A MODEL TO FACILITATE MALE PARTNER INVOLVEMENT IN THE REPRODUCTIVE HEALTH CONTEXTIN

OSHIKOTO REGION

NAMIBIA

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DEDICATION

This dissertation is dedicated to **Meme Anna-Lisa Dama** my role model, for raising me up into the man that I am today, you instilled in me a sense of responsibility, hard work and focus. Your punctuality and dedication to your profession as a Nurse at Oshakati Hospital over 40 years was an inspiration and is a sight that will remain with me.

DECLARATION

- I **Hans Justus Amukugo**, declare that this study "**A model to facilitate male partner involvement in the reproductive health context in Oshikoto Region, Namibia"** is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree in any other institution of higher education.

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SUMMARY

The overall aim of this study was to develop a model to facilitate male partner involvement in the reproductive health (RH) context in the Oshikoto Region of Namibia. This study was brought about by the fact that male partners do not fully participate in the RH context, because the health system lacks provision for or fails to recognise male involvement and underestimates the active role that male partners could play in the RH of their female partners. As a result some male partners might feel excluded from the process when accompanying their female partner in receiving RH services or feel that they do not benefit from RH services. It would also seem that there is a disparity in RH service delivery in Namibia whereby women and children are the main targets of most available RH programmes and services. In addition, it would seem that health facilities are not user friendly and male partners feel excluded and alienated from them.

Namibia is ranked number five in the world in terms of the HIV/AIDS epidemic and males are regarded as the main sources for the spread of this epidemic as well as other reproductive diseases (Jackson, 2002). However, the spread of these diseases can affect mothers, children and the nation as whole. This problem could be alleviated if male partners were supplied with adequate knowledge and skills on RH, which could be obtained by being involved in RH programmes and services. The major questions addressed in the research were the following:

- What are the perceptions of male partners, female partners and nurses on male partner involvement in the RH context in the Oshikoto Region?
- What should be done in order to involve male partners in the RH context?
- How should the male partner be involved in the RH context?

To realise the aim of this research, the following objectives were formulated:

- Analyse the concept of male partner involvement in the RH context of the Oshikoto Region by exploring and describing the perceptions of male partners, female partners and nurses on this issue.
- Develop and describe a model to facilitate male partner involvement in the RH

context of the Oshikoto Region.

- Develop guidelines for operationalising such a model.
- Evaluate the model for facilitating male partner involvement in RH.

The aim of this study was to develop and describe a model to facilitate male partner involvement in RH. However, theory development requires empirical data and, in order to achieve this aim, a theory generative design which is qualitative, explorative, descriptive and contextual was used. A model was developed according to Chinn and Kramer's (1995) approach to theory generation in the form of four steps:

In *step 1*, concept analysis was conducted in terms of two sub steps, namely step 1.1 *concept identification* and step 1.2 *concept definitions and classification.*

Step 1.1 *concept identification:* In order to identify concepts, data were collected in the Oshikoto Region from heath facilities such as clinics, health centres and hospitals. The population under study included the stakeholders (male partners, female partners and nurses) in the RH environment and *inclusion criteria* were set to identify the stakeholders to participate in the study. *Focus group discussions*, *individual interviews* and *field notes* were used as tools for data collection while *communication and questioning techniques* were used to elicit more information during the data collection. A pilot study was conducted to assess the appropriateness of the instrument used. Data from the transcripts of the recorded audiotapes and field notes were analysed using Tesch's step method (in Creswell, 1994). An independent coder assisted with the coding of the results. The reasoning strategies used included inductive and deductive reasoning, analysis, synthesis, derivation, inferences, bracketing, intuition and retroduction, and the results of the research were verified through a literature review.

During the data analysis, categories and subcategories were identified and further analysed and thus a central statement, namely, "management of a partnership environment" was identified.

In terms of step 1.2, each concept from the central statement was analysed thoroughly using dictionaries and subject usage in order to identify the essential and related criteria which later merged. The "management of a partnership environment" was defined on the basis of merged essential and related criteria. The related concepts were classified using a survey list developed by Dickoff, James and Wiedenbach (1968) from whence a model case was constructed using the identified attributes (Chinn & Kramer, 1995).

Step 2, the identified concepts were compared to each other to show interrelationships and the classification of central and relational concepts was used as a framework for the model.

Step 3, the structure and process of a model to facilitate male partner involvement in RH were described. Guidelines for operationalising the model for use in nursing practice and teaching were developed in *step 4*.

To ensure the trustworthiness and quality of the research, a method described by Guba and Lincoln (1985) was used. Ethical considerations were observed and the permission needed to conduct this research was obtained from the Ministry of Health and Social Services in Namibia, as well as from the Oshikoto Regional Health Directorate and the identified authority. Additional permission was obtained from the participants in the form of consent.

From the findings of this study it is evident that the main reason why male partners are not involved in RH is poor interaction (*partnerships*) between male partners, female partners and nurses as well as other significant stakeholders in the community and health facilities environments. In short, one may conclude that there is poor interaction (partnerships) between male partners and female partners, as well as between these parties and the nurses in the RH facilities, arising from negative perceptions, poor interpersonal relationships between stakeholders, the personal attributes of the male partners, the female partners and the nurses, in addition to certain sociocultural barriers such as polygamy practices; myths about male involvement in the reproductive health; gender disparity; alcohol abuse by male partners, migratory labour and household duties. Poor partnerships could also be the result of a lack of knowledge and skills on the part of the agents (nurses), recipients (female and male partner) and other significant stakeholders in the RH environment.

It was further concluded that the context (*environment*) in which RH services are delivered are not favourable in terms of the accessibility and utilisation of resources. It became clear that the RH care delivery system does not facilitate male involvement in RH, one of the reasons being the difficulty partners (female and male) experience in accessing facilities that provide RH, namely the long distances involved and the unavailability of transport, the costs of RH treatment and the relatively lengthy periods spent by the female partners at facilities that provide RH services.

In addition, the way (process) in which nurses manage RH services is inadequate owing to the unavailability and inadequacy of resources, policies and legislation, for *management;* a lack of management principles, as well as the unavailability and abuse of human and material resources to facilitate male involvement in RH. Poor management was expressed in terms of inadequate buildings and poor infrastructure with regard to health facilities that are rendering RH services; poor networking was also considered a problem.

In light of the poor partnerships between stakeholders, male partners, female partners and the nurses in this environment resulting from poor management principles, policies and legislation, one can conclude that the nurse as agent will be challenged to improve the management of the partnership environment in order to facilitate male partner involvement in the RH context. Therefore, a challenge to "manage the partnership environment" was adopted as one of the central concepts of this study. The structure and description of the model was done according to Chinn and Kramer (1991).

The researcher found that the facilitation process could be done in five phases:

Phase 1 – Situational analysis. In this phase the agent utilises research skills to identify the needs and

challenges that affect or influence the stakeholders (male partners, female partners, nurses, and significant stakeholders) in the community and health facility environments. The challenges identified in this phase will form a basis for the nurses' adoption of a management process to manage the partnership environment.

Phase 2 – Establishment of partnerships. In this phase the agent utilises an interactive facilitation process, such as communication, involvement, participation, collaboration and networking. To facilitate partnerships between the stakeholders to operationalise male partner involvement in RH implies adopting a shared vision, cultural realisation and knowledge, good interpersonal relationships based on mutual cooperation, collaboration, networking, communication, shared and sharing resources and responsibility, joint decision, trust, respect and confidentiality. Through partnerships the stakeholders undertake collective action in sharing resources, addressing challenges and barriers and actively participating in matters concerning RH.

Phase 3 – Management process. In this phase the actual process of facilitation is fully implemented by the agent using management steps such as planning, organising directing/leading and control, as well as leadership policies and guidelines for managing the dynamic interaction between the male partner, female partner and the nurse during the facilitation process. Planning is used by the senior registered nurse in collaboration with other stakeholders to set goals, develop action plans and implement and evaluate strategies. The act of organising implies that the registered nurse or nurses working in RH facilities have to design the structure, assign responsibility to subordinates, establish a command structure and coordinate mechanisms in order to facilitate male partner involvement in RH. Leadership and management principles and strategies, such as time management, conflict management and change management, enable the registered nurse to manage the dynamic interaction between stakeholders.

Phase 4 – Maintaining a conducive environment. A conducive environment implies that male partners should feel safe and free of apprehension. They should also be motivated to become involved through encouragement and recognition. They should receive the necessary emotional support and be treated with respect. The nurse should demonstrate patience in her dealings with all stakeholders.

Phase 5 – control and terminus/outcome. In this phase the agent makes use of controlling strategies, such as setting standards, measuring actual performance, evaluating deviations and rectifying such deviations. One of the most important measures to eliminate deviations and improve active participation is the supply of sufficient feedback to the partners by the registered nurse. Such feedback helps the partners to set specific goals for improvement, set measurable targets to be met by a specified time and describe the methods for attaining them. Levenstein (1984) maintains that, by involving all partners in feedback, the best value is produced. By setting the standard to measure actual performance, evaluate and rectify deviations and give feedback to the partner, registered nurses will an able to determine whether male partners are involved in RH.

Theoretical and methodological limitations were identified and, in order to mitigate these limitations, recommendations for nursing education, administration and research were made.

Finally, if the purpose of a partnership model is achieved, the male partners are expected to participate and be involved actively in their own RH, which would be beneficial to their own health, as well as to that of their partners and their *families.*

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LIST OF ABBREVATIONS

RH: RH
RHS: RH system
HIV: Human Immune deficiency virus
AIDS: Acquired immune deficiency syndrome
MOHSS: Ministry of Health and Social Services
UNFPA: United Nations Population Fund
ICPD: International Conferences on Population and Development
STD: Sexually transmitted disease
STI: Sexually transmitted infection
NGO: Non Government organisation
UNAIDS: The United Nations Joint Programme on HIV/AIDS
UNDP: United Nations Development Program
WHO: World Health Organization
USAID: United State Agency for International Development
ICN: International Council of Nurses

CHAPTER 1

OVERVIEW OF THE STUDY

1.10 INTRODUCTION AND RATIONALE

The World Health Organization (WHO) defines reproductive health as "a state of complete physical, mental and social wellbeing and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and its function and process". Reproductive health care is defined as*:* "A constellation of methods, techniques and services that contribute to the reproductive health and

wellbeing of the individual and the family by preventing and solving reproductive health problems." This includes sexual health and has, as its purpose, the enhancement of life and personal relations, as well as counselling and care related to reproduction and sexually transmitted diseases (United Nations Population Fund, 2001a; United Nations, 1995a; Tavrow, 2005; WHO 2006, p. 1; WHO, 2008a; ICPD, 2009).

The aim of reproductive health is to assist people in promoting and protecting their own wellbeing as far as issues around reproductive health are concerned. In order to achieve this people need to be empowered with knowledge and skills that will enhance positive outcomes in terms of human development and maturation; sexuality and sexually transmitted infections (STIs); fertility and infertility; and pregnancy, as well as in creating an environment in which people can use sexual and reproductive health programmes effectively (ICPD, 2009).

In view of the fact that reproductive health care enables both men and women to be well-informed and to have access to safe, effective, affordable and acceptable methods of family planning of their own choice, the WHO regards it as a basic human right of both men and women. By providing women with the opportunity to enjoy a safe pregnancy and childbirth, couples are given the best chance of having healthy infants (WHO, 2006; Republic of Namibia, 2007 a; Republic of Namibia, 2007 b.).

Reproductive health care is a crucial aspect of the general wellbeing of individuals because it deals with the health of the individual from conception, through childbirth, and during childhood and adulthood. Health care providers render reproductive health services in all health facilities but, specifically, in antenatal and postnatal clinics both before and after mothers have given birth. Traditionally, antenatal and postnatal care was regarded as the specific domain of women and children since these services are concerned with pregnancy and childbirth. However, it was realised that men could also play an important role in successful reproductive health care. It should be pointed out that couples, partners and individuals all have the right to decide freely on their treatment and that they should have access to all the information and education which is available on reproductive health. This is possible only in an environment in which male partners also participate fully in the reproductive health care of their female partners, which implies that men must play an active role in the reproductive healthcare context (UNFPA, 2003 a).

Reproductive health (RH) problems are the most challenging problems confronting developing countries. Several studies indicate that there is a growing understanding within the international public health community of the role played by gender as a fundamental influence, together with decision-making power, and access to education on reproductive health, and that this affects the health choices which are available to every individual. This understanding has been instrumental in increasing awareness on the part of the profession on the need to develop creative health care strategies that reach male partners. This need has become increasingly urgent in the face of the growing worldwide spread of sexually transmitted infections (STIs), including the human immuno virus (HIV).

In many countries, pilot programmes and initiatives to ensure the involvement of the male partner in reproductive health services have existed for more than 20 years; however, there has been minimal progress in this regard. This may be attributed to the fact that policy makers and health care providers

appear to assume that men are either not interested or do not fully understand how and why they need to be involved in reproductive health and also what services are available to them and their partners (Nell, Landry, Wilkinson & Tzanis, 1998; Walston, 2005).The benefits of male partner involvement in reproductive health may expand the rights of both men and women; improve family health; ensure better communication with male partners; and assist couples in making joint, informed decisions within their households.

In the United States of America (USA), despite the fact that male partners do participate in reproductive health programmes, health care practitioners are, nevertheless, still dissatisfied with the way in which programmes are structured, with the focus being on maternal and childcare and the limited contraception methods available. Nevertheless, reproductive health care is perceived as being successful in that country and male partners do understand and assume their responsibilities (Bureau of Reproductive Health, 2002).

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

A study on the reproductive health system conducted in Sierra Leone revealed that male clients were considered to be a constraint in terms of family planning programmes, as female clients only were targeted by health care providers (Planned Parental Association of Sierra Leone, 1998). In addition, as a result of both the dominance of men over women and male sexual promiscuity, gender inequity and inequality are critical factors in the spread of reproductive health diseases such as HIV/AIDS in Africa (Jackson, 2002).

Samba (1999) and Mbizvo and Basset (1996) indicate that the majority of people in Africa have a limited knowledge of sexuality and reproductive health, while statistics show that

- 250,000 mothers and 3 million babies die annually in Africa from complications that are related to sexuality and reproductive health
- one in every four married women have unmet needs as regards contraception
- in 2001 there were five million new HIV infections and half of all new HIV infections occurred in people under the age of 25
- worldwide, 70,000 women die every year from unsafe abortions, while more suffer from infections and other consequences relating to these unsafe abortions (ICPD 2009)

- domestic violence, rape and sexual abuse are significant causes of disabilities among women (ICPD 2009).

Although the population of sub-Saharan Africa is increasing at a rapid rate, reproductive health problems and related diseases play a role in the death of millions of mothers and children who die as result of complications related to reproductive health problems (Samba, 1999). The UNFPA (2003a) suggests that, in order to achieve higher quality reproductive health as well as sexual health, it is vital that male individuals receive information and proper education within the context of reproductive health.

In light of the important role of male partners in reproductive health, there has been an urgent call by governments worldwide to involve them in the health sector. This call intensified after the International Conference on Population and Development (ICPD) which was held in Cairo, Egypt in 1994 (United Nations, 1995b). The call was echoed by the United Nations 4th World Conference on Women, which was held in Beijing, China, in 1995 (United Nations, 1995a). Although reproductive health is a complex subject, both these conferences identified those challenges which need to be placed at the centre of the development of health care services. A request was made to different countries and organisations to readdress gender imbalances and to respect the reproductive rights of men and women as necessary preconditions for improving sexuality. In addition, the conferences identified the fact that the role of men had been virtually ignored in the past, especially in respect of sexual and reproductive health. Cultural barriers were among the issues that were recognised as de-motivating factors that prevented males from participating in reproductive health systems (WHO, 1999; UNFPA, 2001).

The International Council of Nurses (2003) has identified important roles that nurses as agents should play in different situations in caring for individuals, families and communities, irrespective of their backgrounds. These roles may also be applied to the Namibian health care system and include the roles of health educator; health provider and supervisor; family advocate; case finder; epidemiologist; researcher; manager and coordinator; and counsellor and consultant.

1.11 BACKGROUND

The Namibian population is growing at a rate of 2.6% per annum, although this does represent a decline of 3.1% per annum between 1981 and 1991. In 2008, about 31% of young women and 13% of young men between the ages 15 and 24 were tested for HIV and given the results. The aim is to increase these teating figures by 2012 so that 38% of women and 16% of men in that age group will undergo testing. Pape (2007) regards this percentage of men as low.

Namibia has an HIV/AIDS prevalence rate of 20% and, thus far, few men are prepared to undergo testing. The researcher suggests that, if Namibia does not reduce the rate of HIV/AIDS, the country will have to deal with this pandemic for many years to come. The widespread incidence of HIV/AIDS

means that it is no longer regarded as a disease, but rather as a pandemic and this situation is exacerbated by adultery. In addition, abuse against women and children is not only widespread but often condoned and alcoholism and risky sexual behaviour affect both young people and members of the upper classes (Uys, 2007a). Migration also poses a challenge with the armed forces always on the move, and separated from their families while on duty in different areas of the country. In addition, the rapid rural–urban migration has facilitated the spread of reproductive diseases. Families and communities are impoverished by both low productivity and by the costs of the widespread illness and death resulting from reproductive diseases such as AIDS. Poor conditions make it more difficult to care for the ill, more difficult to mount effective education campaigns and more difficult to control STIs. These poor socioeconomic conditions also mean that there are women (and a few men) who are forced to exchange sex for money, food or shelter and this phenomenon also contributes to the spread of reproductive diseases. This situation might improve if male partners were to actively participate in reproductive health programmes, as this would allow them the opportunity to acquire greater knowledge and skills (PANOS/NRCS/SAfAIDS, 2003).

Namibia is one of the African countries that have been affected by the challenges that have arisen as a result of the cultural and socioeconomic influences that have given rise to gender roles that hinder male-partner involvement in reproductive health. The involvement of males in the context of reproductive health is only possible in an environment in which a platform has been created which encourages both partners to participate in reproductive health and, also, an environment in which this process has the support and guidance of the health workers who are, indeed, the custodians and advocates of the reproductive health context in Namibia. The current health framework in terms of which reproductive health care is provided lacks any focus on the inclusion of male partners (PANOS/NRCS/SAfAIDS, 2003).

