na litho tsa bona tsa botona li sebetsa joang?

Ee	1
Che	2
Ha ke tsebe	3

☐ 19

11.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 20-21

12. Ke liphetoho li fe tsa botona tse bonahalang tse etsahalang ho bashanyana ba kenang bohlankaneng?

_____

_____ ☐☐ 22-23

13. Ke liphetoho li fe tse amang le tsebetso ea botona tse etsahala ho bashanyana ba kenang bohlankaneng?

_____

_____ ☐☐ 24-25

14. Ke liphetoho li fe tsa botona tse bonahalang tse etsahalang ho banna ba lilemong?

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☐☐ 26-27

15. Ke liphetoho li fe tse amanang le tsebetso ea botona tse etsahalang ho banna ba lilemong?

☐☐ 28-29

16. Na ho nepahetse hore monna a lore?

Ee	1
Che	2
Ha ke tsebe	3

☐ 30

16.1 Ke kopa u hlalose mabaka:

☐☐ 31-32

17. Na ho hloka litapole ho ka amangoa le bonyopa monneng?

Ee	1
Che	2
Ha ke tsebe	3

☐ 33

18. U ithutile ho kae ka litaba tsa liphetoho tse bang teng botoneng kholong ea mohlankana?

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Ntate	1	34
'Me'	2	35
Ntate moholo	3	36
Batsoalle	4	37
Sekolong	5	38
Manese	6	39
Lebollong	7	40
Lingaka	8	41
Mosebeletsi oa tsa bophelo metseng	9	42
Ngaka setho	10	43
Tse ling:	11	44

- **Thibelo ea bokhachane le thero ea malapa**

19. Na banna ba lokela ho tseba ka bokhachane?

Ee	1	
Che	2	
Ha ke tsebe	3	45

19.1 Ke kopa u hlalose mabaka:

_____ 46-47

_____

20. Na motho oa 'me' a ka ima ha ho saba le thobalano?

Ee	1	
Che	2	
Ha ke tsebe	3	48

21. Mohlankana a ka etsa ngoanana mokhachane lilemong life?

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_____ ☐☐ 49-50

_____

22. Na bo-ntate ba lokela ho tseba ka thero ea malapa?

Ee	1
Che	2
Ha ke tsebe	3

☐ 51

23. U utloisisang ka ho thibela pelei?

_____ ☐☐ 52-53

_____

24. Ke lithibela pelei life tsa bo-'me' tseo u li tsebang?

_____ ☐☐ 54-55

_____

25. Ke lithibela pelei life tsa bo-ntate tseo u li tsebang?

_____ ☐☐ 56-57

_____

26. Na batho babeli ba nang le likamano tsa thobalano ba lokela ho lumellana ka mekhoa ea ho thibela pelei eo ba batlang ho e sebelisa?

Ee	1
Che	2
Ha ke tsebe	3

☐ 58

26.1 Ke kopa u hlalose mabaka:

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_____ ☐☐ 59-60

27. Ke mang ea u rutileng ka lithibela pelei?

Manese	1	☐ 61
Lingaka	2	☐ 62
Batsoalle	3	☐ 63
'M	4	☐ 64
Ntate	5	☐ 65
Ntate moholo	6	☐ 66
Ngaka ea Setho	7	☐ 67
Mosebeletsi oa tsa bophelo metseng	8	☐ 68
Tse ling:	9	☐ 69

28. U ka thabela ho rua litsebo life ka litaba tsa lithibela pelei?

Bokhachane	1	☐ 70
Mekhoa ea ho thibela pelei	2	☐ 71
Melemo ea ho thibela pelei	3	☐ 72
Litla morao tsa lithibela pelei	4	☐ 73
Lithibela pelei tsa bo-ntate	5	☐ 74
Lithibela pelei tsa bo-'m	6	☐ 75
Tse ling:	9	☐ 76

29. U ka thabela ho fumana litaba tse amanang le lithibela pelei joang?

Radio	1	☐ 77
Televisene	2	☐ 78
Lithupelo	3	☐ 79
Lipampiri tsa ho baloa	4	☐ 80
Tse ling:	9	☐ 81

- **Mafu a likobo**

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☐☐☐ 1-3

30. U utloisisang ka mafu a likobo?

_____ ☐☐ 4-5

_____

31. Ke mafu a likobo a feng ao u a tsebang?

Mokaola	1	☐ 6
Seso se seholo	2	☐ 7
Koatsi ea bosolla tlhapi	2	☐ 8
Seso se setala	3	☐ 9
Mahae	4	☐ 10
Ho hlohloneloa ka pele	5	☐ 11
Maqhanyatsa ka pele	6	☐ 12