Reproductive health per se is not a new issue in the Namibian health sector, but it would appear that both past and present approaches have been, and still are, inaccessible and inequitable in terms of either reaching or catering for the needs of all the stakeholders, especially men. This is also the case in terms of government policies worldwide in respect of which woman and children are the primary targets of health policies, resource distribution and health programmes. Male partners perceive these exclusive policies as major de-motivating factors in respect of participation within the system (Bureau of Reproductive Health, 2002). In order to overcome these problems, the WHO (1999) has suggested that governments and institutions come up with models of reproductive health that could serve as platforms for male partner involvement. In terms of these reproductive health models nurses could play an important role in the implementation of models by using various strategies, approaches and guidelines. Such an approach could motivate and involve male partners in respect of the use of the available

facilities and resources of the reproductive health services in the same way as women. Both the agent (nurses) and the recipient (male and female partners and influential, significant individuals from the community) should be encouraged to take part in such a process.

The Ministry of Health and Social Services (2001; 2002) has identified two important male partner roles when assisting female partners, which are necessary in terms of the implementation of an effective reproductive health system. These roles firstly include an advisory role in terms of which men take the lead in providing information related to reproductive health, and secondly, a supportive role in respect of family planning in which male partners support their female counterparts in terms of suitable methods of contraception.

Although male partners in Namibia are now being targeted by both the Ministry of Health and Social Services and nongovernmental organisations (NGOs) in order to gain their cooperation in reproductive health matters, this will take time. It would appear that male partners are still not actively involved in the reproductive health of their families in Namibia. This stems from the fact that these health systems do not make provision for, nor do they recognise – if they do recognise, they underestimate – the active role that male partners could play in the reproductive health of their partners. As result, male partners feel excluded.

In general, the Namibian press does increase public awareness of the high incidence of maternal and child ill health, distorted partnership relationships, inequitable gender roles, unwanted pregnancies, neglected children and a diversity of other social problems related to the reproductive health context and the researcher is of the opinion that these problems may be addressed only if male partners become actively involved in the reproductive health context. Accordingly, nurses need to play a vital role in encouraging and facilitating the participation of male partners in the reproductive health context.

In Namibia, mothers and children are the main target population in respect of the available reproductive health systems, including antenatal care (ANC) and postnatal care (PNC). In general, males do not accompany their female partner when they attend these clinics, nor do they participate fully in the antenatal and postnatal care of their partners. It is not clear how male partners perceive of or what they expect from these ante- and post-natal care departments (Ministry of Health and Social Services, 1994).

South Africa is another African country with a rapidly increasing population, and is also affected by the aforementioned reproductive health challenges. Several studies have revealed the need on the part of males to participate actively in the reproductive health of their partners and this is possible should males be motivated to do so. Schmidt and Nice (2002) have identified gender imbalance, violence towards women and male chauvinism as the main problems in terms of sexuality and reproductive health. These problems emanate from the social and cultural construction of society, which, in turn, breeds violence. For example, a woman is raped every 26 seconds in South Africa (Pretorius, 2002). Such happenings may contribute to the spread of HIV and AIDS, which is the major problem in reproductive health services. Research conducted in South Africa on reproductive health indicates that

rape is about dominance, aggression and control by males of their female partners. In view of the fact that 240 out of every 100,000 women in South Africa are raped, Jackson (2002) also supports the above notion. This high incidence of rape has contributed to the increasing levels of HIV and AIDS in South Africa. However, the South African government is using reproductive health programmes as one of its strategies with which to combat reproductive health problems and diseases. Accordingly, dynamic change is possible only if reproductive health systems operate in the mode of a partnership, whereby both male and female partners are able to participate in reproductive health systems as partners and not as individuals.

It is not possible for reproductive health to take place in a vacuum or in isolation. Consequently, the researcher is of the opinion that there should be a model in place that clearly delineates processes that would enable nurses to guide or assist male partners to participate fully and actively in reproductive health. It would, however, appear that the existing health system does not promote this adequately. Therefore, the main aim of this study is to develop a model in terms of which it would be possible for male partners to fulfil their roles in reproductive health care. This model could be used at management level in planning, organising, implementing and evaluating the activities taking place within the context of reproductive health. The model could also be used to facilitate the involvement of the male partner in reproductive health.

1.12 PROBLEM STATEMENT

In Namibia there is one hospital only in the Oshana Region that has an informal programme aimed at promoting the participation of males in reproductive health. However, this programme does not appear to be very effective. It would seem that its ineffectiveness stems from the fact that the health care systems do not make provision for, nor do they recognise – in fact, they appear to underestimate – the active role that male partners could play in the reproductive health of their female partners. As a result, male partners may feel excluded when their female partners make use of reproductive health care services or they may even feel that such services are of no benefit to them. In addition, it would appear that there is a disparity in the delivery of reproductive health services in Namibia, as it is women and children who are mainly targeted by the available reproductive health programmes and services.

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

reproductive health. The male partner could acquire these knowledge and skills from an involvement in reproductive health programmes and services.

It is evident from many sources that males, especially males in African countries, including Namibia, are not participating fully, neither are they actively involved in reproductive health (McCauley & Salter, 1995). Some of the problems that female partners have cited during their visits to reproductive heath facilities include poor or limited communication between partners, as male partners are not well versed in the issues or problems that affect the reproductive health of their female partners; manifestations of masculinity – frequently aggravated by the abuse of alcohol – which often involve violence against women and children; limited financial or other resources and the involvement of the male partners in risky sexual behaviour as a result of negative attitudes and either a lack of, or limited knowledge on the part of male partners in respect of reproductive health issues (Uys, 2007a).

Lumbu (2003) explains some of the possible reasons why males do not participate in the reproductive health services provided, referring to one of the health facilities that provide such services in the north of Namibia:

- Men claim that the nurses are unfriendly, that the nurses do not treat them with dignity and that there is neither confidentiality nor privacy in the way in which the nurses handle diseases. As a result, the men prefer to obtain treatment at private health facilities rather than at the public heath facilities that provide reproductive health services.
- Health care providers often fail to include males in the treatment when dealing with female clients and health facilities are not always user friendly.
- Male partners are far less likely than females to attend clinics for sexually transmitted diseases (STDs) in significant numbers. Male partners are also unlikely to bring their partners to such clinics for treatment if an STD/STI is detected.
- It would appear that male partners prefer to learn of their HIV status indirectly through their female partners. Males may come to the clinic when they are ill, but they are unlikely to seek information and advice in respect of reproductive health problems. Also, male partners tend to attend heath facilities only if they detect the presence of the signs and symptoms of HIV/AIDS and they are afraid of the unknown.

In 2001, a reproductive health study was conducted in South Africa by the Reproductive Health Research Unit (RHRU) of the Witwatersrand University in partnership with the Frontiers Programme of Population Council and the KwaZulu-Natal Department of Health with the aim of including men in their partners' maternity care in order to improve the reproductive health and pregnancies of couples. The study revealed that it was, indeed, both acceptable and feasible to involve men in the care of their partners. Both the men and women were interested in the involvement of men during maternity care.

However, there remain a number of health delivery challenges that need to be addressed within the South African health context before maternity services become either friendly or acceptable to men (Mullick, Kunene & Wanjiru, 2005). The challenges that were identified that prevent male partners from becoming involved in reproductive health services as indicated above include the following:

- Reproductive health services such as family planning, pregnancy and childbirth are regarded as exclusively the domain of women and, generally, men do not accompany their partners to facilities offering such services.
- Men feel that they derive no benefit from the information furnished by health providers.
- Men are rarely exposed to clinical reproductive health services as they tend to seek care for STIs in the private sector. It is not possible to obtain condoms without some form of contact with health care providers.
- Logistical (resources) and cultural problems render male partners inaccessible to RH services.
- The exclusive use of such services by women has to a great extent made these RH services unfriendly for men.

In India, a study conducted by Mavalankar, Banga and Banga (1998) was aimed at investigating the higher morbidity of males resulting from sexual complications and reproductive ill health. These researchers revealed that such ailments occur as a result of the lack of human and material resources in rendering reproductive heath services to males in this regard (Mavalankar et al., 1998). Similarly, the lack of human and material resources may be regarded as demotivating factors in countries other than India and probably also in Namibia.

However, to date no in-depth study has, been undertaken in Namibia that examines the challenges posed by inadequate, or the lack of, involvement of male partners in reproductive health. It is for this reason that the following research questions have been posed:

- What are the perceptions of male partners, female partners and nurses of the involvement of male partners in the reproductive health context in the Oshikoto Region?
- What should be done in order to involve male partners in the reproductive health context?
- How should male partners be involved in the reproductive health context?

1.13 SIGNIFICANCE OF THE STUDY

The results of this study will contribute both to an understanding of the challenges in respect of male involvement in reproductive health and to an improvement of the health services in this regard. The model developed from the study findings should enable stakeholders to improve these services by facilitating the involvement of the male partner in reproductive health.

1.14 AIM OF THE RESEARCH

The aim of this study is to explore and describe the perceptions of stakeholders (male partners, female partners and nurses) in the Oshikoto Region in respect of male involvement in the reproductive health facilities. The study aims to develop and describe a model to facilitate the involvement of male partners in reproductive health and to formulate guidelines to operationalise this model.

1.15 OBJECTIVES OF THE RESEARCH

The objectives of this research are to

- analyse the concept of male partner involvement in the reproductive health context in the Oshikoto Region by exploring and describing the perceptions of male partners, female partners and nurses in respect of the involvement of male partners in the reproductive health context in the Oshikoto Region-
- develop and describe a model to facilitate male partner involvement in the reproductive health context in the Oshikoto Region
- develop guidelines to operationalise such a model
- evaluate the model that facilitates male partner involvement in reproductive health.

1.16 PARADIGMATIC PERSPECTIVE

A study of this nature requires a paradigmatic perspective; this is a collection of logically linked concepts and propositions that provide a theoretical perspective or orientation that tends to guide the research approach to a specific topic (Naude, 1995; Ulin, Robinson, Tolley & McNeill, 2002; Amukugo, 2002). Assumptions are useful in directing research decisions (Chinn & Kramer; 1991; Mouton, 1996; Tomey, 1998). The department of nursing at the University of Johannesburg uses the Theory of Health Promotion in Nursing (THPN) as a paradigmatic point of departure. In this study the researcher also adopts THPN as a theoretical framework (Rand Afrikaans University, Department of Nursing, 1999).

The THPN focuses on the whole person (body, mind and spirit), nursing, the environment and health (Rand Afrikaans University, Department of Nursing, 2000). The mission statement of the Rand Afrikaans University is based on a Christian philosophy which, in turn, is based on both values and attitudes that promote an unconditional acceptance of people, respect for human rights, and cultural sensitivity through empathy and caring. The THPN (Rand Afrikaans University, Department of Nursing, 2000) provides a framework which is used as a basis for nursing education, nursing practice and nursing research. The nursing process (assessment, diagnosis, planning, implementation and evaluation) is embedded within this theory.

1.7.1 Meta-theoretical assumption

In this study the researcher has made particular assumptions about specific theories and methodological strategies that have been tested in order to direct him towards the guidelines on which decisions should be based (Mouton, 1996). Accordingly, this research is based on the THPN (Rand Afrikaans University Department of Nursing, 2002). The meta-theoretical assumption in this study comprises person, environment, health and nursing (Walker & Avant, 1998).

1.16.1.1 Persons: male partner, female partner and nurse

The persons in this study comprise the male partner, the female partner and the nurse. Each person is viewed as a whole person and, as such, embodies the dimensions of body, mind and spirit. The person functions in an integrative, interactive manner with the reproductive health environment (Rand Afrikaans University, 2002). A person's environment comprises both an internal and an external environment.

1.16.1.2 Environment: reproductive health context – health facilities and community environments

The environment comprises an internal and external environment. A person's internal environment comprises the dimensions of body, mind and spirit. The external environment comprises both the physical (RH clinic and resources), social (female partner and nurses) and spiritual dimensions (religion and beliefs) (Rand Afrikaans University Department of Nursing, 2002). In this study "environment" refers to both the internal (intrinsic) and the external (extrinsic) factors/conditions that influence the male partner either directly or indirectly in his involvement in the reproductive health context.

1.16.1.3 Health: reproductive health

In this study the term “health” refers to reproductive health, which may be described as the partnership, interactive and dynamic methods, techniques, and services in which the male partner is involved and which interact with the internal and external forces in such a way as to result in the optimal use of the necessary resources and services available in order to minimise vulnerabilities in respect of reproductive health diseases and issues (George, 1995).

1.16.1.4 **Nursing: reproductive health services**

In this study the term “nursing” refers to those reproductive health services which are regarded as an interactive and partnership process whereby the nurse manages the partnership environment in order to facilitate the involvement of the male partner in reproductive health. This process is facilitated by the nurse by promoting reproductive health through the mobilisation of available resources (Potter & Perry, 1993; George, 1995; Mellish, Brink, & Paton, 1998; Rand Afrikaans University Department of Nursing, 2002). During the process the nurses use scientific nursing approaches which include the following:

- **Assessment**

Assessment takes place in terms of both the internal and the external environment of health, which provide reproductive health as well as community health. This assessment is conducted in order to identify those needs and problems that are hampering the facilitation of male partner involvement in reproductive health.

- **Diagnosis**

The diagnosis is formulated in terms of interpersonal relationships, interactions, the personal attributes of the stakeholders (male partner, female partner and nurses as well as significant stakeholders within

the community), resources, and the health facility infrastructures which provide the reproductive health services that are impeding the involvement of the male partner in reproductive health.

- **Planning**

All the problems and needs that have been identified and diagnosed need to be managed in order to promote the facilitation of male partner involvement in reproductive health. The researcher and a senior registered nurse, in collaboration with other stakeholders from the NGO, Line Ministry, will plan the way in which to manage the environment in order to promote male partner involvement in reproductive health.

- **Implementation**

The activities planned to manage the problems that hinder male partner involvement need to be implemented. This implementation requires active participation and involvement, not only on the part of the male and female partners, but also on the part of community members. This will assist stakeholders to realise how they could effectively mobilise those resources within the community that would influence positive perceptions of male involvement in reproductive health.

- **Evaluation**

Evaluation is essential in view of the fact that male involvement in reproductive health both constitutes a challenge and requires ongoing monitoring if male partners are to participate actively in reproductive health.

The steps of the nursing process correspond with the management process – planning, organising, directing (implementing) and control (evaluation).

1.16.2 Theoretical assumptions

Assumptions are useful in directing research decisions (Chinn & Kramer, 1991; Mouton, 1996; Tomey, 1998). Theoretical assumptions include both model and theory (Mouton & Marais, 1990). The significance of theoretical assumptions is measurable and often pronounced in the research field (Botes, 2001/01). Theoretical assumptions also include all testable statements derived from existing theories and models (Mouton & Marais, 1990). This study uses the THPN (Rand Africans University, Department of Nursing, 1999), as well as the survey list drawn up by Dickoff, James and Wiedenbach (1998).

1.16.2.1 **Definition of concepts**

The concepts to be defined in this study are derived from the work "A model to facilitate male-partner involvement in the reproductive health context in Oshikoto region in Namibia" and also from all the major stakeholders in the reproductive health services. The concepts used in this study comprise the following:

- **Male partner:** Individual who has an organ with which to produce sperm for the fertilising of the female ovum and who has a female partner with a sex organ that is capable of producing ova and/or bearing young. A male who has a female partner who is making use of reproductive health services.

- **Female partner:** Individual female partner with a sex organ that is capable of producing ova and/or bearing young. A female partner who is making use of the reproductive health services together with a male partner.

- **Reproductive health (RH):** Health refers to a state of complete physical, mental and social wellbeing – not merely the absence of disease or infirmity. Reproductive health involves the reproductive process, functions and systems at all levels (WHO 2008). Reproductive health, in this context refers to a dynamic, ongoing, interactive and interpersonal process which takes place within a real environment such as a community, district or region, and which aims at promoting and protecting the health of individuals and families through the provision of equitable, acceptable, accessible and affordable quality care by using a constellation of methods, techniques and services in order to prevent and to solve reproductive health problems. The nurse, as facilitator, is responsible for creating an environment which is conducive for the male partner to participate in the reproductive health context of the Oshikoto Region in order to enable the male partner to contribute to his own wellbeing, as well as that of his partner and family, and also the community at large (WHO, 2006).

- **Reproductive health care**: A constellation of methods, techniques and services that contribute to reproductive heath and wellbeing by preventing and solving reproductive health problems (WHO, 2008 b).

- **Facilitation:** Facilitation refers to the act of making easy or the state of being made easy or easier (American Heritage Dictionary, 2008). This indicates that the aim of facilitation is to help instil the sharing of a passionate interest in something in a group. Facilitation also helps a group to immerse itself in a common problem and to work together. On other hand, dynamic facilitation ensures that people feel safe to communicate. The aim of facilitation is to make it easier for the male to become involved in the reproductive health activities and to enable the nurse, who is a facilitator in this process, to be able to manage the process.

- **Involvement:** Involvement refers to a process whereby an individual is actively engaged and is thus able to participate actively in, for example, the planning, organising, leading and implementing of a specific phase (American Heritage Dictionary, 2007a).

- **Context:** Context refers to an environment or a region surrounding a particular place – the context or setting, structures and conditions within which an organism is able to operate or a system that enables a person to operate (Brown, 1993). In this study "context" refers to those external and internal factors and conditions that influence an individual.

1.17 CHAPTERS ARRANGEMENT

Chapter 1: Overview of the study

Chapter 2: Research designs and methods

Chapter 3: Identification of central concept by means of research findings from step 1.1

Chapter 4: Definition, classification and construction of the relationship between concepts and statement 1.2

Chapter 5: Description and evaluation of the model

Chapter 6: Guidelines in terms of which to operationalise a model

Chapter 7: Conclusions, limitations, and recommendations of the study

1.18 SUMMARY

In this chapter the background to the problem, the problem statement, and the significance, purpose and objectives of the study were discussed. The paradigmatic perspective, meta-theoretical assumptions and methodological assumptions on which the study is based were outlined.

Chapter 2 contains a comprehensive discussion of the research designs, methods of theory generation and research methodology of the study.