32. Motho a ka fumana tsoaetso ea mafu a likobo joang?

_____ ☐☐ 13-14

_____

33. Na bo-ntate ba nyetseng le ba sa nyalang ba ka tsoaroa ke mafu a likobo?

Ee	1
Che	2
Ha ke tsebe	3

☐ 15

34. Matšao a mafu a likobo ke afe?

Seso se qhitsang	1
Tsoelesa	2
Motsetse o chesang	3
Maqhanyatsa a bohloko botoneng	4
Mahae	5
Leqeba le bohloko botoneng	6
Leqeba le sa openg botoneng	7
Tse ling:	8

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☐ 16
☐ 17
☐ 18
☐ 19
☐ 20
☐ 21
☐ 22
☐ 23

35. Mafu a likobo a ka thibeloa joang?

_____

_____

☐☐ 24-25

36. Na HIV/AIDS li ka tsoaetsana ka tobalano?

Ee	1
Che	2
Ha ke tsebe	3

☐ 26

37. Na mafu a likobo a ka ama litaba tsa pelei ho bo-ntate?

Ee	1
Che	2
Ha ke tsebe	3

☐ 27

38. U hloka li-tlhakisetso life mabapi le mafu a likobo?

_____

_____

☐☐ 28-29

- **Tse ling tsa lintho tse ka amang bophelo ba bo-ntate**

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39. Na bokuli bo ka ama tsebetso ea botona ba bo-ntate?

Ee	1
Che	2
Ha ke tsebe	3

☐ 30

39.1 Ke kopa u hlalose mabaka:

_____ ☐☐ 31-32

_____

40. Na litlhare (meriana) li ka ama tsebetso ea botona ba bo-ntate?

Ee	1
Che	2
Ha ke tsebe	3

☐ 33

40.1 Ke kopa u hlalose mabaka:

_____ ☐☐ 34-35

_____

41. Na litloaelo tse kang ho tsuba le ho noa joala li ka ama tsebetso ea botona ba bo-ntate?

Ee	1
Che	2
Ha ke tsebe	3

☐ 36

41.1 Ke kopa u hlalose mabaka:

_____ ☐☐ 37-38

_____

SECTION C: Maikutlo a banna ka litsebeletso tsa bophelo tse amanang le botona bo-ntate

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42. Makuitlo a hao ke afe ka thobalano pele ho lenyalo?

Ke ntho e mpe	1
Ha e tsoanele ho etsoa	2
E ntle ha feela batho ba sebelisa lithibela pelei	3
Tse ling:	4

☐ 39

42.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 40-41

43. Maikutlo a hao ke afe malebana le bonyatsi ba bo-ntate?

Ke ntho e mpe	1
Ke ntho e ntle	2
Ha ke tsebe	3
Tse ling:	4

☐ 43

43.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 44-45

44. Na ho se etse bana e kaba bothata ba bo-ntate?

Kea lumela	1
Ha ke lumele	2
Ha ke tsebe	3

☐ 46

44.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 47-48

45. Maikutlo a hao ke a fe ka hore bo-ntate ba lumelloe ho kena ka lehlakeng ha 'me' a pepa?

Ke ntho e ntle/ho nepahetse	1
Ha ke lumellane le hona	2
Ha ke tsebe	3

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☐ 49

45.1 Ke kopa u hlalose mabaka:

_____

_____

☐☐ 50-51

46. Maikutlong a hao na bo-ntate ba lokela ho Kenya letsoho knolisong ea bana?

Ho nepahetse	1
Ha ke lumele	2
Ha ke tsebe	3

☐ 52

46.1 Ke kopa u hlalose mabaka:

_____

_____

☐☐ 53-54

47. Maikutlong a hao na bo-ntate ba lokela ho buisana le bo-'me' ka litaba tsa bophelo tse ba amang?

Kea lumela	1
Ha ke lumele	2
Ha ke tsebe	3

☐ 55

47.1 Ke kopa u hlalose mabaka:

_____

_____

☐☐ 56-57

48. Maikutlo a hao ke a fe ka likamano tsa thobalano lipakeng tsa banna ba babeli?

Ho nepahetse	1
Ha ke lumele	2
Ha ke tsebe	3

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☐ 58

48.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 59-60

SECTION D: Litloaelo tse ka amang botona ba banna

49. Mekhoa e meng ke efe eo banna ba ka e sebelisang ho khotsofatsa litakatso tsa thobalano?

_____

_____ ☐☐ 61-62

50. Na banna ba tšoanetse ho etsa thobalano e sireletsehileng?

Ee	1
Che	2
Ha ke tsebe	3

☐ 63

50.1 Ke kopa u hlalose mabaka a hao:

_____

_____ ☐☐ 64-65

51. Na u tšehetsa lebollo la Sesotho?

Ee	1
Che	1
Ha ke tsebe	2

☐ 66

51.1 Ke kopa u hlalose mabaka:

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_____

_____ ☐☐ 67-68

SECTION E: Litsebeletso tsa bophelo tse amanang le botona ba banna

52. Na u kile oa chakela litsebeletso tsa bophelo tse amanang le bo-ntate?

Ee	1
Che	1
Ha ke tsebe	2

☐ 69

52.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 70-71

53. Ha litsebeletso tsa bo-ntate tsa bophelo line li le teng u ne u tla li sebelisa?

Ee	1
Che	1
Ha ke tsebe	2

☐ 72

53.1 Ke kopa u hlalose mabaka:

_____

_____ ☐☐ 73-74

54. Ho ea ka maikutlo a hao, litsebeletso tsa bophelo tse ka fanoang tsa bo-ntate ke life?

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Litaba tsa thibelo ea mafu a likobo, ho kenyeletsa le koatsi ea bosolla tlhapi (AIDS)	1	3
Litaba tsa thero ea malapa	2	4
Tataiso (boeletsi) le phekolo ea ho sebe le bana	3	5
Tataiso (boeletsi) ka tsa hose sebetse ha litho tsa botona	4	6
Tlhatlhobo le phekolo ka mofetse lithong tsa botona	5	7
Litaba tsa kholiso ea bana	6	8
Litaba tsa tšebeliso ea lithethefatsi le le tsa thobalano	7	9
Tse ling:	8	10

1-3

55. Litšebeletso tsee li lokeloa ho fanoa ke bo mang?

Bo-ntate	1	11
Bo-'me'	2	12
Lingaka	3	13
Manese	4	14
Basebeletsi ba bophelo metseng	5	15
Lesotho Planned Parenthood Association (LPPA)	6	16
Lingaka tsa setho	7	17
Baruti	8	18
Tse ling:	9	19

56. U nahana hore litsebeletso li fanoe libakeng life?

Motebong oa litlhare oa bo-ntate	1	20
Motebong oa litlhare oa bo-ntate le bo-'me'	2	21
Mesebetsing	3	22
Lipapaling	4	23
Mekhatlong ea boithabiso	5	24
Tse ling:	6	25

57. U nahana hore litsebeletso li fanoe ka nako life?

Lihoreng tsa hoseng	1
Ka tinare	2
Motseare oa mantsiboea	3
Letšeare lohle	4
Tse ling:	5

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	26
	27
	28
	29
	30

58. U rata ho bona litsi tsa litsebeletso tsa bophelo tse amanang le bo-ntate li hlophisitsoe joang?

	31-32

Ke leboha ha u nkile karolo ho araba lipotso, tsena!

ADDENDUM I

Focus group transcriptions

FOCUS GROUP TRANSCRIPTIONS

A. Knowledge of male reproductive health

- **What knowledge do you think men must have regarding reproductive health?**

Participants revealed that they lacked knowledge related to the anatomy and physiology, sexual developmental changes, undescended testes leading to infertility as well as factors that may affect their reproductive health.

- *Nobody has taught me about how my body works.*
- *As I have never went to school I don't know how my body works.*

➢ A few participants particularly boys aged 15-24 years knew the male reproductive anatomy and physiology.

- *I have heard how my body works at school because we are taught biology.*
- *At school I have learned about the human and social biology.*

➢ Regarding the developmental changes, a few men knew of them.

- *Nobody has taught me about the changes but I have seen that when I was a boy I grew pubic hair and my voice deepened.*
- *When I was at the initiation school I was told that at a certain age I will be able to reproduce and have wet dreams.*

- Participants did not know that undescend testicles could lead to infertility.

  The following are responses expressed:

  - *A man always produce children.*
  - *Infertility is a female problem.*
  - *A man cannot have a problem of producing children.*
  - *A man never gets old.*
  - *All men can make children without any problems.*

- Regarding factors that may affect male reproductive health the following emerged from the discussions.