CHAPTER 2

RESEARCH DESIGNS AND METHODS

2.6 INTRODUCTION

The aim of chapter 2 is to describe the research design and methods used in developing a model to facilitate the involvement of the male partner in the reproductive health context in the Oshikoto region. The components of the research design and the reasoning strategies will be described first. This will be followed by a description of both the research methods which were used for the theory generation and the measures that ensured trustworthiness.

2.7 RESEARCH DESIGN

A research design refers to a set of guidelines, plans and instructions to be followed in addressing the research problem. The rationale behind a research design is to enable the researcher to anticipate the appropriate research decision in order to minimise errors and maximise the validity of the research result (Chinn & Kramer, 1991; Mouton, 1996; Babbie & Mouton, 2001).

The research strategy used in this study is the theory generative approach (Chinn & Kramer, 1991). This approach is qualitative, exploratory, descriptive and contextual in nature (Chinn & Kramer, 1995; Mouton, 1996; Burns & Grove, 1997).

2.7.1 Theory generative design

Theory generation design includes theory development and the evaluation of that theory. It is also a dynamic process of research whereby scientific knowledge is generated (Mouton, 1996). It involves a directed, creative and rigorous structuring of dominating ideas that project a tentative, purposeful and systematic view of phenomena (Chinn & Kramer, 1991). Walker and Avant (1983) state that theory development is a complex level of theorising in terms of which the researcher must deal with concept identification, statements, theories, linkages and definitions simultaneously. Dickoff and James, in Chinn and Kramer (1995), state that it is essential that nursing generate theory that will realise its practice, goal or purpose. The facilitation of male involvement in the reproductive health has, as its goal, the promotion of health.

In view of the fact that theory provides a more complete picture for practice than factual knowledge alone, Walker and Avant (1995) are of the opinion that theory provides the foundation for professional knowledge. They further distinguish between four levels of theory generation – meta-theory, grand theory, middle-range theory and practice theory.

During the current study a model was developed using practice theory, which implies that a specific goal (in this case, the management of a partnership environment in order to facilitate the involvement

of the male partner within the reproductive health context) will be explored to determine actions and guidelines with which to address this goal.

- **Practice theory**

Commitment to practice based on sound, reliable knowledge is integral to the notion of professional and practice discipline. The proponents and supporters of the development of practice theory in nursing, Dickoff *et al*. (1968), view a nursing theory as a conceptual framework that is invented by theorists for the ultimate purpose of creating situations so as to attain the desired, preferred end results. It is for this reason that the survey list of Dickoff *et al.* (1968) was adopted as a thought map in the construction and formulation of theoretical relationships between the concepts for theory development. The six elements of practice theory are as follows – the context, the agent, the recipients, the purpose, the process and the dynamics.

2.7.2 Qualitative design

A qualitative approach was adopted in order to explore and describe the perceptions of participants in respect of the involvement of male partners in the reproductive health (RH) context in the Oshikoto Health Region. This approach was chosen specifically because it is regarded as a systematic approach that would allow the researcher to explore the perceptions of the participants and their problems in totality, and it takes place within the natural setting of the different health facilities in the Oshikoto Health Region (Burns & Grove, 1993). A qualitative design was used because of its rich descriptions, data synthesis and abstraction. Thus, qualitative enquiry is a process of documentation, description, the identification of concepts and the relationships between concepts, and the creation of theoretical explanations that explain reality. The insights gained from the process guided the description of the model and the formulation of guidelines with which to operationalise the model.

2.7.3 Exploratory design

The rationale behind the selection of an exploratory design was, firstly, to determine the facts and gain insights in respect of the perceptions of male partners, female partners and nurses about male partner involvement in the RH context in the Oshikoto Region. The following questions arose:

- What should be done in order to involve the male partner in the RH context in the Oshikoto Region?
- In what way should the male partner be involved in the RH context in the Oshikoto Region?

Seaman (1987) identifies the following advantages of an exploratory design – advantages which are also relevant to this study:

- It enables the researcher to assemble a broader range of data with a richness of detail. Such data assist the researcher to develop and describe a model with which to facilitate the involvement of male partners in reproductive health. .

- It helps the researcher to view all the findings that are involved in describing and classifying the data holistically.

This study facilitated the gathering of new ideas that assisted the researcher in obtaining an overview of what was actually happening in the clinical situation of reproductive health in which the research was conducted (Mouton, 1996; De Vos, 2002). The researcher explored the perceptions of the participants at different health facilities such as clinics, health centres and the hospital in the Oshikoto health region. An extensive survey of relevant literature was undertaken and, after the identification of the concepts – categories and subcategories – the identification of the central statement (chapter 3), and the definition and classification of the concept for model description and formulation of the guidelines to operationalise such a model (chapter 4), the model was described (chapter5) and guidelines were formulated (chapter 6).

2.7.4 **Descriptive design**

Descriptions were used to gain accurate and complete information and a comprehensive understanding of the participants as well as the setting of reproductive health. A conceptual framework was described that led, in turn, to the development of the model in terms of which to facilitate the involvement of male partners in reproductive health (Burns & Grove, 1993; Brink, 2002). As a result of the descriptive design, in-depth descriptions of the identified attributes and connotations identified, the conceptual framework (context, recipient, agent, purpose and dynamics), the model (structure, process and outcomes), and the guidelines for operationalising the model emerged.

2.7.5 **Contextual design**

The aim of using a contextual design in this research was to study the perceptions of the participants in respect of their own health facilities in the Oshikoto region. This was done intentionally so as not to disturb the natural setting of the phenomenon under study. This, in turn, ensured true, valid and accurate information without the influence of external factors. This specific design also allowed the researcher to study perceptions of the phenomenon of the participation of male partners in reproductive health within a specific region, namely, the health facilities in the Oshikoto Health Region. This is indicative of the intrinsic and immediate contextual significance of the study (Mouton, 1996).

2.8 REASONING STRATEGIES

The reasoning strategies used in generating a model include inductive and deductive reasoning, synthesis, analysis, derivation, inferences, bracketing, intuition and retroduction. These strategies enabled the researcher to analyse and organise the data during the analysis of the theoretical and empirical concepts; to explore and describe the perceptions of the participants regarding the involvement of male partners in RH; to describe the conclusions and recommendations which arose from the data analysis; conceptualise the findings; and finally, to describe guidelines for the operationalisation of the model. A discussion of the reasoning strategies now follows**:**

2.8.1 **Inductive reasoning**

Inductive reasoning was adopted in step one (Chapter ch 3) – describing the perceptions of both male and female partners, and nurses. Inductive reasoning refers to a process during which the researcher argues from specific conclusions to general conclusions (Fawcett & Downs 1986; Burns & Grove, 1993, in Bandman & Bandman, 1988; Chinn & Kramer, 1991). Rossouw (2000/01) suggests that the strongest claim a researcher can make is that conclusions are likely to be either true or possible, but, nevertheless, still extremely valuable. This claim makes it possible to discover new knowledge from the knowledge that is available. Inductive reasoning was used in phase 2 during the development of categories and sub-categories; in phase 3 during the concept analysis and conceptualisation; and lastly, in step 4 during the development of the guidelines for operationalising the model

2.8.2 **Deductive reasoning**

Deductive reasoning refers to a process of developing a specific prediction from general principles (Polit & Hungler, 1995; Morse & Field, 1996; Rossouw; 2000/01). Deductive theory builds on previous knowledge and research and is available in situations in which the researcher has clearly identified the constructs and concepts from which to depart (Morse & Field, 1996). In this study the researcher used deductive reasoning to develop guidelines for operationalising the model and to describe and evaluate the model according to the principles of Chinn and Kramer (1991).

In chapter 4, practice theory, as described by Dickoff *et al.* (1968), was used deductively as the survey list – context, agent, recipient, terminus, procedure and dynamics. This survey list was used to conceptualise the central concepts, define these concepts, classify them, establish their relationship to each other and, lastly, to describe a partnership model for the facilitation of male partner involvement in RH. In chapter 6, deductive analysis was also applied to describe the guidelines for operationalising a partnership model to facilitate male partner involvement in the RH context.

2.8.3 **Synthesis**

Theory synthesis refers to a process of transforming practice-related research about phenomena of interest into an integrated whole. Such an integrated whole allows the theorist to bring together bits and pieces of knowledge in a more useful and coherent form (Walker & Avant, 2004). Theory synthesis builds on a base of *empirical evidence*. Synthesis is a scientific process which encompasses either dealing with extracts, or pulling together concepts and statements from a body of data, a set of observations or an empirical statement which has been acquired through both qualitative (synthesis) and literary approaches (Burns & Grove, 1997; Walker & Avant, 2004). In this study this reasoning strategy was used during step 1 for exploring perceptions of male partner involvement in RH, in step 2 for data analysis and the development of categories and sub-categories and in step 3 for concept analysis and for conceptualisation in chapter 4. Lastly, this process was also employed during the development of the guidelines for operationalising the model to facilitate the involvement of male partners in the reproductive health context.

2.8.4 **Analysis**

Analysis refers to the process which is aimed at clarifying or redefining existing concepts, statements and models (Morse, 1994; Morse & Field, 1996; Babbie & Mouton 2001; De Vos 2002; Walker & Avant, 2004). Analysis was used both inductively and deductively for concept analysis in step 1 of this study, as well as for concept identification, definition and classification. Analysis was also used in step 2 during the construction of theoretical relationships. The concepts and statements formed the basis for the development of a model to facilitate the involvement of male partners in RH.

2.8.5 **Derivation**

Derivation may be defined as a process in terms of which an entire set of interrelated concepts and statements is either borrowed or shared from another field, and modified to fit the theory developed. Derivation also implies that the researcher is adopting and adapting the structure to fit the concepts under consideration (Walker & Avant, 2004). After the analysis and derivation process, which involves the sifting and redefining of concepts and statements from another field, was employed. This was done in order to formulate meaningful concepts and a central statement in terms of the model for facilitating male partner involvement in reproductive health.

2.8.6 **Inferences**

Chabeli (2001, p. 41) defines inference as a process by which one proposition is arrived at and affirmed on the basis of some other proposition. During conceptualisation and the development of the model, inference was used in the exploration of literature to clarify the meaning of male partner involvement in RH (see chapter 3).

2.8.7 **Bracketing**

Bracketing is a technique used in qualitative research whereby the researcher suspends his/her everyday assumptions in order to view the processes by which the apparent concreteness of the perceptions is verified (Polit & Hungler, 1995; Gubrium & Holstein, 1997; Polit & Beck, 2004). This technique enables the researcher to deal with personal biases by "bracketing out" the self and examining his/her own prejudgement in order to become a clear receptor of the phenomenon under examination. In this study, the researcher suspended his prejudgement of what was needed to facilitate male partner involvement in RH during the data collection, the analysis, and the conceptualisation phases. Prior to each interview, the researcher wrote a full description of his own perceptions – the aim of this self-examination is to enable the researcher to gain clarity in respect of his own preconceptions. The self-examination is part of an ongoing process rather than a single, fixed event (Patton, 1990).

2.8.8 **Intuition**

The process of intuition may lead to a greater understanding on the part of the researcher of the reality that is being investigated, which, in turn, will ensure a true and accurate interpretation of the meaning

of a particular description (Streubert & Carpenter, 1995). The process of intuiting works hand in hand with bracketing, as it facilitates the description of what is being studied. It also follows the technique of bracketing. The researcher participated in the data collection, analysis and conceptualisation to ensure that no prejudice or bias arose.

2.8.9 Retroduction

Retroductive reasoning involves a logical "jump" beyond the data. It entails going beyond the evidence at hand and thinking up an explanation. This type of reasoning entails a logical inference in respect of the most appropriate explanation for perceived occurrences (Mouton, 1996). In this study, the researcher used selected interview skills and communication techniques (interpersonal attitude and interpersonal skill) in order to obtain the in-depth perceptions of participants with regards to male partner involvement in RH. This information was also used in the conceptualisation phases as well as in the development of the model.

2.9 THEORY GENERATION RESEARCH METHOD

The method of theory generation, as explained by Chinn and Kramer (1995), was adopted and utilised in the current study in order to develop and describe a model for the management of a partnership environment in which to facilitate the involvement of male partners in the RH context. In terms of this method a theory is generated within an existing framework. This study was carried out in a sequence of four steps, namely (Chinn & Kramer, 1995):

- Step 1 – Analysis of concepts
  - Step 1.1 – Identification of concepts (Chapter 3)
  - Step 1.2 – Definition and classification of concepts (Chapter 4)
- Step 2 – Construction of relationship statement(Chapter 4)
- Step 3 – Description and evaluation of model (Chapter 5)
- Step 4 – Guidelines for the operationalising of the model (Chapter 6)

2.9.1 Step1: Analysis of concepts

The first step in theory generation design involves the analysis of concepts. This takes place in two sub-steps – the identification of concepts and the definition of concepts (Chinn & Kramer, 1995). The analysis of the concepts was conducted in the following way:

2.9.1.1 Step 1.1: Identification of concepts

The first step in theory development involves identifying the concepts. The concepts to be used for the development of the model should emanate from empirical data such as life experiences or clinical practice (Chinn & Kramer, 1995). In this study the creation of the conceptual meaning led to the identification of the new concepts. This process began during the fieldwork when the researcher explored and described the perceptions of the male partners, female partners and nurses in respect of male partner involvement in RH. The data were interpreted and classified into categories and sub-

categories. Thereafter, central concepts were identified

In order to identify the concepts and statements in respect of this model, field work was conducted in the following way:

2.9.1.1.1 Preparing the fieldwork

According to Van der Waal (2000) field work in qualitative research is context bound. This means it is a method of enquiry whereby the researcher comes into direct contact with the respondents in order to collect and to analyse the data.

Despite this fact, however, the researcher undertook familiarisation tours to the health care facilities involved in the study in order to meet all the nurses and explain what would be expected of them and also to organise the venue that was to be used. Detailed preparation is vital before entering the field to conduct research. The researcher was in a fortunate position because of being a member of the community in which the research was conducted. The researcher also practises in the community as a registered male nurse which meant that he enjoyed a positive personal relationship with the participants and, specifically, with the male participants. This also meant that the researcher was familiar with the research sites.

The preparation of the participants for both the interviews and the focus group discussions was facilitated by the nurse in charge at each health facility in collaboration with both the researcher and the primary health supervisor in the district. The supervisor informed each health facility by writing a letter to each person in charge of the relevant health facilities, indicating the aim and objectives of the study as well the role of the nurse in charge with regard to the interview process.

2.9.1.1.2 Locating the field

The location of the research should first be assessed to determine if it is suitable for data collection. With the assistance of the district primary health supervisor localities where male and female partners utilise the reproductive health services which are rendered by the nurses, for example, at the hospital, the health centre and clinics, were identified. Factors such as geographical accessibility and the availability of the participants were also taken into account. After determining the location of the study the researcher considered the ethical aspects in order to guard against any violation of the principles of conducting research.

2.9.1.1.3 Ethical considerations

The ethical aspects involved in this study included permission to conduct the research; informed consent; confidentiality; anonymity; and privacy. A discussion of these ethical aspects will follow:

- **Permission to conduct the research**

The research proposal for the study was approved by the Ministry of Health and Social Services and by the University of Namibia. Permission to use the health facilities as well as the services of the nurses was obtained from the superintendent of the hospital, the district primary health supervisor for the clinic and health centre and the regional director to the Permanent Secretary of Ministry of Health and Social Services (see Annexure C).

- **Informed consent:** Written consent was obtained from the participants, who were informed of the purpose, objectives, method and duration of the study, as well as of the identity and qualifications of the researcher. They were made aware of their right to withdraw at any time. Since a tape-recorder was to be used to collect data from the participants their permission to do so was requested. The participants were assured that recorded tapes would be kept under lock and key for a period of five years after completion of the study (see Annexure A).

- **Confidentiality and anonymity:** The worth and dignity of the participants was protected at all times during the study. The instruments and methods to be used during the interviews were made known to the participants. During data collection the researcher did not, at any time, gather information illegally, for example, by taping conversations or using hidden cameras and microphones without the knowledge of the individuals concerned. All data collection methods were scrutinised to protect the privacy of the participants.

- **Right to privacy:** The worth and dignity of the participants were maintained. An invasion of an individual's privacy might cause a loss of dignity, or result in feelings of anxiety, guilt, embarrassment or shame and, hence, any such invasion of privacy was guarded against by ensuring that no information was/would be shared without the knowledge of the participants or against their will,. The instruments and methods to be used during the interviews were made known to the participants.

2.9.1.1.4 Setting

The Oshikoto Health Region consists of two district hospitals, three health centres and 13 clinics. For the purposes of this study all three of the health centres were included. One hospital and six clinics were randomly selected using a lottery method to ensure that there was an equal chance that any of the health facilities would be selected (Bless & Higson-Smith, 1995). The names of the 13 clinics were written on separate pieces of paper and the pieces of paper placed in a container. Six pieces of paper were randomly drawn out the container and the six clinics selected in this way comprised the sample of clinics to participate in the research. The same method was used in respect of the district hospitals to select one hospital to participate in the study.

2.9.1.1.5 Population

The next step involved identifying the target population in terms of participants. Registered nurses were in charge of these facilities. In this study the target population included all male and female partners attending the health facilities and all the nurses in charge (registered), including enrolled nurses of those health facilities that provided RH services in the Oshikoto Health Region in Namibia. During the study it was found that no specific data were recorded in any of the health facilities on the number of male and female partners attending the health facilities. At the time of the study 30 registered nurses were in charge of the health facilities.

2.9.1.1.6 Sample and sampling

After the health facilities had been selected, the sampling process for participants commenced. Purposive sampling was the sampling method selected for the study. In terms of a purposive sample participants are included in the study because they happen to be in the right place at the right time. The rationale for choosing purposive sampling was because it was considered the most appropriate method to address the purpose of the study and because it is useful for exploratory study (Burns & Grove, 1993).

In this study the participants were chosen by means of convenience sampling because the selection of the participants was based on the following set of criteria:

- The participants should be able to speak English, Afrikaans or Oshiwambo.
- The participant was a male in a relationship with a female partner and visiting the RP health care facility with or without the partner.
- The participant was a female in a relationship with a male partner visiting the reproductive health care facility with or without the partner.
- The participants would agree to participate on a voluntary basis.
- The participants should be in the reproductive age group of 15 to 59 years.
- Participants should have an interest in providing input into the research process (Ipinge, 2000).
- The participant was a registered or enrolled nurse working in the department in the Oshikoto Health Region.
- The participant was a nurse working in a department of reproductive health or in a programme dealing with reproductive health services.