  - *I have never heard of any diseases that affect male reproductive health.*
  - *I have heard that drugs like dagga increases sexual desire in men.*
  - *I smoke but I don't have a problem with my sexual drive.*
  - *I have heard that drugs for diabetes decrease sexual drive.*

- Men suggested they would like more information on male reproductive health issues in general – how their body works and on sexually transmitted diseases.

- **Knowledge of pregnancy and childbirth**

Men expressed that like women they should be knowledgeable of pregnancy and childbirth.

- *I want to know about contraception to avoid pregnancy.*
- *I want to understand childbirth so that can help my wife.*

- *I want to know more about childbirth so that I can know related problems.*
- *If I know about childbirth I will know the time when to expect my child.*

➢ Knowledge of contraceptives used by males

Participants know about the condoms as a method of protection against sexually transmitted diseases, but not for family planning purposes.

- *Condoms are not used with wives but with other women.*
- *I use a condom to protect myself against infection.*
- *Condoms are useless, they decrease sexual satisfaction.*
- *Condoms are not reliable they can burst during sexual intercourse.*

➢ Knowledge of contraceptives used by females and how they feel about them.

The pill, injection and intra uterine device were mentioned as contraceptives used by females. However, some participants were in favour of female contraceptives while some opposed their use.

Those who approve female contraceptives cited various reasons:

- *It is good for females to use contraceptives to avoid pregnancy and have many children.*
- *Life is expensive this days so it is better to use contraceptives.*

Those not supportive of female contraceptives expressed the following:

- *I heard that women who use pills put on weight.*
- *Some women have heavy menses while on contraceptives.*

- *Contraceptives have harmful side effects – I heard that they destroy kidneys.*

➢ Benefits of using contraceptives

Some participants recognise the importance of using contraceptives.

Here are some of the remarks:

- *With use of contraceptives one can decide on the number of children to have and when to have them.*
- *Contraceptives prevent unwanted pregnancies and sexually transmitted diseases.*
- *Use of contraceptives encourage promiscuity as some women use them secretly.*
- *Contraceptives destroy women's bodies.*

➢ Decision maker regarding use of contraceptives

As indicated by the discussion, the decision to use contraceptives is mainly the responsibility of women.

- *Women use contraceptives on their own without involving their partners.*
- *A woman and a man have to decide together to avoid cheating each other.*
- *Family planning clinics encourage women to decide on their own as they visit the clinic alone.*

➢ Where they obtain contraceptives

Some participants suggested chemists as their source of contraceptives. Some never seek for contraceptives as they said it was the responsibility of women.

- **Understanding of sexually transmitted diseases**

Most respondents were aware that STDs are diseases acquired through sexual intercourse.

– *I think usually a man brings STDs to their partners.*

➢ How STDs including HIV/AIDS can be contracted

The following responses emerged from the discussion:

– *I think one can get a STD through sexual contact with an infected person.*
– *Some people get the infection by having sex with multiple partners.*
– *A person can get HIV/AIDS by sharing needles or blades.*
– *A person can contract a STD from toilet seats.*

➢ Sign and symptoms of STDs

The following were highlighted:

– Burning micturiction
– Urethral discharge
– Itching rash
– Enlarged inguinal lymph nodes
– Public lice

One participant said, "sometimes the discharge may be so profuse that one may need to place a pad to avoid messing the pants".

- How STDs can be prevented

The following measures emerged from the discussion:

- Condoms are the best method of STD prevention, followed by health education and avoiding sharing blades or needles.

- Behaviours that can put men at risk of STDs

The following were reported:

- Having multiple sex partners
- Premarital sex
- Commercial sex
- Sharing blades

- Where men seek consultation when experiencing STDs

The following remarks were given:

- I prefer to use traditional healers because such providers offer confidential treatment.
- I prefer to use both traditional and western medicines so that they can compliment each other.
- For fear of being ridiculed by staff at clinics I prefer the traditional healers.
- Local preparations are more effective than western medicines as such traditional healers are the best.

B. Attitudes towards male reproductive health

- **How do you feel about own sexuality?**

The following are typical quotes from the discussion:

- *I am happy with my sex as a man.*
- *I am glad the way I am because that is how I have been created.*

➢ What are their concerns?

- *I think sexually transmitted diseases are the main concern of men.*

➢ How they feel about development of sexual desire?

The following were expressed:

- *Development of sexual feeling is natural.*
- *I sometimes feel embarrassed when the feelings come specially because sometimes they occur in the presence of other people.*
- *Development of sexual desire indicates that one is a man and is a sign that one can reproduce.*

➢ How do they satisfy sexual desires?