Sampling continued until the point of data saturation.

2.9.1.1.7 Pilot study

A pilot study was conducted in order to identify unforeseen problems and to assess the feasibility of the study (Brink, 2002). This pilot study was conducted in the Oshikoto Region and four male partners from one clinic, one health centre and one hospital were interviewed individually. A female partner and a nurse from the hospital were also interviewed to ensure representation in the pilot study. The selection criteria which were indicated in 2.3.3 were also applied during the pilot study. The following research question was posed: “What are your perceptions in respect of male involvement in reproductive health?”

The problems which were identified during the pilot study were rectified. The findings and remedial action taken were as follows:

Data collection:

- The interview sessions were too long and, accordingly, probing questions need to be more focused.
- Participants attached different meanings and different interpretations to concepts such as perception and experiences despite the fact that, in the vernacular language (Oshiwambo), these concepts do have the same connotation.

Prior to the main interviews the researcher gave a detailed explanation of the meaning of the word "perception" in order to avoid the above-mentioned phenomenon.

2.9.1.1.8 Selection of data collection methods

The triangulation method for data collection was used in the study, namely, focused group discussions, individual interviews and fieldwork notes. The reason for this choice of method was twofold. Firstly, the researcher had no control over the availability of the participants at the sites on data collection days. In terms of, for example, focused group discussions a minimum of five persons are needed to conduct such a discussion and that number of participants was not always available at the health facilities that were providing reproductive health services, especially those facilities which were in rural areas. Accordingly, at certain research sites six focus group discussions were held with fewer than five participants. Stewart and Shamdasani (1990) suggest that focus groups should not be so large as to be unmanageable or to preclude adequate participation by most members. In addition, they suggest that focus groups should also not be so small as to fail to provide substantially greater coverage on the topic concerned. Secondly, the triangulation method was selected to enhance the trustworthiness of the data (Polit & Hungler, 1999). The methods used for data collection may be described as follows:

2.9.1.1.8.1 Focus group discussion

Krueger and Casey (2000), Krueger (1988) and Denzin and Lincoln (1994) define a focus group as a carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive and non-threatening environment. The researcher chose focus group interviews in order to obtain data directly from the participants, to ensure good interaction with the group, and to ensure free and adequate responses (Merton, Fiske & Kendall, 1990). The participants were selected because they all had certain characteristics in common that were related to the topic. A smaller group of four to six participants (composed of homogeneous persons) is preferable when the participants have a great deal to share, but, in general, groups are composed of six to ten participants (De Vos, 2002). A total of 16 focus group discussions were conducted.

During these focus group discussions the researcher established the ground rules in order to regulate the smooth interaction between the participants in either a non-directive or a directive manner (De Vos, 2002). Furthermore, the interviewer briefed the participants about the whole process and encouraged them to participate actively. The researcher also urged them to express themselves without fear. Sixteen focus group discussions were held with male and female partners and nurses. Each group was

conducted separately in order to maintain confidentiality, to provide the participants with the opportunity to express themselves without fear and to avoid conflict between participants, especially between the male and female partners.

2.9.1.1.8.2 In-depth interviews

An in-depth interview is a method of data collection in terms of which an interviewer obtains responses from participants during face-to-face encounters. The researcher chose this method because it is appropriate for an exploratory and descriptive study; it is also a useful method for eliciting facts from the respondents (Brink, 2002).

The researcher conducted ten individual interviews with male partners, female partners and nurses. These interviews were held in a private room in which there was no possibility of intrusive noise.

The focus group discussions and the individual interviews for male partners, female partners and nurses were conducted in the following way:

Male partners

Four focus group discussions with four participants at Clinic A, seven participants at Clinic C, 12 participants at Clinic E and 12 participants at Health Centre D. Eight individual, in-depth interview with two participants at Hospital B; one participant at Clinic C and four participants from the pilot study.

Female partners

Six focus group discussions with nine participants at Clinic A, two (one with eight participants and the other with five participants) in Hospital B, thirteen participants at Clinic C, eleven(11) participants at Health Centre D and eight participants at Clinic E. One individual, in-depth interview was held with a participant at Clinic A.

Male nurses

One focus group discussion with three participants at Hospital B

Female nurses

One individual, in-depth interview with a participant from Clinic A; six focus group discussions at Clinic A, two participants in Hospital B, two participants (ANC and PNS nurses) at Hospital B, two participants (maternity nurses) at Hospital B, two participants at (Clinic C), two participants at Health Centre D and two participants at Clinic E.

2.9.1.1.8.3 Field notes

Field notes were taken both during and after the interviews. The aim of this process is to remember

what happened during the interviews, and to incorporate and correlate this information with the tape-recorded data in order to meet the requirement of trustworthiness. Field notes also serve to supplement the data that cannot be portrayed by audio taped interviews, for example, nonverbal communication, as well as a description of the layout of the health facilities. The field notes consisted of, firstly, observational notes whereby the researcher writes down what he/she hears and sees and a description of events, which is derived from watching and listening (Wilson, 1993; De Vos, 2002) and, secondly, reflectivity notes/personal notes which include the researcher‘s reflections on his/her feelings, thoughts and experiences during the interview (Creswell 1994). The latter helps the researcher to avoid personal influences affecting the research process as these could lead to bias (Lincoln & Guba, 1985, p. 281).

2.9.1.1.9 Communication techniques/approaches during data collection

Interpersonal attitudes and skills are regarded as important during interviews and focus group discussions when obtaining relevant information from the participants without harming the participants since there may be sensitive issues involved in the subject of reproductive health.

Interpersonal attitude – the word attitude in this study refers to an orientation on the part of the researcher that communicates *care* to the participants. During the conversation there is a need to demonstrate warmth, caring and a non-judgemental understanding of the participants (Barker & Gaut, 1996). Accordingly, the basic attitudes adopted in this study include the following:

- *Congruence:* Congruence refers to the ability of the researcher, during the interview, to be aware of the way in which he/she interacts with the participants as well the ability to communicate this to the participants. This means that, during the interviews and the focus group discussion sessions, the researcher played his role in such a way that what he said to the participants and the way in which he spoke remained consistent. This consistency would help build the relationship of trust which would enable the participants to provide valid information which could then be explored and the concepts and statements described which were needed for the development of a model to involve male partners in reproductive health.

- *Acceptance:* During the interviews and focus group discussions the researcher took account of the attitude of acceptance in order to avoid making any judgements, either covert or overt, in respect of the participants. The research topic is extremely sensitive, especially in the Oshiwambo culture in terms of which men are not allowed to participate in issues which are related to women. Therefore, during conversations, the researcher did not either directly or indirectly indicate that answers were right or wrong – all answers were acceptable.

The interviewer listened carefully and considered all the verbal and nonverbal messages. He also took into account the participants’ body language, facial expression, quality and tone of voice and gestures – all of which were clearly indicated in the field notes and also in the transcription of the data. During the listening process the researcher focused on extracting the factual information that the participants were conveying (cognitive message). For example, if a female participant stated “*I wonder if I become pregnant again while I am thin like this mhh ...”* The interviewer also attempted to ascertain the feelings behind what the participants were conveying, although this could be a more difficult task

(affective messages).

The researcher also used various responsive communication techniques as tools to encourage the participants to share their perceptions during both the interviews and the focus group sessions (Becker, Radius, & Rosenstock, 1978; Kreigh & Perko, 1983; Burns & Grove, 1993):

- *Reflecting feelings* is a method of reflecting back what the participant has said. This must be done in a natural and genuinely warm way so that the participants do not perceive the researcher as monotonous and stilted (stereotyped).
- *Timing* is also important as the participants must be given sufficient opportunity to finish speaking before reflecting the perceptions of the participants. In other words, a reasonable amount of time is allowed to elapse between the time the participants have finished speaking and the researcher makes a reflection. In this way, the participants are given adequate time to hear the reflection.
- The *language and terminology* that the researcher used was simple and appropriate to both the culture of the participants and their level of education and their previous involvement with the health facilities.
- *Paraphrasing* was used by the researcher to restate the participant's message in a simple way and using fewer words, but without adding new ideas to the message.
- *Clarification* was used when the researcher was not sure of the meaning of the participant's message. Clarification with the participants enabled the researcher to ascertain that what he had heard was correct.
- *Focusing* was used to direct the conversation between the participants and the researcher in such a way that the participants focused only on the question being asked or on the topic of discussion.
- *Silence* was a means to give both the participants and the interviewer a chance to think, and also to motivate the participants to talk and to share perceptions.
- *Probing* assisted the participants to identify and explore their perceptions in such a way as to help them to engage more constructively in communication (Ipinge, 2000).

2.9.1.1.10 Data analysis

In qualitative studies data analysis occurs concurrently with data collection (Babbie & Mouton, 2001). The researcher used qualitative analysis techniques, which are used to analyse words, rather than numbers. The data analysis in this study was concerned with the theoretical and empirical data. The following steps – reading, coding, displaying, reducing and interpreting – were adopted (Ulin, Robinson, Tolley & McNeill, 2002):

- *Reading*: During this phase, the researcher started with immersion, reading and re-reading texts, and reviewing the notes with the aim of extracting the categories and subcategories.
- *Coding*: While reading the researcher started to listen for emerging categories and subcategories. During the coding process the researcher began to attach codes to those chunks of text that represented those categories and subcategories.

- *Displaying*: After coding the researcher began to explore categories and display the subcategories.
- *Reducing*: After displaying the information relevant for each category in detail the data were reduced to the essential points.
- *Interpretation*: Finally, the overall interpretations of the study findings were indicated, namely, the way in which the categories related to one another and also the way in which the network of concepts corresponded to the research questions.

This analysis was carried out in conjunction with Tech's eight steps as indicated in section 2.4.1.1.10.1.

During the data analysis, strategies such as inductive and deductive reasoning, synthesis, inferences and derivation were used (Walker & Avant, 1983; Chin & Kramer, 1995; Mouton, 1996). The data were reduced by selecting, focusing, simplifying, abstracting and transforming the information that had emerged in the writing of the field notes and the memos. The data reduction/transformation processes were repeated until the final report was completed and the conclusions drawn and verified (Ulin *et al.*, 2002).

- *Conceptualisation*: The lists of concepts were reorganised and rearranged into new categories and subcategories. This was done by using the *ethic* approach. The ethic approach implies the generalisation of data as developed by the researcher on the basis of cross-cultural knowledge and from the relevant findings which emerged from the literature study (De Vos, 1998; Ipinge, 2000; Brink 2002).

2.9.1.1.10.1 Transcription and translation of data

The tape-recorded data were transcribed verbatim by the translator (researcher). In order not to lose any meaningful information and to incorporate nonverbal data, such as the tone of voice or facial expressions, the data were transcribed soon after the interviews had taken place. Translation from vernacular expression is always challenging and it is a task which requires two-way consultation between the transcribers and translator. After the translation has been completed the transcribers and the translator come together to confirm whether what has been translated corresponds with what the participants said (Ulin *et al.,* 2002).

Two individual interviews were conducted in English and the eight individual interviews and16 focus group discussions conducted in Oshiwambo were later translated into English because the external, independent coder was not conversant with Oshiwambo.

An independent coder was used to analyse the data. Prior to the analysis of the data the coders were furnished with the aim and objectives of the study in order to enhance their focus during data analyses (see annexure G). The external coder was given the transcribed, audio-taped material of the individual, in-depth interviews and the focus group discussions together with references to Tesch's eight steps, which are used in qualitative data analysis. These eight steps include the following:

- Step 1: Read through all the transcripts carefully to obtain a sense of the whole, and jot down thoughts as they come into your mind.
- Step 2: Pick any data document from the pile and read through the document focusing on the meaning rather than the content. Jot down any thoughts in the margin of the document.
- Step 3: After reading and coding all interview documents make a list of all the concepts and group similar concepts together. Rearrange these concepts in three different columns under the headings "major", "unique" and "leftovers".
- Step 4: Revisit the data. Abbreviate the concepts as codes and write down the codes next to the appropriate segments of text. Try out this preliminary system of data organising to ascertain whether it is possible to observe the new categories.
- Step 5: Try to find the most descriptive wording for your concepts and convert into categories. Reduce the list of categories by grouping related concepts together. Capture interrelationships by drawing lines between the categories.
- Step 6: Make final decisions regarding the abbreviations for each category and alphabetise these codes.
- Step 7: When finished with coding, assemble the data material belonging to each category in one place and perform a preliminary analysis. Take note of the research questions and the purpose of the research study in order to maintain focus during the analysis. Look for commonalities, uniqueness, confusions and contradictions in the content, as well as missing information with regard to the research questions and the purpose of the research study (see attached copy of research questions and purpose of research).
- Step 8: If necessary, recode the existing data.

❑ **Identification of the main categories, categories and subcategories**

Three main categories, six categories and 12 subcategories, as well as the central concepts, were identified using Tesch's eight steps, as cited in Creswell (1998) and Ulin *et al*, (2002). The main categories, categories and subcategories are discussed in detail in chapter 3.

❑ **Identification of central concepts**

After the data analysis the data were grouped into three main categories, six categories and 12 subcategories and the central concepts were identified. The central concepts identified included "management", "partnership" and "environment". The central statement is described in full in chapter 4 by using a dictionary and subject definition in order to identify the concepts necessary for the development of the model.

2.9.1.2 Step 1.2: Definition and classification of concepts

The definition and classification of concepts comprises the second sub-step of concept analysis. This sub-step follows the identification of concepts which comprise the first sub-step, that is, the central

concept of "management of partnership environment".

2.9.1.2.1 Dictionary and subject definition

Although the central concept of "management partnership environment" has been identified, it is essential that these concepts be defined in order to avoid confusion in the process of developing the model (Chinn & Kramer, 1995). Accordingly, a dictionary and subject definition was used to clarify these concepts. This definition of the concepts was formulated in order to meet the criteria proposed by Copi (1986). These criteria include:

- Definition of the concepts:

A definition should state the essential attributes, namely

- definition must not be circular.
- definition must be neither too broad nor too narrow.
- definition must not be expressed in either ambiguous or figurative language.
- definition must not be negative if the possibility exists that it may be affirmative.

- Evaluation of criteria. The concepts identified in this study were analysed, defined and evaluated using the following criteria:

  - Concept definition should be consistent and cohesive.
  - Attributes should be identified.
  - The preconditions of the concepts should be described and demonstrated.
  - The conceptual boundaries should be delineated. This indicates the uniqueness and the maturity of the concept.

After the examination of the central concepts, criteria for each of these concepts, that is, management, partnership and environment, were identified. The criteria identified for each central concept mentioned were reduced to form both essential and related criteria.

2.9.1.2.2 Development of essential and related criteria

Criteria with similar meanings that contribute to the formulation of the concepts of "management", "partnership" and "environment" were grouped together to form a list of both essential criteria and other related criteria in (chapter 4).

2.9.1.2.3 Definition of central concepts

Following the identification of the essential and the related concept (chapter 4), the central concepts were defined.

2.4.1.2.4 Model case

The essential and related concepts formulated from the dictionary and subject definitions were used to

construct a case that represents the experiences being explored. A model case is fully discussed in chapter 4.

2.4.1.2.5 Survey list (classification of the concepts according to Dickoff *et al.*)

The classification of the concepts was carried out in accordance with the of Dickoff *et al's* survey list, that is, the context, agent, recipient, dynamic, procedure and terminus (Dickoff *et al.*, 1968).

- *Context*: In which context must the activities be carried out? The health facilities, such as clinics, health centres and hospitals, which provide reproductive services.
- *Agent*: Who performs the activities? The researcher and the nurses.
- *Recipient*: Who are the recipients of these activities? Both the male and female partners.
- *Dynamic*: What will the dynamic be?
  - Different perceptions of male involvement in reproductive health and aspects of this involvement.
  - Lack of optimum functioning of heath care delivery systems to facilitate male involvement in reproductive health (RH).
  - Lack of education, training and dissemination of information to facilitate male involvement in reproductive health.
- *Procedure*: What is the procedure? Management of partnership environment.
- *Terminus*: What will be the end product? Male involvement in reproductive health RH.

2.9.2 Step2: Construction of relationship statement

According to Mouton (1996), conceptualisation refers to both the classification and the analysis of the key concepts in a study and the way in which the research is integrated into the existing body of knowledge or into existing theory and research. Conceptualisation involves embedding or incorporating one's research into the body of knowledge that is pertinent to the research problem being addressed. The essential concepts identified in step 2 together with the data analysis in chapter 3 were conceptualised within the six elements of practice theory (Dickoff *et al.*, 1968). The researcher conducted detailed research into literature pertaining to previous theoretical and empirical work in the field and related this research study to existing literature (Mouton, 1996). Subsequently, the concepts identified were arranged according to their relationship through interrelation statements. The related statements were formulated to provide links among and between concepts (Chin & Kramer, 1991; Walker & Avant, 1998; Creswell, 1998).

2.9.3 Step3: Model description and evaluation

In this step the methods of theory generation are applied in accordance with Walker and Avant (1998), Chinn and Kramer (1991), Dickoff *et al,* (1968), Rossouw (2000/01), and Copi and Cohen (1994). The model is described according to Chinn and Kramer (1991).

2.9.3.1 An overview of the model

In this study all the elements of practice theory and their relationship statements as to the way in which to facilitate male partner involvement in reproductive health are indicated. A schematic representation illustrating the main concepts and sub concepts, and the relationship statements used to construct a model to facilitate male partner involvement i

2.9.3.2 Purpose of the model

The purpose the model is to facilitate male partner involvement in the reproductive health context.

2.9.3.3 Structure of the model

The structure of the model consists of those assumptions on which the model is based, concept definitions, relationship statements and the nature of the structure (Chinn & Kramer, 1991). The structure of the model described in chapter 5.