- *I think sexual intercourse is the only way on can satisfy sexual desire.*
- *If a man is way from home he can masturbate or have sex with other men.*

➢ If ever had feelings for other men

Participants had mixed feelings. Some were conservative while others were free to verbalise their feelings.

- *It is dirty and bad to have feelings for other men.*
- *Nature does not allow a man to have feelings for another man.*

♦ **How would you react if you cannot father a child?**

Typical responses expressed included the following:

- *I would feel like I am not a real man.*
- *I would feel like I have been castrated.*
- *I would feel hopeless and guilty.*

♦ **How do you feel about premarital sex?**

The responses below indicate the feelings that men had:

- *Sex before marriage is not acceptable and therefore I cannot encourage it.*
- *Sex before marriage is a sin before God.*
- *Sex before marriage predisposes to pregnancy and sexually transmitted diseases.*
- *As boys we need to experiment before we reach adulthood.*

♦ **How do you feel about extra-marital relationships?**

Men had mixed feelings – some support the idea while others disapproved it.

For those who support extramarital relationships the following remarks were given:

- *Extra marital relationships cannot be stopped.*

- *Extramarital relationships help widows who desire to have children.*
- *Extramarital relationships help women who cannot have children with their husbands – especially if it is a male who is infertile.*
- *Extramarital affair serve as a sexual fulfilment for men while their wives are pregnant or breastfeeding.*

Among men who disapproved extramarital relationships the following emerged:

- *Extramarital relationships are a sin before God.*
- *Extramarital relationships predisposes to STDs.*
- *Extramarital relationships break marriages.*

♦ **Feelings about men being allowed into the delivery room and participation in childrearing**

➢ Entrance into delivery room

Some men supported the idea, while other disapproved it.

For those men who supported the idea the following were expressed:

- When a man is present he will feel for his wife and in future will know what his wife experienced and will have a limited number of children.
- If a man witnesses the pain a woman experiences, he will not want to have many children.
- The presence of a man will give a woman emotional support – shows that a man cares.

For those who disapproved the following remarks emerged:

- *It is not necessary for a man to be present.*
- *Childbirth is a woman's secret.*
- *The Sesotho culture does not allow that.*

➢ Feelings about participation in childrearing

Most men support the idea.

The following responses were given.

- Men have to take part as a child is for both a man and woman.
- A man needs to participate so that when his wife is sick or away he could be able to care for children.

♦ **Feelings about homosexuality**

Men had mixed feelings. Some supported homosexuality while mothers opposed it.

Among men who supported the following responses emerged.

- *Homosexuality is another way to satisfy sexual feelings especially among men in places like mines or prisons.*
- *I don't see anything wrong with it if those men who practice homosexuality enjoy it.*

For those against homosexuality the following remarks were reported:

- *It is bad before God.*
- *It is dirty acts – sex is for opposite genders.*
- *Homosexuality may predispose to STDs.*

♦ **Attitudes towards people infected with STDs as well as HIV/AIDS**

Generally men regarded people infected with STDs as promiscuous and for this reason people avoided them.

C. Male reproductive health practices

- **What alternative ways of realising sexual desire other than sexual intercourse can men use?**

The following were suggested:

- *Masturbation*
- *Sex between thighs*

Participants indicated that it was difficult for them to say whether the ways were acceptable as sex is a taboo and that it was practiced privately by individuals.

- **Do men practice safe sex?**

The participants said it was difficult to respond to the question because sex issues are done privately. What they knew was that most men object to use of condoms because they do not trust them.

- **Is traditional circumcision a safe practice?**

Some participants approved the practice while others did not.

Among those who supported the practice the following responses emerged:

- Through initiation schools boys were prepared for marriage and how to be responsible adults.

For men who opposed the practice emerged the following:

- If you could see the behaviour of young men when they come back from initiation schools you could wish they never existed.

- People from initiation schools have bad manners – they rape and steal. For this reason are no longer important.
- These days the initiates die, I don't know what kills them. The question is do people who it is (trainers) know what they are doing.
- The instruments used (blades) are not sterilised and as such are predisposes initiates to HIV/AIDS.

- **How can traditional circumcision be made safe?**

The following were suggested:

- Traditional circumcision should be done only by trained people.
- Trainers should be taught about HIV/AIDS.
- Trainers should encourage use one blade per person.