2.9.3.4 Process description of the model

In chapter 5 the researcher demonstrated the way in which male involvement may be facilitated by using the results of the concept analysis, the perceptions of the stakeholders, conceptualisations and rational statements to describe the methods and evaluation methods that are appropriate to the managing of the partnership environment. This process description of the model consists of five phases:

- **Phase 1:** Exploratory and situational analysis
- **Phase 2:** Establishment of the partnership
- **Phase 3:** Management process
- **Phase 4:** Maintaining the conducive environment
- **Phase 5:** Control and terminus/outcome

2.3.3.5 Evaluation and refinement of the model

The evaluation of the model was carried out in accordance with the criteria set by Walker and Avant (2004) and by Chinn and Kramer (1991) see table 2.1.

2.9.4 Step 4: Guidelines for the operationalisation of the model

Guidelines are statements that suggest or recommend professional behaviour, endeavour or conduct on the part of a practitioner. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, guidelines are inspirational in intent. The significance of guidelines is the facilitation of the continued, systematic development of professions. Guidelines help assure a higher level of professional practice. However, guidelines are not definitive and the intention is not that they take precedence over the practitioner' judgement (APA, 2002a).

Empirical data, conceptualisation, relationship statements, a conceptual framework and a model description formed the basis of the description of the guidelines for facilitating male partner involvement in reproductive health. The conceptual framework which emerged from the results of the concept analysis provided the outline for the guidelines. Both the reasoning strategies and reasoning per se, such as deductive and inductive reasoning, inference, synthesis, derivation and analysis, were used during the development of the guidelines. The guidelines were also developed on the basis of the Practice Guidelines Attributes of the American Psychological Association (APA, 2002c). These attributes include the following:

- *Respect for human rights and dignity.* Practice guidelines reflect sensitivity to cultural, individual and role differences between the health services providers and their client populations, including, but not limited to, differences arising from age, gender, race, ethnicity, national origin, religion, sexuality orientation, disability, language, and socioeconomic status (APA, 2002c).

Table 2.1: Criteria for evaluating the model according to Walker and Avant (2004) and Chinn and Kramer (1991)

Walker and Avant (2004, p. 161–173	Chinn and Kramer (1991, p. 129–137)
▪ Identify the *origins* of the theory. ▪ Examine the *meaning* of the theory. ▪ Analyse the *logical adequacy* of the theory. ▪ Determine the *usefulness* of the theory. ▪ *Parsimony.* How	▪ How clear is the model? ▪ How simple is the model? ▪ How general is the model? ▪ How accessible is the model? ▪ How important is the model?

simple and brief without sacrificing the model's content, structure or completeness. ▪ *Generalisability or transferability* of the model. ▪ Determine the *testability* of the model.	

▪ *Need.* Practice guidelines are developed for an area with a clearly demonstrated and documented need only. The guidelines should describe the impetus for endeavour. This demonstrates the need for the guidelines and their relevancy to current practice. Relevant sources of information may include demonstrated patient or client needs, practitioner demand or legal and regulatory requirements that justify the necessity for the proposed guidelines.

▪ *Delineation scope.* Practice guidelines have a clearly defined scope in terms of content, users and context. These guidelines are focused on professional practice rather than on physical or treatment protocols.

▪ *Avoidance of bias.* Practice guidelines avoid bias or the appearance of bias by documenting considerations of alternative views, providing the reasoning behind decisions and judgements, and including citations of relevant literature.

▪ *Educational value.* Practice guidelines inform practitioners, the public and other interested parties about desirable professional practice.

▪ *Internal consistency.* No part of practice guidelines should conflict with any other part in intent or application.

▪ *Flexibility.* Practice guidelines recognise the importance of professional judgement and discretion and do not unnecessarily or inappropriately limit the practitioner.

▪ *Basis.* Practice guidelines take into account the best available sources of current theory, research, and ethical and legal codes of conduct and practices.

- *Feasibility.* The implementation of the particular practice guidelines is feasible in the current practice environment.
- *Aspiration language.* Practice guidelines avoid words such as "should" and "must" because these connote mandatory intent. Such intent would be more appropriate for standards rather than guidelines. Words such as "encourage", "recommend" and "strive" connote the aspirational intent of practice guidelines and are, therefore, recommended.
- *Clarity*. Practice guidelines are clear, succinct (to the point) and unambiguous in their use of language.

In chapter 6 four guidelines for the management of a partnership environment in which to facilitate male partner involvement in reproductive health were developed. The introduction explains the aim, the objective and the activities carried out to implement such guidelines (APA, 2002a).

2.10 MEASURES TO ENSURE TRUSTWORTHINESS

Specific criteria were used in order to ensure trustworthiness. According to Babbie and Mouton (2001) and Ulin *et al*. (2002), there are important criteria or principles that guide the researcher in maintaining the true value, applicability, consistency and neutrality of the entire research process. There are four criteria in qualitative research which ensure trustworthiness. In this study these criteria were implemented as follows:

2.10.1 **Credibility**

In this study credibility was maintained through prolonged engagement, persistent observation, triangulation, referential adequacy, peer group debriefing and member checks.

Table 2.2 Criteria and application for credibility

STRATEGY	CRITERIA	APPLICATION
	Prolonged and field observation	• Researcher is a registered nurse. • The researcher has worked in maternity and in male medical and surgical wards.
	Examine the phenomenon	• Data were collected at different health

Credibility	under different circumstances	facilities such as hospital, health centres and clinics in the RH area. • The participants were male and female partners and the nurses in the RH context.
	Re-flexibility (field journal)	• Researcher's background and interest were clearly indicated. • Researcher participated fully in the research, i.e. in data collection, analysis and interpretation.
	Triangulation	• Individual interviews and focus group discussions were used in data collection. • Different literature controls were used. • Purposive and random samplings were used. • The services of three coders were used in the thematic development.
	Member checking	• Participants were debriefed at the end of each interview when necessary. • The tape recordings were played back for the participants.
	Peer examination	• The University of Namibia and the Ministry of Health and Social Services analysed the research proposal. • Faculty seminars were conducted.

	• Different experts in the nursing research field, i.e. from South African universities, were also used. • External coders were used • The model was evaluated, critiqued and commented on by different experts.
Interview techniques	• Reflecting, timing, paraphrasing, clarification, focusing, silence and probing were used during the interview. • Interpersonal attitudes such as congruency, acceptance and empathy were also employed.
Structural coherences	• Nursing meta-paradigmatic: RAU (2002) Theory for Health Promotion in Nursing (THPN). • Data analysis process: Tesch's (1990) eight steps and Ulin *et al*.'s (2002) steps for data analysis were used. • Dickoff *et al.'s* (1968) elements of theory and practice were applied.
Referential adequacy	• The researcher underwent specific training before the commencement of the research process – doctoral programme at the University of Johannesburg.

2.7.1 Transferability

Transferability was ensured through thick, descriptive, clear criteria when nominating the sample, as

well as time sampling, and a clear description of the participants based on the intensive way in which the data were collected. The researcher will also endeavour to report sufficient and precise information in response to inquiries or to the participants.

Table 2.3 Criteria and application for transferability

STRATEGY	CRITERIA	APPLICATION
Transferability	Nominate sample	• Criteria for the sample of male and female partners and nurses were identified.
	Generalisation from sample to the target population	• Data were collected until saturation to allow generalisation to the RH context in this region.
	Dense description	• The researcher provided an adequate and clear database which allowed transferability of judgement by others.

2.7.2 Dependability

Dependability was maintained through an external inquiries audit, a dense description of the research method, stepwise replication, triangulation, peer examination and code–recode procedure (Krefting 1991; Babbie & Mouton, 2001). The researcher will send the notes which emerged from the interviews and the interpretations of these notes together with the tape cassettes which were recorded during the interviews to supervisors to check whether the researcher adhered to acceptable standards in respect of the research process.

2.5.5 Confirmability

The researcher ensured the safekeeping of the recorded tape cassettes and written documents and notes from the interviews to enable the supervisor to determine whether it is possible to trace the conclusion and interpretation back to their sources and whether the conclusion and interpretation are supported by the inquiries.see table 2.5.

Table 2.4 Criteria and application for dependability

STRATEGY	CRITERIA	APPLICATION
Dependability	Dependability audit	• Peer examination was conducted. • Intense guidance on the part of supervisors. • Dense description of the methodology. • Experts in the field were consulted. • Literature controls were also carried out.
	Dense description of the research methods	• Research methods such as the nomination of the participant population, sample and sampling, data collection and analysis were clearly indicated.
	Triangulation	• Sampling, data collection and data

		analysis were also conducted.
	Peer examination	• Experts in the field were also used to critique and to comment.
	Code–recode procedure	• The services of two internal and two external coders were employed.

Table 2.5 Criteria and application for conformability

STRATEGY	CRITERIA	APPLICATION
Conformability	Conformability audit	• Researcher attended doctoral seminars throughout the study. • The researcher conducted a literature control during the study.

2.8 QUALITY OF RESEACH

Prior to conducting the study, the researcher underwent intensive training in basic and advanced research at the University of Johannesburg and passed the examination. The aim of this training was to ensure that the researcher possessed the necessary expertise in respect of the way in which quality research of a high standard should be conducted.

Prior to the commencedment of the research, approval was sought and obtained from the University of Namibia and the research committee of the Ministry of Health and Social Services in Namibia.

Three experts in the field of nursing education and another who was knowledgeable in quality research and theory generation played an important role in the research process and in the development of the model.

A panel of experts from Namibia and South Africa evaluated and refined the model. The researcher presented the model nationally and internationally in order to validate the research.

The supervisors and the researcher have approached the study honestly, and any biases and limitations will be indicated in the study. All the findings are fully reported without omitting any data, including

all the components of the research methodology. The inputs from the participants, interviews and independent coder will be acknowledged.

2.9 SUMMARY

This research is qualitative, exploratory, descriptive and contextual in nature and it includes the empirical evidence that leads to theory generation. The study was conducted in the Oshikoto Region with a population of both male and female partners and nurses taken from the RH context. Random sampling was performed to select the health care facilities to be used in the studyand convenience sampling with inclusion and exclusion criteria was used. The research process as a whole is summarised in the table below:

Table 2.6: The relationship between the level of theory generation and the research steps in the research plan

THEORY GENERATIVE LEVEL	RESEACH METHODS	REASONING STRATEGIES
Step 1: Concept analysis	**Step 1.1 Identification of concepts** ❑ **Data collection:** Data collection was as follows: • *Population*. Male partners, female partners, and nurses in the Oshikoto Region • *Sampling technique*. A purposive sample (see inclusion criteria) • *Method of data collection*. Focus group discussions and	• Inductive • Bracketing • Intuiting • Synthesis

	individual interviews • Questioning techniques were used to elicit more information from the participants • The researcher guided the interview around the research questions (Lincoln & Guba, 1985) • A pilot study conducted to assess appropriateness of the questions ❑ **Data analysis**: Qualitative analysis conducted in accordance with the following: • Tesch's eight steps (Tesch in Creswell, 1994); and Ulin *et al.* (2002) or data analysis were used. • Categories and subcategories were identified. • Central statement was formulated.	
	Step1.2 Definition and classification of concepts ❑ **Data collection:** • Results of the research from	Deductive

	step 1.1 (central statement) ❑ **Data analysis:** • Dictionary and subject definitions were studied. • Concepts classified according to the of Dickoff *et al.'s* (1968) survey list. • A model case was constructed (Chinn & Kramer, 1995) with the attributes identified.	
Step2: Construction of theoretical relationship	❑ **Data collection:** • Concepts from step 1 • Interrelationship between the concepts was established (Creswell, 1994; Walker & Avant, 1995; Chinn & Kramer, 1999). ❑ **Data analysis:** • Interrelated statements were formulated.	Synthesis
Step 3: Model description and evaluation	❑ **Data collection:** • Concepts and statements from steps 1 and 2. • Structure and process of the	Synthesis

	model described according to Chinn and Kramer (1999). • Evaluation of the model conducted according to the strategies of theory evaluation of Chinn and Kramer (1991). The services of an expert in model development were also employed. • Recommendations made.	
Step 4: Guidelines for the operationalisation of the model	Guidelines formulated to operationalise the model in education, research and practice.	Deductive

CHAPTER 3

IDENTIFICATION OF CENTRAL CONCEPTS BY MEANS OF THE RESEARCH FINDINGS FROM STEP 1.1

3.1 INTRODUCTION

Chapter 2 focused on the description of theory generative research designs and the methods used in this study. This chapter focuses on the identification of the central concepts from the esearch findings obtained in step 1.1. The chapter culminates in the description of the central statement.

One of the main objectives of this study was to explore and describe the empirical data in order to identify the concepts and the central statement that comprised one step in the development of the model for the involvement of male partners in the context. The participants consisted of the stakeholders in the process in the Oshikoto Health Region and included both male and female partners and nurses. These participants were selected by means of purposive sampling based on the inclusion criteria that had been set. The following question was formulated in order to accomplish the above-mentioned purpose.

- What are your perceptions of male partner involvement in reproductive health?

Probing questions addressed a number of issues including the reason why male partners were not involved in reproductive health, and what could be done to facilitate male partner involvement in the reproductive health context.

Data collection was conducted by means of focus group discussions (16 focused discussions) and individual interviews (10 in-depth interviews). The researcher used a tape recorder to record all the data which were transcribed verbatim. Some of the data were collected by observation. Data collection ceased when the researcher had achieved data saturation of the information on male partner involvement in RH in the Oshikoto Health Region. Quotes by various participants will be addressed.

The process of data analysis used in this study included open coding combined with conceptualisation (De Vos, 1998). Main categories, categories and subcategories were identified using the Tesch method – following Tesch's eight steps as illustrated in De Vos (1998). The central concepts were concluded from the main categories, categories and subcategories, of which the following were identified:

3.2 DISCUSSION OF MAIN CATEGORIES, CATEGORIES AND SUBCATEGORIES

In chapter 3 three main categories, six categories and twelve subcategories were identified using open coding and the conceptualisation of the data. The main categories, categories and subcategories are presented in table 3.1

Table 3.1 Main categories, categories and subcategories of data analysis

MAIN CATEGORIES	CATEGORIES AND SUBCATEGORIES
3.1 Main Category 1: Different perceptions of male involvement and factors that influence these perceptions	**3.1.1** Category 1.1: Positive and negative perceptions of male involvement in RH 3.1.1.1 Subcategory 1.1.1: Positive perceptions of male involvement in RH 3.1.1.2 Subcategory 1.1.2: Negative perceptions of male involvement in RH **3.1.2** Category 1.2: Factors that influence male involvement in RH Subcategory 1.2.1: Poor interpersonal relationships: • Negative attitude of the stakeholders • Poor communication between the stakeholders, negative attitudes • Lack of respect, secrecy, confidentiality, trust, responsibility, and support, and ignorance among the stakeholders Subcategory 1.2.2: Personal attributes: Fear Shyness and embarrassment on the part of male partners in terms of participation in RH Subcategory 1.2.3: Sociocultural barriers: Polygamous practices

	Myths in respect of male involvement in RH Gender disparity Alcohol abuse by male partner Migratory labour Household duties
3.2 Main Category 2: Lack of optimum functioning of health care delivery system to facilitate male involvement in RH.	**3.2.1** Category 2.1: Inaccessibility of health facilities that cater for RH.
	3.2.1.1 Subcategory 2.1.1: Long distances and unavailability of transport for male and female partners to attend the health facilities for RH services Subcategory 2.1.2: Higher costs involved in the RH services and treatments
	3.1.1.1 Subcategory 2.1.3: Long periods of time spent at the health facilities that provide RH services
	3.2.2 Category 2.2: Poor or inadequate management principles and structures in respect of the facilitation of male involvement in RH
	3.2.2.1 Subcategory 2.2.1: Inadequate policy and legislation in respect of male involvement in RH 3.2.2.2 Subcategory 2.2.2: Poor and inadequate building and structures housing the RH services 3.2.2.3 Subcategory 2.2.3: Inadequate human and material resources in respect of the RH services 3.2.2.4 Subcategory 2.2.4: Poor

	networking/partnerships between stakeholders and within the heath facilities that provide RH services
3.3 Main Category 3: Lack of knowledge and skills pertaining to RH	**3.3.1** Category 3.1: Lack of education and training (lack of up to date knowledge and skills) on the part of both male and female partners and the nurses **3.3.2** Category3.2: Unavailability of training and education resources to facilitate male involvement in RH

3.2.1 Main Category 1: Different perceptions of male involvement in RH and factors that influence such perceptions

Perception is defined as a process in which individuals receive and make sense of or give meaning to their environment (Runyon 1977; Zaltman & Wallemdorf, 1979; Wells, Burnett & Moriarty, 1995). A person's perceptions of another person may exert an influence on the way in which a person either accepts or rejects a certain situation (Hugh & Foley, 2007). These perceptions also allow the individual to select, organise and interpret stimuli to form a meaningful picture of the world. According to Wells *et al*. (1995) perceptions are shaped by the following three sets of influences (A2zpsychology, 2002–206): the physical characteristics of the stimuli, the relationship of the stimuli to conditions within the individual and personal traits. Factors that influence this frame of reference include learning experiences, attitude, personality and self-image. Other factors include moods or frame of mind, physical abilities, personalities and motivations, the social and physical context in which the world is perceived, the social and physical context of the stimuli being perceived (Zaltman & Wallemdorf, 1979).

This category will involve the negative and positive perceptions of male involvement and will also examine those factors that influence these perceptions.

3.2.1.1 Category 1.1: Positive and negative perceptions of male involvement in RH

This category describes both the negative and positive perceptions of the male partners, female partners and the nurses of male involvement in RH. The category may be described as follows:

3.2.1.1.1 Subcategory.1.1.1: Positive perceptions of male involvement in RH

In this study the term "perceived positively" refers to the notion that certain of the stakeholders who participated in the study supported the idea of male involvement in RH. Male partners expressed their appreciation for the fact that the study was being conducted through laughter, smiles and gestures (field

notes). They viewed the information on RH provided by the health facilities as extremely important and pertinent in terms of leading healthy lives. This was contrary to the findings of the study conducted by Robey, Thomas, Baro, Kone and Kpakpo (1998), which found that, despite testimony from the males themselves that they favoured this move of being involved in the RH, the women who had participated in the study were labouring under the misconception that male partners opposed RH services such as family planning. These misconceptions were also observed in studies conducted in sub-Saharan Africa and in the Dominican Republic. Several of the women who participated in the study of reproductive health mistakenly assumed that male partners would disapprove of reproductive services but, on further investigation, it was found that men actually approved of these services and that they would be happy to participate in the services offered (Lasee & Becker 1997). Conflicting findings regarding the perceptions of female partners that men are indifferent towards RH services were also highlighted by Best (1998) who showed that, on the contrary, men are interested in RH.

Male partner participants:

Many of the male participants interviewed were of the opinion that the information provided by the health care facilities was relevant, especially in light of the importance that the Namibian government is placing both on health in general and on the negative effects of the AIDS pandemic on the future of communities in particular. This notion was supported by the male partner participants. They expressed their perceptions of the availability of information in the following ways:

"*It is important to us males, to be assisted to do things in a correct way."*

Furthermore, the male participants (male partners) indicated their gratitude and their appreciation for their inclusion in the research, especially in light of their perceptions of their past. One of the male participants in Health Centre B stated:

"… *We would like to be present or participate but nobody will allow you."*

"*It is a good move indeed."*

The data collected also indicated that the male partners had a positive perception of RH because they expressed their belief that being part of the process of RH could be beneficial for both their families and themselves. The male partner participants expected to acquire skills, understanding and information on how to take care of their own health, as well as the health of their partners and families. As regards the benefits of RH one male partner expressed himself as follows:

"*It's a good thing, indeed, and it will assist us in many ways, we will assist the family because it is part of family investment and. it will avoid possible disability."*

In another individual interview a male partner revealed that he saw RH as an opportunity to take part in family matters and contribute to the wellbeing of the nation. He stated: "*It will foster the relationship with my partner, and more understanding and responsibility of what my partner expects of me*."

"*It will contribute, not only to the development of the country, but also to the development of the health system."*

Despite the fact that information on RH had often been distributed it would appear that male partners had been under the perception that they were not involved, which, in turn had contributed to their overall impression that they were not needed in the process. Best (1998) identified this same belief when his research participants stated that, in view of the fact that traditional RH services viewed women as their primary clients, the result was that the healthcare provider had made little effort to consider the RH needs of male partners. However, the findings in this current study indicate that male partners do realise the importance of their involvement in the RH context and that they are willing to take responsibility for ensuring the wellbeing of their wives, children and family units. One of the male partners expressed this sentiment as follow:

"*Reproductive health should get us involved with our children and female partner, so that we could work in a good faith and ideas that will assist men not to work in bad mood."*

"*Because, you only discover that your wife is pregnant, but you don't know about the complications involved … we are longing to attend to such things."*

"*To be closer to your wife while she is delivering, it's really a good thing and really needed, so that you could go forward, and being there for one another."*

The in-depth interview with a male partner in Hospital B revealed the following perceptions:

"*It will assist families, because it's part of the family's investment."*

"*So within this information will assist the family."*

"*In case of a child getting sick, if it is possible should be taken by two people to the hospital (father and mother)."*

In conclusion, the above data has revealed a willingness on the part of male partners to be involved in the RH context. Nevertheless, there is a lack of openness between stakeholders.

Female partner participants:

During the focus interviews female partners gave the impression (field notes) that they had already involved their male partners in the RH process. This is contrary to findings in studies conducted by Robey *et al.* (1998), Biddlecom *et al*. (1997), and Salway, (1994), which indicate that female partners were under the impression that their male partners would disapprove and that they would decline to

participate in the RH process.

It would appear that female partner participants in this study perceived that the participation of men in the process would empower the men with the necessary information on RH and that this, in turn, would enable male partners to assume their responsibilities in taking care of their families. Female partner participants welcomed the fact that they would be sharing responsibility, and that they would be supported when visiting the RH facility. It was also deduced from the female partner participants that, should the male partners be able to take part in the process, it would increase their level of understanding in respect of their own health as well of that of their partners and their siblings.

Female participants expressed their perceptions of male partner involvement as follows:

"*We will be happy if our partners partake."*

"*… as we want men also to take part in matters related to child grooming."*

In conclusion, it would appear that the female partner participants were of the opinion that the participation and involvement of their male partners in RH could assist the male partners in assuming their responsibilities and increasing the level of their understanding of reproductive health.

Nurse participants:

Nurses from the health facilities acknowledged the importance of male partner involvement in RH. They stated**:**

"*It's a good thing really …"*

"*It is important for male partners to participate in RH."*

"*I hope it's a brilliant idea to carry out such a task, because it will be" useful."*

Furthermore, nurse participants believed that the involvement of men would also encourage men to seek proper information on family planning and, thus, prevent unwanted pregnancies. In this respect, one participant from clinic A stated the following in her individual interview:

"*Because by involving them (male partner) the child which is going to be born it will be looked after as from conception until birth."*

In this study the nurse participants were concerned about the advent of the AIDS pandemic and they suggested that, if both partners were involved in the RH process, it would be easier to start treatment for both spouses should HIV/AIDS be confirmed. Participants in a focus group from Hospital B stated the following

"*It will make easy to men and women to be conscious about their own reproductive wellbeing, whereby it is not regarded as a one-sided effort on the part of women, but collective effort where all partners are fully involved."*

"*It is good indeed for them to be examined together and receive our treatment together."*

In conclusion, in view of the fact that the nurses are extremely aware of the importance of RH, they were all very much in favour of male involvement. Accordingly, nurses could play a vital role in facilitating male partner involvement in RH.

The data analysis of the subcategory on positive perceptions in respect of male partner involvement indicated that both male and female partners showed a willingness to be involved in RH. The nurses were also in support of the participation of male partners. However, one of the problems observed in the study was that both the male and female partners, as well as the nurses, revealed a lack openness in discussing RH matters with each other. This would indicate that all the participants in this study have realised the importance of male partner involvement in RH, thus emphasising the fact that male partners should enter into a partnership with their female partners. Hence, assisting nurses to improve their current knowledge of RH and then to communicate this knowledge may encourage male and

female partners to participate in RH, as health education on various topics in respect of RH could bring about a change in the participation of male partners in RH. In addition, the Ministry of Health and Social Services has realised the importance of the *process* of male involvement in RH since many Namibians have multiple sexual partners, and the prevalence of STIs increases the risk of transmission. The abuse of alcohol in Namibia also exacerbates the situation because male partners may lose control when intoxicated, which this makes people more prone to risky behaviour and sexual abuse (Republic of Namibia: National Policy on HIV/AIDS, 2007). The involvement of male partners in RH could make it easier to avoid this type of behaviour, but this would be possible only if male partners were equipped with knowledge and skills in respect of the RH services.

3.2.1.1.2 Subcategory 1.1.2: Negative perceptions of male involvement in RH

Negative perceptions in this study refer to a state of being against the idea of involving male partners in RH. Such negative perceptions were observed in a few of the male partner participants. It appeared as if certain of the male partner participants were uncomfortable with male involvement in RH because they perceived RH as being a female activity and, if they chose to participate in this "female activity", they were afraid that they would be labelled as abnormal/feminine. One the male participants expressed himself as follows:

"*It is insane because they will think that my head is not functioning well."*

There were also indications that the perceptions of male participants in respect of the postnatal care environment were similar. Some of the male participants expressed the following sentiments:

"*Post Natal Care (PNC) (silent) as something just for women."*
"*I don't feel proud at a place where women are."*
"*… a place for women and us men are not important here."*
"*Men never come to this place even when their staffs are filled with women."*
"*Women at the ANC department will look at me with big eyes, because I am at their place."*

Nevertheless, some of male partner participants indicated that the reasons why they had not visited the department or centre (health facilities providing RH) could be attributed to ignorance, and inadequate information and education, which could, in turn, contribute to their lack of knowledge or understanding

about the RH context in particular. This was expressed as follow:

"*If we had enough information we would attend."*

"*If we are given such an opportunity …"*

"*If I get correct information, like how to plan my children so that it is not always the responsibility of a woman to … plan the family."*

The above findings indicate ignorance on the part of male partners and this reluctance to take *ownership* of the programme arises from a lack of information on RH and a feeling of not being empowered in the process of partnership. Nurses indicated their disappointment at the lack of male partners who participated in RH services. It is, thus, obvious that the involvement of male partners is essential in this regard (AVC international, 1997). Best (1998) assumes that male partners may, originally, have had a positive attitude towards these services but that the service providers themselves made little attempt to consider and to support the RH needs of men, which resulted in fewer male partners attending the clinics. The words of an individual nurse from clinic C support this view:

"*What I have observed in our department, I noticed that male partners they are not participating actively and their attendance is very poor."*

In the subcategory of rejection of male partner involvement the findings indicated that male and female partners should both be the *owners* in terms of their roles in RH. The nurses should be sufficiently *knowledgeable* to provide partners with the correct information and this should take place in a *supportive environment* in order to *empower* male partners to become *involved* in RH. In other words, male partners should be the *partners* of their female partners and nurses. This process would be facilitated by increased *collaboration and partnership* between the stakeholders, which, in turn, would be possible only through good *networking*. The nurse should *facilitate* this process.

3.2.1.2 Category 1.2: Factors that influence male partner involvement in health

This category consists of three subcategories, namely, poor interpersonal relationships, personal attributes and sociocultural barriers. These subcategories and their attributes may be described in the following way:

3.2.1.2.1 Subcategory 1.2.1: Poor interpersonal relationship between the stakeholders

Interpersonal relationships in this study refer to the relationships between the male and female partners and the nurses within the RH context. It is possible to observe these interpersonal relationships in situations where the clients are in the process of receiving the services or when nurses are rendering these services to clients. However, in this study participants (male partner, female partner and the

nurse) felt that this relationship is not strong, thus the male partner should also be involved in the RH relationship. Basford and Slaving (1995) suggest that, in order for nurses to understand and to meet the needs and perceptions of their clients, the nurses need to possess special interpersonal skills such as communication, empathy and sensitivity.

In addition to the above-mentioned theory, the responses of the participants (empirical data) indicated that the interpersonal relationship between client and nurse might alter their perceptions of one another. In the interpersonal relationship subcategory the following categories emerged, namely, attitude; poor communication; fear, shyness and embarrassment; and a lack of secrecy, confidentiality and trust. The participants perceived the latter issue as playing a significant role in the relationship required to facilitate male involvement in RH.

A negative attitude was identified in terms of male partners towards both the female partners and the nurses, and in terms of the nurses towards the male partners

Attitude is described as the way in which a person thinks or behaves towards something (Collins Pocket Dictionary, 1994). In this study, attitude refers to the way in which the stakeholders – males, females and nurses – think or behave about the involvement of the male partner in RH. These attitudes may either be negative or positive in nature.Negative attitudes on the part of the stakeholders were observed in many of the participants' responses, particularly in the male partners. Although no in-depth study has been carried out to determine the relationship between attitude and culture, it would, nevertheless, appear that these negative attitude problems emanate from culture. The negative attitude on the part of the male partners stems from the fact that the males tend to make all decisions autocratically in the home, and this dominant behaviour results in their wives being inferior and more dependent on their husbands (Odetola & Ademola, 1994; Gorgen, Yansane, Marx & Millimounou, 1998). This predisposition to a negative attitude is also confirmed by Jackson (2002) who indicates that attitude is a product of gender inequity and inequality which, in turn, comes about as a result of culture. Evidence of negative attitudes emerged from the following responses of male participants:

"*(Laughs) are you implying that I should accompany my wife when she goes to the hospital?"*

"*There is no need for the male partner to accompany her to a clinic or a hospital."*

"*I will just drop her off at the ANC and then go and walk around, than I will come back to see if she is done so that we can go home."*

"*… It's going to be or look a bit funny by being there with my wife amongst women at the women's department (griming smile on his face) even the women."*

"*… it would not be a good portray of me as a man."*

"*People are now becoming gay because of the women, so I am also waiting to become a gay or "moffie" which impossible."*

Negative attitudes not only prevailed (observed) between the male and female partners, but also emerged in respect of the nurses. Negative attitudes on the part of nurses are a source of immense concern in Namibia and they may have played a role in the failure of male partners to participate and be involved in RH.

The following comments from the male partners bear testimony to this fact:

"*Nurses shout at their clients."*

"*Nurses they don't have manners".*

A male partner participant perceived that he w*as not welcome at the health facility.* "*They will say even there is something wrong with me."* He further assumed that his presence made his female partner feel uncomfortable in the front of the nurse. She herself stated that the nurses had said: "*So they will ask themselves ... what does this men want or what is his aim and he is not even a health worker?"*

These negative attitudes in stakeholders, especially in respect of male partner involvement in the RH contact, are regarded as playing a role in the global spread of reproductive diseases such as HIV/AIDS (Jackson, 2002). The prevalence of such attitudes in terms of reproductive diseases such as HIV/AIDS is confirmed in many of the studies that have been conducted in Africa, Europe and Asia. Stanhope and Lancaster (1996) found that positive or negative attitudes on the part of male partners, in conjunction with RH services, vary from country to country and are shaped by several other factors such as age, the environment and socioeconomic circumstances. These factors could significantly influence male partner attitudes, and perceptions as well as understandings in respect of the male partner's own heath. Age and geographic factors were also observed as playing a role in RH (Roudi & Ashford, 2004) and support the sentiment that young men are more interested in RH than is commonly believed and that men in the developed countries are more interested in RH than those in developing countries.

This finding is borne out by the fact that, in the Oshikoto Region, negative attitudes on the part of stakeholders, for example the nurses, are to a large extent affected by the inefficient distribution of resources. These factors will be discussed under category 3. Age, education and geographic location were also identified as contributory factors in the Oshikoto Region. This stems from the fact that senior citizens, illiterate people and those who live in the rural areas tend to manifest negative attitudes towards RH as compared to the young, the educated and those people who live in the city (Ezeh, Seroussi & Raggers, 1996; Hughes & McCauley, 1998; Roudi & Ashford 2004).

A study conducted in Cameroon and Senegal indicated that younger men are more supportive and approve more of family planning than older men. Men who are more highly educated are also more likely to approve of family planning than the less well educated. This study revealed that 25% of male partners with no education approved of family planning compared with 75% of male partners with education that approved family planning (Hulton & Falkingham, 1996; Handelsman, 1995; Bertrand, Makani, Edwards, Baughman, Niwembo & Djunghu, 1996).

The field notes from this study show that those male partners who live in the rural areas and are probably less educated manifest more negative attitudes compared to those male partners who live in the suburbs and are well educated. In confirmation of this assertion one of the participants (a farmer) from a rural area stated: "*I am not feeling proud at all, simply because this place is for women, I am saying that it would not be a good portrayal of men, people are now becoming gay because of the women, so I am also waiting to be a gay. Me, myself to be interested in this* (laughing and clapping hands in complete dismay), *you must be joking*."

However, another participant who was a school teacher maintained: "*Male should participate in such matter, for example, when their female partner is pregnant, it is correct*." It is, thus, possible to conclude that education does play an important role in the attitudes of the male partners attending RH facilities.

A positive attitude in respect of male involvement in RH may be attained only if there are changes in, for example, gender stereotypes, and through the creation of gender equity and gender equality. This would be possible only through the empowerment of stakeholders by imparting knowledge and skills in terms of RH.

(a) Poor communication between the stakeholders

Communication may be described as the process of exchanging meaning between individuals through a common system and common symbols – a process whereby meaning is assigned and conveyed in an attempt to create a shared understanding (Merriam-Webster, 2007). Communication requires a vast repertoire of skills in both intrapersonal and interpersonal processing, listening, observing, speaking, questioning, analysing and evaluation (Andrews & Herschel, 1996; Armstrong, 1997).

Hence, communication is the key to accurate perception and it is also a tool with which to promote behavioural change (Robey et al., 1998). A major problem which emerged from the responses of the participants was poor communication between the partners themselves and also between the nurses and the partners. The improvement of couple or spousal communication would be a crucial step towards enhancing male partner participation in RH because this would assist male partners in gaining an understanding of the attitudes of other people (Biddlecom et al., 1996). Lasee and Becker (1997) support the notion that the research which has been conducted over the last 40 years has demonstrated that both men and women who possess communication skills are likely to use contraception. Thus communication is seen as an essential tool in facilitating male partner involvement in RH.

Communication between nurses and clients is essential for establishing and maintaining a flow of information. This study indicated that poor communication between the male and female partners and the nurses could be one of the factors hindering male involvement in RH (Basford & Slaving, 1995).

Communication may be regarded as an important facet of the relationships under investigation here, because it takes place between both the male and female partners and the nurse partners (male and

female). It is clearly important that this interpersonal relationship be maintained. It was possible to observe communication in terms of interpersonal relationships in situations in which the clients were making use of the RH services, in which the nurses were rendering the services to the clients, or in situations between the male and female partners. Good communication between the partners is regarded as crucial for male partner participation in RH. According to research conducted over more than forty years men and woman who discuss reproductive issues are more likely to use RH services (Lasee & Barker, 1997). Barker and Gaut (1996) suggest that communication, either verbal or nonverbal, requires the following:

- A conducive context (environment) and system that is favourable for communication processes, such as the encoder sending the message, or the message being received and understood by the receiver.
- A channel of communication for the message to be sent by the encoder (nurse) to reach the receiver or decoder (male or female partner), and the receiver(s) and decoder(s) to receive and interpret the message correctly, and to provide feedback (positive or negative).

The nurses who were facilitating the communication indicated that they did not possess adequate knowledge and skills to train or educate male partners to participate in the RH services. Some revealed that they may have possessed the necessary information on reproductive health while others were not sure what information to convey. One may assume that this could be the result of either a lack of, or unsuitable, training for the nurses. The nurses who participated in the sample clinic indicated:

"*We did not get training which included RH, for men to participate and how to attract males to attend to ante natal care and follow up."*

"*In our training as nurses, we were not taught how to work with males, especially in this regard (RH)."*

"*Require skills to be able to encourage men, more especially those who are a bit cruel or harsh towards their partners."*

"*We, ourselves, lack these skills of attracting men to come to RH centre, as this was not part of our training."*

"*As we did not have skills in this regard."*

The *message* (male partner involvement in RH) was not clear to the nurses and, therefore, not to the male partners. Nurses were supposed to know about male partner involvement but they claimed that they were not sufficiently empowered to deliver the message. This may be the result of a lack of policies or guidelines on RH that explicitly describe the structures, processes and outcome of RH. The following statements from nurse participants endorse this assertion:

"*We need policies in place."*

"*There should be straightforward policy in place …"*

"*I am just saying, should the policy be there to assist men, maybe I am having problems which were*

detected by the doctor and instructed that I have to share such problems with my husband, and eventually bring him along to the hospital."