- **Do you have access and use reproductive health services in this community?**

- *Male reproductive health does not exist in this area.*
- *We would use such services if they existed provided male providers will serve us.*
- *Male reproductive health services should be available in all districts of Lesotho. We want our own services like women have theirs.*

D. Reproductive health services

- **Do you know of anywhere that offers reproductive health services for young men?**

➢ Where do boys learn about their body and how to care for it?

The following are selected excerpts from the focus groups:

- *At school we are taught about human and social biology (urban man).*
- *I learned about my body parts at the initiation school (rural man).*
- *By communicating with our friends was learning much about our bodies.*

➢ Where do they learn about sex?

- *Initiation schools and formal schools as well as teachers, friends and mass media were cited as sources of information.*
- *By reading magazines such as Bona and True Love we learn a lot about sex, though sometimes we do not understand quite well.*

➢ What are common reproductive health problems among boys and adult men?

- *Sexually transmitted diseases are common problems. Many friends of mine usually complain about sores on their private parts.*
- *I have heard some me complaining about burning urine and enlarged glands on groin. The problem is some leave the problem untreated.*

- *It is not good to tell other people when you have a problem on private parts. So I will stay with problem till it gets better.*

➢ Would they consult a health facility when experiencing reproductive health problem?

The following remarks emerged:

- *I cannot consult a health facility because my parents may find out.*
- *I would consult if I would be served by another man because he will understand my problem because he is a men.*
- *If I visit the clinic nurses will gossip about my problem.*
- *I prefer to see a traditional healer because he will keep my problem as a secret.*

♦ **Whether they would attend reproductive health services if they existed?**

It depends on the gender of the service provider:

- *We would attend only if we are served by a man.*
- *We would like to have our own services just like women have their own services.*

➢ Who should provide such services?

- *I would like to be served by nurses and doctors because they know health issues.*
- *I would be more comfortable to be served by another men because if it's a man he will understand my problem better as he is a man.*
- *A man will not gossip about the presented problem.*

- Type of setting preferred

  - *Services should be away from those of adults.*
  - *We want separate services for men only.*

- Preferred hours of services

  - *Morning ours are the best as we are going to school.*
  - *Afternoons are ok because we can go after school.*
  - *Working hours are convenient for working and men not working.*

- Barriers for not using services

  The following are typical quotes from the focus groups:

  - *Since services are for adults, I do not want them to see me.*
  - *I believe such places are only for adults.*
  - *I cannot use such services because I am shy to be seen by people who know me.*
  - *If I knew of the type of services provided I would visit.*
  - *We though services were only meant for women and children.*

ADDENDUM J

Summary of responses given to open-ended questions

SUMMARY OF RESPONSES TO OPEN-ENDED QUESTIONS

Direct responses from men obtained through the structured interview follows:

A. Knowledge of male reproductive health

1. What men understand by term "male reproductive health"

   The following responses were given:

   - Male services
   - Advice for men
   - Male clinic
   - Male education
   - Know nothing about the term
   - Sexually transmitted diseases education
   - Family planning

2. What reproductive health concerns males in general have

   The following responses were cited:

   - Sexually transmitted disease including acquired immuno-deficiency syndrome
   - Syphilis
   - Burning urine
   - Hydrocele
   - Warts
   - Discharge
   - No feelings

3. Individual reproductive health problems that men experience:

- Genital warts
- Have burning urine
- Experience discharge
- I have ants on pubic area
- Have no feelings
- Lazy in bed
- Do not produce kids
- Prostitution
- Painful waist
- Syphilis
- Painful penis

4. Whether males should know the structure of the male reproductive organs

Men gave the following reasons:

- To know about them
- To feel when problems arises
- To get help when problems occur
- To know how to care for their parts
- To know themselves better
- Each person should know himself better
- Distinguish them from females
- Man should know themselves
- To see a doctor when sick

5. Whether males should know functions of the male reproductive organs

The following reasons were expressed:

- Be able to see a doctor when sick
- Be able to tell when a problem arise
- So that I can care for them
- Understanding how the body works

- Be able to care for them

6. What reproduce physical changes occur in boys during puberty
   - They have beard
   - Have beard and deep voice
   - Grow pubic hair
   - Big genital
   - Begin to have sex feelings
   - Experience wet dreams

7. What reproductive physiological changes occur during puberty

   The following were reported:
   - Grow beard
   - Boys can be able to make kids
   - Can produce sperms
   - Deep voice and pubic hair
   - Have sexual feelings
   - Do not know
   - Have wet dreams
   - Genitals grow