"*We do have a programme which is about RH and sexuality, but we are requesting that, if it is possible for a special programme to be prepared, to be given information directly targeting men, and encouraging them to accompanying their partners."*

To conclude, for the message to reach the participants there should be a policy in place that would facilitate the entire communication process regarding male involvement in general or specifically on issues relating to RH. These policies could either be for the nurse (service provider) or for female partner to deliver the message to the male partner.

The *receiver or decoder* (male and female partner) possesses attitudes which are shaped by culture and a limited understanding. Age, environment and education were among the issues identified that could influence male partners in whether they received either positive or negative messages.

The *feedback,* either from the nurse or from the client, was always negative or ambiguous, but never constructive. The feedback observed was twofold: Participants perceived male involvement as a positive contribution to their wellbeing (subcategory: acceptance of male involvement) while some of the male participants viewed it as disgusting and as inappropriate male behaviour (theme: gender disparity). This may result from a lack of knowledge and understanding about the benefits of the programme, or from the influence exerted by attitude, gender and culture. The latter may be regarded as issues that hinder communication among men with regard to RH. Mabote (2003, p. 26) observes that this lack of communication may stem from the nature of man, as men perceive themselves as strong, independent and unlikely to ask for help, and they are uneasy when discussing anything related to sexual problems. The researcher believes that the most severe stumbling block occurs as a result of the fact that male partners apparently do not feel the need to be nurtured by another, especially their female partners. This could, in turn, hinder the process of males contributing within the RH context.

Context (RH facilities which should be conducive to male partner involvement and meant for female partners but in reality are not.)

- The environment refers to health centres, clinics and hospitals that are built in such a way as to cater for the needs of females and children only despite the fact that they should also facilitate the inclusion of male partners. The major problem appears to be a lack of privacy which is important as RH deals with private matters.

- Shortage of staff to facilitate the process and to convey the messages. The facilitators of the message, namely, the nurses, are mainly female and as a result of personal preferences which stem from sociocultural influences, male partners often do not trust them.

- Inadequate material, such as posters, to convey the message (field notes)

The above perspective is supported by Roudi and Ashford (2004) who highlight the lack of appropriate strategies with which to talk about and demonstrate RH issues. For instance, in most of the health

facilities there is very little demonstration material with which to explain contraception. The health facilities in which the message is delivered are meant for women and even the people conveying the message are generally female. This is a problem especially in terms of the Oshiwambo or African culture in which men are not supposed to listen to women. The male partner perceives that a message coming from a woman does not carry as much weight as it would if it were to come from a man and, even in terms of the acceptability of the messages themselves, men tend to accept things from other men more readily than from women. Accordingly, all the participants – nurses, male partners and female partners – suggested having at least one male nurse at each health facility for the purposes of conveying messages to male partners. This would, in turn, encourage male partners to accept and make use of the services.

The system (Ministry of Health and Social Services and its health facilities and policies) does not clearly specify possible ways in which to reach the male and his partner in order to promote the involvement of the targeted group of male partners in RH services. It is unclear whether the Ministry of Health and Social Services does have policies in place for dealing with the involvement of male partners in the RH services of Namibia. Currently, the system is experiencing shortages in terms of both human and material resources.

Communication between nurses and clients may be both verbal and nonverbal. This interpersonal communication plays a vital role and is essential in the establishment, maintenance and building of a relationship of trust between nurse and client (Basford & Slaving, 1995). Poor communication was identified as a problem by all the participants, with claims that the nurses who play a primary and significant role in the facilitation of the process of involving male partners in the RH context do not communicate well with their clients. It was claimed that the nurses do not respect their clients. This poor communication constitutes a barrier in all the facilities providing RH services.

In his field notes, the researcher noted that “caring” is one of the components of nursing, with touching representing a form of nonverbal communication. Issues regarding caring were observed in all the

facilities in which the interviews were conducted. Communication may be regarded as an important issue especially in respect of the involvement of male partners in the RH context. Poor communication on the part of the nurses could result in male partners either not attending the facilities or else neglecting to seek medical attention. This could also result in male partners ignoring information in respect of treatments pertaining to RH.

On the other hand, a male partner participant mentioned that the "generally poor communication of the nurse" could also be triggered by factors such as a lack of human and material resources, unfavourable working conditions and a shortage of staff. Nurses are frequently required to treat several clients at the same time and there is often little or no recognition of what the nurses are doing. This resource problem could also result in nurses using their clients as the targets for their frustration and anger, instead of communicating with their clients with empathy and sensitivity

In order to overcome the problem of poor communication, Basford and Slaving (1995) suggest that nurses, as the agents in health care systems, should have the interpersonal skills needed to facilitate this partnership relationship. These interpersonal skills include trust, empathy and sensitivity.

Empathy and sensitivity involve the sharing of a client's feelings in a given situation, while sensitivity embraces the human emotion of empathy along with the anticipation of need. However, in this study the nurses who are playing a vital role in facilitating these processes seem, on the whole, to lack these interpersonal skills. The participants, especially the male partners, were of the opinion that nurses do not handle their RH issues with either empathy or sensitivity. This tends to discourage men from involving themselves fully in the RH services at the respective health facilities (Basford & Slaving 1995).

(b) Lack of respect, secrecy, confidentiality, trust, responsibility and support, as well as ignorance among the stakeholders

Poor observance of ethics and human rights by nurses and between partners were among the issues which were raised by the participants as playing a role in the refusal of men to be involved in the RH context.

This lack of ethical behaviour is not only a problem in those facilities that provide RH services; there is a national outcry against the fact that nurses behave unacceptably and unprofessionally towards their clients. For example, it was stated over the radio, in the newspapers and in all the media across the country that nurses shout, are disrespectful towards their clients and, most seriously, that they are abandoning their professionalism and ethics because they divulge confidential issues relating to clients in public. This unethical behaviour (lack of confidentiality, lack of support and secrecy) has a negative effect on the psychological wellbeing of the male partners.

Ethical factors include the lack of respect and confidentiality of nurses in respect of male partners, ignorance or selfishness on the part of both the male partners and the nurses in RH issues, a lack of responsibility on the part of both male and female partners and nurses as regards RH issues, a lack of

confidentiality among female partners and nurses in terms of RH issues and a lack of support among the stakeholders in the RH services.

- Lack of respect:

Respect may be expressed by displaying appreciation, interest, encouragement, concern, trust and consolation. However, in this study the participants indicated that respect is lacking in those health facilities that provide RH services (Basford & Slaving, 1995, p. 539). For instance, the male partners felt that they were not respected by the nurses when receiving treatment while the nurses were of the opinion that the male partners did not appreciate their services. One nurse participant expressed the following

"*Male partner does not have respect."*

"*As he will regard it as a testimony that male do not have any respect for them."*

A male respondent indicated a lack of respect on the part of nurses in the following response:

"*With no respects, as you see a nurse walking in a corridor, from inside, coming to you are visiting someone, they would only say that it's not yet a time and sometime they just look at you without telling you anything."*

A female participant indicated a lack of respect on the part of her male partner with the following words:

"*Once he comes back home from the Cuca shops, he asks you, why you did not take the child to the hospital, as if he did give you money for treatment"*

- Lack of trust:

The word "trust" also denotes trusting (an admission of dependency on the part of the person involved) and trustworthiness (acceptance of an obligation not to exploit control in an interpersonal relationship (Barker & Gaut, 1996). Male partners did not trust the nurses as they exhibited a lack of confidentiality, that is, that they discuss people's illnesses with other community members. "*So that's why we usually twist facts that I am even having feet pain with a fear that if he reveals her really illness nurses will divulge this to people."*

One of the other male participants expressed the following: "*What I have noticed ... I do not trust them and they are going to blame/charge him."*

This lack of trust on the part of the male partners towards the nurses was also confirmed by the nurse participants themselves with the following statement: "*Yes, they do not trust us, you explain everything to them but they are not listening and they do have some hesitation."*

- Lack of confidentiality

Confidentiality may be defined as a situation in which you are expected to keep information secret (*Compact Oxford Dictionary*, 2007). Male partner participants were of the opinion that a lack of confidentiality (secrecy) and support from both their partners and the nurses were among the issues affecting their involvement in the RH process. They emphasised that for them to attend programmes of this nature these ethical issues should be addressed and that loopholes in the system should be attended to.

According to the male partners, they perceived that female nurses have a tendency to "*broadcast their diseases to other people in the community",* namely, issues related to the RH process. In this regard some of the participants expressed their concerns as follows

"*What I have noticed male partners they do not like to be treated by the female nurses, due to facts that nurses will spread the news that he/she has seen with particular person for such disease so."*

"*Nurses talk about patient problem."*

"*Nurse in hospital will report X mother Y male patient was seen at the hospital X."*

"*She will spread the news that she has seen a particular patient for with such diseases."*

In some cases, male partners indicated that they opt to attend other health care facilities away from their own towns or villages, with the sole purpose of being examined by a person who does not know them in order to avoid the dissemination of confidential information to third parties. One of the participants also indicated the fact that male partners have a tendency to seek treatment in health facilities in other regions or away from people they know. Participants stated in this regard:

"*You would find this person getting treatment at A health facility or B facility where he is not known."*

"*Nurses do not keep secrets."*

"*They hardly retained confidentiality and this attitude prevents us to come."*

"*The big obstacles which prevent us are female nurses who divulge others' secrets."*

"*Which is the testimony that female nurses divulge men's secrets?"*

"*The main problem are female health workers, a woman is just like small kids, once she hears something, will be divulged."*

In order to solve this problem one of the participants suggested the following: "*They should establish private places at the clinics for us men only as we have indicated it already that, as men, we would be*

able to discuss our male related problems very freely, even I am sick at my private parts, I would be able to discuss that with my fellow men and that freedom to go to the hospital."

Female partner participants:

In respect of the female partners these issues of irresponsibility, ignorance, lack of respect and support, and lack of confidentiality on the part of female partners and nurses towards male partners, were also expressed in a female focus interview as having impacted on or made it difficult for nurses and female partners to attract male partners to the RH programme. In this regard some female partners expressed the following:

"*Myself I do not feeling well because of men who are impregnating us and later they do not accept the responsibility…." (Irresponsibility)*

"*Men leave this responsibility to the women alone."*

"*Because if they think it's not their duties to do so, it's solely a woman's responsibility" (ignorance).*

"*Husband is just there for travelling" (lack of respect).*

"*I understand it this way that men do not really come to hospital if a child is sick."*

- Lack of support:

In terms of a lack of support the female partners continued by saying: "*What I want to say, is there no assistant to assist my husband for us to have a baby?"; "Because up to now we did not get anybody to assist us"; "Yes, we do not have kids and I am having a problem, because the people in the community they gossiping about me that I do not have a baby (she starts crying); "Yes we try several times and I was at the gynaecology and nothing has happened"; "Me and my husband we visited the clinic for the investigation and the doctor diagnosed my husband with lower sperm count. But my husband do not eager to go for follow ups and always blames me that I am a useless woman and sometimes he beats me and chased me way from the house."*

Nurse participants:

In terms of the lack of confidentiality, the nurse participants indicated that it could be a problem for male partners to participate in the RH process because nurses have a tendency to divulge clients' health information. They also indicated that the reason why male partners tend not to participate in the RH process is because the majority of nurses and health caregivers are female. Men believe that, in general, women gossip and do not respect confidentiality. As a result, men choose not to come to the health facilities in order to avoid being embarrassed and humiliated by the nurses. They expressed these sentiments in the following ways:

"*Because nurses talk (forget that he is also a nurse) about client problems"; "But we did not have an opportunity to deliver the information, but when we get a chance"; "Nurses in the hospital know them also in and out, this worsens the situation … will report to X's mother that Y was seen at the hospital with X"; "Means, nurses you divulge your clients' illness to other people?";"She/he will spread the news that he/she has seen a particular person for such disease so."*

In conclusion, client/nurse-confidentiality, respect, commitment and responsibility are important factors which may help male partners to involve themselves actively in RH services (Helzener, 1996).

3.2.1.2.2 Subcategory 1.2.2: Personal attributes of male partners

Emotional aspects such as fear, shyness and embarrassment are some of the main issues that were raised by the majority of participants as negatively affecting male partner involvement in RH services. As stated, these emotional factors include:

- Fear

The fear of coming to a hospital for treatment, of being diagnosed with HIV/AIDS, or that their disease or problem could become widely known as result of a lack of confidentiality on the part of health workers; feelings of insecurity at the place where female partners were being treated; or the fear of being attacked by the enemy (participants were referring to the war-torn past) were among the issues raised by the male participants. These issues could all comprise major stumbling blocks for male partner involvement in the RH context. In this respect one participant expressed himself as follows:

"*I fear to come to hospital."*

One male partner participant felt that fear is one of the issues that might contribute to the poor involvement in the RH context. There is the belief or fear that nurses do not keep confidential information to themselves; as one partner said: "*They are going to tell my wife."*

"*What other men going to say if they see me here?"*

"*ANC – it is a place for woman."*

Female partner participants were of the opinion that male partners feared the unknown – being tested and diagnosed with diseases such as HIV/AIDS and being rejected by their partners should they find out that they had contracted an STD. These sentiments were expressed in several ways:

"*I think what gave men fear of going to the hospital, they are afraid of being diagnosed and tested."*

"*Some men are afraid to test HIV positive or gonorrhoea."*

"*Injection (shot) that's aggravating fear in him."*

"*Some have multiple sexual partners and know that their wives are faithful to them." "When he asked to go for a blood test, in times of pregnancy."*

"*He is likely to deny because he is afraid of the possibility that the married wife will leave him."*

Nurse participants agreed that the fear of the unknown is common in male partners, and indicated that men were both "*afraid to be diagnosed with any diseases"* and also of "*the thought of their faithful*

partner leaving them", should the male partner be diagnosed with a disease.

Other issues include the fear of going to hospital to be diagnosed with HIV because the majority of the male partners do have multiple sexual partners. Attending a hospital constituted a problem for these participants as they could be found out.

"*I think what gave men fear of going to the hospital, they afraid of being diagnosed and tested."*

"*Some people are attending and what you have to know is that the African men are like that because in some cases he is having more than two partners and having that fear of going to the hospital thinking that he will get more problems."*

"*In that case the disease can spread in that way, when they go with his partners in some case he will not come openly because he is afraid to be shouted at by the nurse."*

"*Thinking that maybe he will be tested for HIV/Aids without prior preparation or pre- counselling."*

- Shyness and embarrassment

Shyness and embarrassment may be described as experiential – as discomfort or inhibition in an interpersonal situation that interferes with the pursuit of one's interpersonal goal(s) (Henderson, 2007; Zimbardo, 2007). These emotions were indicated as constituting a major problem that could affect male involvement in the RH context. According to one of the female partner participants "*most of our men are shy"*. This emotional and behavioural phenomenon could result from a fear to being treated by female nurses, fear of an environment in which women undergo treatment, fear arising from culture, and a fear of being labelled as a dishonest partner or associated with promiscuity. Shyness and embarrassment were expressed by female partner participants in the following ways:

"*Another problem which is an obstacle men from taking part is shyness."*

"*They are embarrassed to be seen carrying a child to hospital because the traditionally others do not carry babies" (fear of the environment in which women undergo treatment).*

"*When it comes to the sexual transmitted diseases or family planning, men are ashamed…" (Fear of being labelled as a dishonest partner).*

"*One could see that, shyness is there among our people" (fear because of culture).*

"*Some people are embarrassed; as they have too many sexual partners."*

"*So, if an unmarried young impregnates a woman, he would be embarrassed to accompany their girlfriends to the clinics (fear of being labelled as a dishonest partner)."*

"*Fear of unknown"*

"*What prevents people is shyness to go; the person is not free to go though he wants to go" (fear because of culture).*

One may conclude that the reason why male partners do not fully participate in the RH services is because of fear – fear resulting from culture, fear of being labelled as a dishonest partner, as well as the fear of an environment in which woman undergo treatment.

3.2.1.2.3 Subcategory 1.2.3: Sociocultural barriers

The social and cultural barriers that influence male partner involvement in RH services include polygamous practices, myths about male involvement in RH, gender disparity, abuse of alcohol by male partners, migratory labour practices and household duties.

Society comprises groups of people and individuals. These groups are characterised by common interests and may display a distinctive cultural, religious and economic orientation. These factors may play a role in the way in which an individual perceives the world. In a sociological context, society is described as a group of people that form a semi-closed system in which the individuals are interactive.

In this study the perceptions indicated by the participants in respect of the social factors related to male partner involvement in RH included alcohol, migratory labour and household activities.

Culture may be defined as all the behaviours, arts, beliefs and institutions of a population that are passed down from generation to generation. As such, culture includes codes of manner, dress, language, religion, rituals, norms of behaviour such as law and morality, the systems of beliefs as well as the art and gastronomy (Bourdieu, 1977; Jary & Jary, 1991).

Culture in Namibia has become challenging as a result of the diverse cultures and religions**,** the influence of Western culture, forces at work within society, contact within society and changes in the natural environment**.** All these factors have made it extremely difficult for the younger generation, including male partners, to be focused, especially in issues that are related to RH. These dynamic influences could, in turn, encourage society either to accept the new approach or to reject and resist change (O'Neil, 2006).-

The culture which is relevant to this study is the culture of the stakeholders – male partners, female partners and nurses. According to Farrante (1997), culture may be regarded as an important aspect of a society because it provides its members with ideas about the way in which the world is structured, what culture means and how to go about it. It also determines that generalisation or stereotype can have profound effects on people's relationships with others. Culture can be borrowed, discovered or invented and can attach meaning (material culture); it can also be an intangible creation or essence that we cannot identify directly through the senses (nonmaterial).

A culture may be expressed in terms of beliefs, values and norms. Beliefs refer to conceptions that people accept as true and they include the way in which the world operates and where the individual fits into the relationship. Values refer to general conceptions of what is good, right, appropriate, worthwhile and important with regard to conduct, appearance and state of being. Norms are written and unwritten rules that specify behaviours which are either appropriate or inappropriate to a particular social situation (Farrante, 1997).