8. What reproductive physical changes occur during adulthood

   The following were reported:
   - Have big genitals
   - Deep voice
   - Grow grey hair
   - Have feelings for sex
   - Sexual performance get low
   - Grow beard
   - Voice become deep
   - Wet dreams at night

9. What reproductive physiological changes occur in adulthood

- Become less sexually active
- Deep voice
- Grow pubic hair
- Lack of sexual performance
- Lazy in bed
- Get wet dreams
- Produce sperms
- Produce a child when they sleep with a woman

10. Whether it is normal for a man to experience wet dreams

Reasons given included:

- Can produce children
- He is now growing
- Its natural, it comes automatically
- He is a man
- Show he is a grown man
- Show that he is at a correct stage
- Show that he can marry
- Show that he is in right age

11. Whether men should be knowledgeable of pregnancy

Reasons given included:

- To avoid unwanted pregnancies
- To help a pregnant woman
- Help their wives
- Care for their pregnant wives
- Have responsibility
- They equally responsible for pregnancy
- They have to know problems of pregnancy
- To be able to help when problems arise

12. What age is a boy old enough to get a girl pregnant

The following responses were given:

- 10 years
- 11 years
- 12-13 years
- 13-14 years
- 15 years
- 15-16 years
- 16 years
- 16-18 years
- 19 years
- 20 years
- 21 years

13. Whether men should be knowledgeable of family planning

The following responses were cited:

- To avoid pregnancy
- To avoid sexually transmitted diseases
- To know about contraceptives
- It is not necessary to know
- To help them know different contraceptive method that exist
- To be able to choose which contraceptive method to use

14. What men understand about contraception

The following responses were cited:

- Avoid children
- Is a means to avoid pregnancy
- Birth control method
- Birth control device
- Involves use of contraceptives
- Is family planning

15. What different male and female contraceptives men know

Men gave the following responses:

- Injection
- Loop
- Condom
- Pill
- Sterilization
- "Pitsa" (traditional medicine)

16. What male contraceptive devices men know

Men gave the following responses:

- Condom
- Pills
- Vasectomy
- Injection
- Loop
- Do not know them
- Cut veins
- "Pitsa" (traditional medicine)

17. Whether partner should decide together whether to use birth control methods

Reasons given included:

- A child is not from one person
- To make agreement on the number of children they should have
- To avoid unwanted children
- To chose the method to use
- To avoid conflict/fighting

18. What men understand by the term sexually transmitted diseases

The following responses emerged:

- Diseases transmitted by sexual intercourse
- Diseases like HIV/AIDS
- Diseases that affect genitals
- Diseases caused by sexual intercourse without a condom
- Diseases brought by bad behaviour
- Are same diseases like AIDS and Syphilis
- Are sexual diseases

19. How a person can contract sexually transmitted diseases

The following responses were given:

- By bad sexual behaviour
- Sex without a condom
- By sexual contact
- By having unprotected sex
- By sex with multiple sex partners
- By sleeping with prostitutes
- By changing women
- Having sex with the affected person

20. How sexually transmitted diseases are prevented

Men gave the following responses:

- By using condoms
- By abstaining from sex
- Avoid many partners
- Avoid sex before marriage
- Through education
- By using medications
- Not having sex with many women
- By being truthful to your partner
- By using Sesotho medicine

- With good behaviour

21. What information men would like to have regarding STDs

Men reported the following:

- Explanation on AIDS
- Explanation on syphilis
- Explanation on condoms
- Do not need knowledge
- Deep explanations about STDs
- Have knowledge about "mahae" (warts)
- How I can protect myself from STDs
- How to fight STDs
- How we can cure STDs
- The cause of STDs

22. Whether illnesses affect men's reproductive health

The following responses were reported:

- Illnesses affect libido
- Illnesses can make you loose your feelings
- Illnesses do not affect anything
- Sickness can make you loose performance
- May experience pain when passing urine
- Some illness cause men not to have children
- A man who is sick does not perform well in bed
- If sick you cannot get sexual enjoyment

23. Whether drugs affect men's reproductive health

The following responses were cited:

- Diabetes drugs affect sexual performance
- Some drugs increase libido
- Other medications are strong and promote feelings
- Some drugs make you tired to perform well

24. Can life styles such as smoking and alcohol affect men's reproductive health

- Alcohol destroy feelings
- Alcohol drives you to rape
- Alcohol takes away the performance
- Get more feelings
- They make a man loose sexual appetite
- Smoking and alcohol reduces feelings
- I am smoking and drinking but I do not have any problem

B. Attitudes toward reproductive health

25. What is your feeling about premarital sex

Men expressed the following:

- It is a sin, it is against the Bible
- Premarital sex lead to unwanted pregnancy
- It is immoral
- Premarital sex promote sexually transmitted diseases
- Premarital sex destroy the future
- Premarital sex causes children without fathers
- Sex before marriage is a taboo
- Premarital sex promote prostitution

26. Feelings about the practice of extramarital relationships among men

The following responses were given:

- Extra marital relationships destroy marriages
- Extra marital relationships break peace in the family
- Extra marital relationships bring sexually transmitted diseases in the family
- It is a bad thing for a man to leave his wife
- It is a sin before God

- Extra marital relationships are good because a man is for many women
- Extra marital relationships help men to satisfy their feelings when their wives are away or pregnant

27. Whether childless can be due to male infertility

Men expressed the following:

- A man can have no kids sometimes
- A man never get old
- Infertility is a problem for women only
- Man always make kids
- We have grown knowing that infertility is a female problem
- There is no man without kids
- Men are always producers of children

28. Feeling about men being allowed into the delivery room

The following statements were expressed:

- Men should be allowed as a child belong to both a man and a woman
- A man must be allowed to support his wife
- A man must be allowed to help his wife
- Child birth is meant only for women – it is a woman's secret
- Men must be allowed to see the pain that a woman experiences
- Culturally it is not allowed for a man to enter the delivery room – in "Sesotho" we do not allow men in labour rooms

29. Feeling about men's participation in childrearing

The following responses emerged:

- Men must participate because a child belong to both a man and a woman
- Childrearing is a woman's job
- Men must also participate to give help

- Men must also participate because they are parents for the kids
- Men must participate to be able to look after children when his wife is away
- Females are good at raising children

30. Whether men should discuss reproductive health issues with their partners

The following responses emerged:

- Men need to discuss with their partners to be able to advice each other with problems
- Men need to discuss with their partners in order to share opinions
- Men need to discuss with their partners in order to resolve problems
- Men need to discuss issues with their partners to help each other when problems arise
- Men need to discuss issues with their wives to avoid sexually transmitted diseases

31. Feeling about the practice of homosexuality

The following statements were cited:

- A man does not have to sleep with another man
- Sex is for opposite sexes
- Homosexuality is immoral
- Homosexuality is against the law of God
- It is bad to practice homosexuality
- Homosexuality is unhygienic and unhealthy
- Homosexuality gives high risk to sexually transmitted diseases
- If men enjoy – it is good

C. Reproductive health practices

32. Alternative ways of realising sexual desire

The following responses were given:

- By using a hand
- Having sex with animals
- Having sex with another man
- No other way
- Kissing
- Have sex between thighs

33. Whether men practice safe sex

Responses given included the following:

- Men practice safe sex to avoid sexually transmitted diseases including acquire immuno-deficiency syndrome
- Men practice safe sex to avoid pregnancy and unwanted children
- Men practice safe sex by having sex only with their partners
- Men practice safe sex to protect themselves from diseases
- Men practice safe sex by using condoms

34. Whether they support traditional circumcision

The following responses were given:

- Traditional circumcision is Basotho tradition
- Traditional circumcision educate about Sesotho culture
- Traditional circumcision has no meaning
- Traditional circumcision is good for Basotho
- Traditional circumcision is the beginning of manhood
- Traditional circumcision promote sexually transmitted diseases like acquired immuno-deficiency syndrome

D. Male reproductive health services

35. Ever visited any reproductive health facility

The following responses were given:

- Such services are not available near us
- I have not visited because I do not need help
- I have no time to visit such a place
- I do not know about such services
- I visited to get health education on sexually transmitted diseases and to get condoms
- I have never visited because I am still young
- I did not visit because I do not know where such services are offered.

36. Whether would visit male reproductive health services if they existed

The following responses were given:

- I would visit to get information about acquired immuno-deficiency syndrome
- I would attend to have knowledge about males
- I would visit to have knowledge about my body parts
- I would attend to get condoms
- I would attend to get treatment for sexually transmitted diseases (discharge problem)

37. How would you like male reproductive health services designed

The following statements were stated:

- I would like services to be provided throughout the country
- Services should be brought to villages
- Provide men only clinic
- Young men should also be served
- Bring education about sexually transmitted diseases, and prevention

- Services be given by men
- Open services day and night
- Open males services at school
- Services should solve male problems