The responses of the participants focused on the cultural factors that were expressed in terms of beliefs, norms and values in respect of male partner participation within the RH context.

The male partner participants from Health Centre D stated the following:

"*Our culture (believes) that it is not a right thing to walk together as husband and wife in public."*
"*To walk with his wife it portrays coward manner and behaviour" (norm).*
"*We men long time do not mingle with women" (norm).*
"*This man just being amongst women he is useless" (belief).*
"*Man has not been really working or mixing with women affairs culturally (value).*

Many of the participants in the focus interviews were from the Oshiwambo culture in Namibia and it is not culturally correct for them, as male partners, to participate in or even be part of RH. However, aside from this fact, the researcher observed (field notes) nervousness on the part of male partners visiting the RH facility.

Male partners could be in culture shock (the strain that people from one culture experience when they have to deal with a dynamic culture or a new way of operating, for example, in this study, the male partner experiences the problem of transition from the Oshiwambo culture to the Western health care culture). At the same time, these men suffer from cultural genocide (people of one society define the culture of another society as offensive and intolerable). Male partner participants were of the opinion that certain cultures, especially Western culture, had been forced on them, and they were having extreme difficulty in adjusting to the prescriptions of such cultures. It could even, sometimes, be confusing for the individual to judge for example, whether to follow the old, traditional ways or the new, contemporary ways:

"*About the traditional now we are bit confused."*

"*In Oshiwambo culture, beliefs ....culture ....male do not take part in the matter that are related to the RH" (belief).*

"*Our tradition indicates that male could not be able to assist or take care of a woman in the stage of pregnancy" (belief or norms).*

"*At the same time they expressed that it is difficult to follow the culture or to change." "According to our tradition ... was regarded as sole responsibility when they are pregnant" (beliefs).*

"*Traditionally it is a belief that man cannot raise a child, it has to be taken care of by the mother" (norm).*

The participants are aware that it is difficult to change cultures, but they need to find a way in which to live in this contemporary world. In this respect one male partner participant expressed his opinion as follows: "*It is difficult to change culture but in this modern world we need really to change some, but not everything and accept some of the things in our culture"*.

O'Neil (2006) supports the fact that changing cultures is a complex issue and that human existence may best be looked at as a multifaceted whole. It is only from this vantage point that one is able to grasp the realities of culture change.

In this study, cultural perceptions in the form of behaviour, norms, beliefs and practices relating to the male partner may be regarded as a major obstacle that negatively influences the involvement of the male partners in RH. In light of the above-mentioned background of the cultural aspects such as beliefs, norms and values this could impact on the male partner. Several practices which were identified during the study may be regarded as the result of sociocultural influences: practices such as polygamy, myths about RH, gender disparity and attitudes such as poor communication, ignorance, a lack of responsibility, a lack of confidentiality and a lack of support on the part of the male partner in terms of RH could all make it difficult for the male partner to participate in the RH system.

(a) Polygamous practices

Wikipedia (2007a) states that polygamy has been a way of life since Biblical times. Historically, polygamy has always been extremely widespread in Africa in general and in Namibia in particular

(Odetola & Ademola, 1994). Thus, in Namibia, it is possible for a man to have more than one wife and, indeed, this is regarded as a matter of pride and status in society. However, the current economic instability and the HIV/AIDS pandemic has made it more difficult for a man to support more than one wife.

This study revealed that the criticism of the practice of polygamy in the Western world has resulted in partners feeling both too ashamed and too fearful to seek treatment at health facilities in case any problem or disease is identified. Furthermore, extramarital affairs and large numbers of children have made it impossible for men to support their families.

One male partner in an individual interview stated: " … *and this tendency of a negative pride, that as a man you should have as many women as possible, brings confusion, so if he has more than three pregnant wives, which one will he bring … this will also create problems"*.

Men have also come to realise that having sexual relations with several women is not healthy and the community at large is both disapproving and rejecting of such social evils (Men and HIV& AIDS regional conference 2003 report 2003). The author of this article suggests that it would be better to stop apportioning blame and making both men and cultural practices the scapegoats for reproductive diseases and problems. Men "*themselves should think not about what we stand to lose, but what we stand to gain"*.

In worse scenarios, one of the female partners from one clinic E indicated that although many male partners practise polygamy and produced many children they tend to care more for their extended

families rather than their own children, as pointed out by one participant. "*We have also noted that, men are discriminating against families …"*

"*Do not show any concern, whenever their own biological children fall ill."*

"*But if they hear that it's either their niece or nephew, they react immediately and blame for not acted promptly to take the child to the hospital."*

In conclusion, this practice has become problematic for most of the men who are involved in these relationships in the sense that they have difficulty in choosing which wife to take to the clinic. Some of the participants claimed that the process may even become complicated for the women who are in polyandrous relationships (romantic or sexual relationships involving multiple partners at the same time, regardless of whether these relationships involve marriage) (Odetola & Ademola, 1994). It may happen that women choose to be in polyandrous relationships in order to survive because they are not able to afford the cost of living and these relationships provide the women with sufficient resources to care for themselves and their offspring. This phenomenon occurs mostly in urban areas and affects those men who are part of the migratory labour force. The practice of polygamy in Namibia affects families in terms of issues such as unsafe motherhood and RH (RHO, 2004).

(b) Myths about male involvement in reproductive heath

Myths may be described as "unjustified beliefs and values about an individual's behaviour, conduct and state of being something" (*Oxford Dictionary*, 1998). A myth may be rooted in blind faith, experiences, and even in tradition. Farrante (1997) observes that the effects of a myth may exert a powerful influence on individual actions, and may be used to be generous to the violent. Although this study did not go deeply into the relationship between myths and culture, it did become obvious from some of the responses that myths play a very significant role in the involvement of male partners in RH and it would appear that this phenomenon is rooted in the culture of the participants.

One of the myths to emerge was that a man who participates in the RH services is actually participating in women's services, and that such a man could either be mentally sick, abnormal or bewitched by his

female partner.

One male participant stated:

"*A man taking part in RH can be regarded by the society as abnormal."*

In addition, some family members could not approve of the behaviour of a man who participated in female-related activities. This was borne out by the male partner who maintained:

"*Women at the ANC department they will look at me with big eyes, because I am at their place*."

The participants from the ANC clinic sample expressed their perceptions as follows:

"*… this thing in my husband's family … that saw me with my husband going to the ANC, they concluded that I bewitched my husband."*

"*Men following their wives around, family, they think that it is a coward move, indeed, and man is useless."*

In addition, men who mingle with women may be labelled by fellow community members as "gay" or "*moffie*" (a derogatory Afrikaans word referring to gay men). Participants expressed the following:

"*To be at a women's place … I would not be a good portray as a man."*

"*People are becoming gay because of women, so I am also waiting to become a gay or 'moffie'" (a derogatory Afrikaans word referring to gay men).*

In conclusion, in respect of these contemporary cultural issues, one realises how strongly a myth may influence an individual partner; for example, it emerged from the researcher's field notes that negative attitudes in respect of male partner involvement in RH are more prevalent among men who live in rural areas than among men living in urban areas. This problem may be solved only if male and female partners are empowered with knowledge and skills in respect of issues relating to RH.

(c) Gender disparity as a problem in respect of male partner involvement in RH

As confirmed by Jackson (2002) gender disparity and inequity may be regarded as critical factors in programmes involving male partners in RH. He maintains that gender plays a vital role, can even be regarded as a driving force, in the spread of HIV/AIDS. Riley (1997) states explicitly that gender refers to the roles that men and woman play in society and also to the rights and responsibilities that come with these roles. Riley (1997) also reveals that gender roles reflect in virtually every social institution, such as family structures, household responsibilities, health care systems, and public policies, and that gender influences are very strong in issues such as religion, race, social status and wealth.

Although there has been no in-depth study carried out to determine the relationship between gender inequality and inequity and culture, it would appear that gender disparity may arise as a result of cultural influences. Male and female partners, as well as society as a whole, may have become confused about the roles, rights and responsibilities of men and women in terms of RH facilities. This confusion could have led to a lack of understanding on the part of male partners in respect of their roles and their responsibilities.

According to Green, Cohen and Belhadj-el Ghouayel (1995), gender exerts a powerful influence on RH decision making and men are often used as gatekeepers because of the powerful roles they play in society as husbands, fathers and policymakers, and in positions as local and national leaders. This phenomenon seems to occur predominantly in black Namibian society in which the male partners make most of the decisions in the family relating to financial and reproductive issues. One of the participants in an in-depth interview in one of the clinics stated that: "*This mentality of selfishness as result of gender ... influences males ... tend not to accept or respect the information from the female partner ... or even the female nurses."*

During a focus interview some of the participants expressed the following gender-related statements:

"*Man to get information from the woman that is an insult."*

"*A woman is just a woman."*

"*Men are not respecting women.*"

"*Men are not trusting women."*

In another focus interview, the following statements indicated the need on the part of male partners to be treated by male nurses:

"*We do not have male staff here; the majorities here of the nurses who are here are women."*

"*If we could have male nurses at these clinics it would be good."*

The participants in this study were doubtful about any possibility of changing their cultural perceptions. Nevertheless, it is the responsibility of the nurses to find a way to reside within the contemporary RH context. RH should be viewed as a multifaceted whole with partners who perceive communication, ignorance, responsibility, confidentiality and support within their own cultural context. A partnership between male and female partner is essential, and it is through cultural sensitivity that one would be able to grasp the realities of cultural changes in respect of the involvement of male partners.

(d) Alcohol abuse by male partners

Alcohol abuse has been identified in Namibia as both a major developmental hazard and a social evil.

Alcohol abuse on the part of individuals has a negative effect on their performance. Many of the male partner participants concurred that alcohol abuse does have an effect on their participation in the RH process, especially as they tend to spend more time drinking at the cuca shops (bottlestores in the rural areas where people gather and sell alcohol or home-brew alcohols) instead of joining their female partners in activities at home and elsewhere.

One participant in an individual interview at Clinic B described the effects of alcohol as follows: "*I have noted that, in regard to alcohol, it causes and brings a lot of things especially it weaken one's interest to visit the hospital often. So like now … your wife is giving birth but you always not around, so you are just drinking tombo* (a derogatory Oshiwambo word referring to home-brewed alcohol made out of sorghums) … *if you go to the cuca shop you will find them in numbers, but whatever happens we put it at the government's hands."*

Female partner participants stated that they were of the opinion that alcohol was the reason why many of the male partners do not participate in activities with their families – the male partners are busy drinking. The female participants also believed that this overindulgence in alcohol causes men to become irresponsible and ignorant, especially in respect of the wellbeing and support of their families. In this regard they said:

"*While your husband is drunk or using alcohol instead of taking the child to the hospital …"*

"*While he is going to the cuca shops, they will just hear that you are admitted."*

"*The majority of men do not want to think, most of them have became alcohol addicts, a person is at home, sometimes wants to go to the cuca shops."*

" *Even I'm having a child or pregnant they just leave u, penniless because the money they have is for consuming alcohol."*

"*Majority of men do not want to think positively, and most of them abuse alcohol."*

"*Though I'm having a sick child, or being pregnant, he doesn't care much about me, they just leave and go, the money they have is for buying alcohol."*

The nurses also believe that the consumption of alcohol constitutes an obstacle to male involvement in the RH process. They are of the opinion that men become unreliable in the sense that they do not make time to be actively involved in the wellbeing of their families. In other words, their irresponsible behaviour while under the influence of alcohol causes them to forget about their female partners and their offspring.

In this regard participants stated: "*Make turns at the cuca shop (bottle stores) and they hardly leave these places, though the aim was to go to the hospital …"*

"*Our colleagues spoke about alcohol consumption but."*

"*The most important problem is alcohol."*

"*Alcohol abuse is to be blamed."*

"*Though you have informed a person about problems which are prevailing and once he got drunk, he will just forget everything, even all the benefits, and he forgets everything."*

The participants all indicated the need for the male partners to be *responsible* in their behaviour and to become involved in the health care needs of their families. All the stakeholders, such as Line Ministry and NGOs should participate actively in terms of the mobilisation of human and material resources.

(e) Migratory labour as problem in respect of male partner involvement in RH as a "partner"

The migration of labour has had a negative influence on the family unit in Namibia for many years. Having been entrenched in the social life of many Namibians, the need to search for work far from home has created the opportunity for male partners to have multiple sexual partners and this, in turn, may lead to partners contracting STDs such HIV/AIDS should they not use protection. This phenomenon has also been observed in Zimbabwe where migrant workers are vulnerable to reproductive diseases and STDs. This poses a high risk to the health of the community (Murapa, 2003). Murapa suggests that, to overcome the problem of RH diseases in the workplace, in the community at large and in the family, programmes in RH should be developed and monitored.

The contract labour system that was created and implemented by the South African apartheid regime forced many of the male partners to leave home in search of work, especially in mining towns such as Tsumeb, Arandis and Oranjemund. This phenomenon may be seen as an obstacle to male partner involvement in the RH process because obtaining leave from work dictates when to be at home for a holiday.

Both the female partners and the nurses perceived the practice of migratory labour as a major problem in male partner involvement in the RH process. Female partners expressed their belief that male partners might be willing to participate in the RH process, but that the migration of labour could constitute an obstacle to this participation. In this regard some of the female partners stated:

"*He does not refuse but another problem he is working in the south."*

"*Mine, he is at work."*

"*I see that one of the constraints would be that mm … most men are working far from home."*

The nurse participants also maintained that commitment to work could constitute an impediment in terms of male partner involvement in the RH process because the male partners would be not available to participate or to obtain treatment. The nurse participants expressed the following:

"*The opportunities are many, but, but they are not here. In some cases males are working far away from their partners and families."*

"*And most of the time they will find this thing already done while he is in the south he will look at it and go."*

"*The first thing is that what I have noticed, families are not staying together because of work."*

"*That's why it will be difficult if a woman gets pregnant, and she will then invite the man to come over, then due to that kind of life they live far from each other, a woman would come alone."*

The participants perceived that migratory labour impacts strongly on male involvement in the RH context, for example being away from the family, obtaining leave from work, time to be at home for a holiday and also for a visit to the health centre. However, this is not an excuse for male partners not to participate and to commit both to their own RH needs and those of their female partners or to neglect and evade their responsibilities. At the same time it is the responsibility of the employer to support their employees (male partner) through the mobilisation of resources, empowerment through knowledge and skills in terms of RH issues in consultation with or in partnership with NGOs and the provision of health facilities for RH. This will become possible only through a good relationship between all the stakeholders – male partners, female partners, nurses, external stakeholders from NGOs and other significant stakeholders within the community.

(f) Household duties influencing male partner involvement in RH

The male and female partner participants were of the opinion that household activities, such as looking

after cattle and looking after the homestead, could be one of the issues hampering the involvement of male partners in the RH context

It was also deduced from the male partners' responses that the reason why they would not participate in the RH process was that this would hinder them in the fulfilment of their household activities – looking after the cattle, agricultural activities and other household chores. This was confirmed by the following statements**:**

"*Yes, it has mostly advantages, is just that it prohibit work to be done at home (referring to women).*"

"*It is just that when I bring my partner here may work at home are delayed.*"

"*You visit these traditional houses, you would only find in the house wives, while their husbands are gone to work or are at cattle posts.*"

The female partners indicated that household activities might be one of the issues contributing to the inadequate involvement of male partners in the RH process. This was observed mostly in the rural areas where men (farmers) look after their cattle, dig wells for water and cut trees in order to build traditional houses and fences. Therefore, instead of going to the health facilities they tend to concentrate on these household activities.

The female partners expressed their perceptions as follows:

"*More especially men from this part tend to look after their cattle, and so are obliged to take their animals to water canals and wells.*"

"*We talked about taking cattle to the water canal …*"

The data analysis on the subcategory of social factors indicated that factors such as alcohol abuse, migratory labour and household activities were perceived by both the male partners, female partners and the nurses as reasons for the lack of *commitment* on the part of male partners to be *involved* and to *participate* in the RH context.

3.2.2 Main Category 2: Lack of optimum functioning of health care delivery systems to facilitate male involvement in RH.

This category in respect of a lack of optimum functioning of health care delivery systems to facilitate male involvement in RH was expressed in terms of the inaccessibility of those heath care facilities for the partners, inadequate management principles and inadequate building facilities.

3.2.2.1 Category 2.1: Inaccessibility of health facilities that provide RH services

This category focused on factors such as long distances, unavailability of transport, higher costs for treatment and inadequate buildings/facilities that could influence male partner participation or involvement in RH. These factors may be described as follows:

3.2.2.1.1 Subcategory 2.1.1: Long distances and unavailability of transport for male and female partners to visit the health facilities providing RH services

Some of female partner participants expressed their concern about the distance of the facilities from their homes as this could sometimes prevent the male partners from attending the facilities. This situation could be exacerbated by a lack of financial resources to pay for transport to the hospitals and also to pay for the medication. In this regard the female participants expressed the following:

"*Yes, money is a problem, sometimes both of us could not go, due to transport fares constraints."*

Thus, factors hampering male partner involvement in RH include distance, transport and costs involved in travelling. The male partners experience these problems as an obstacle in assisting their female partner.

3.2.2.1.2 Subcategory 2.1.2: Higher costs involved in the RH services and treatment

A further problem is the medical aid schemes which do not include or make provision either for RH or for the costs of travelling to hospitals as part of a medical plan. If medical aid does not cover these costs then the male partner has to have sufficient disposable income available. This was a major concern for participants who stated the following:

"*Men's treatments, especially for infertility, are very expensive."*

"*Another problem is financial related, the medical aid cards that we are using from the government, do not cover treatment cost, for RH-related problems or prescriptions for men related to reproduction."*

"*Medicines of such nature are so expensive, client refer to the infertility treatment."*

"*Travelling to hospital to receive such treatments, it's also very costly."*

"*It is very clear that income is very low."*

With the high current cost of living, health care services are facing constant increases in respect of services. Limited income makes it difficult to attend RH facilities on a regular basis.

3.2.2.1.3 Subcategory 2.1.3: Long periods of time spent by the partner at the health facilities that provide RH services

Both the time factor and overcrowding at the health facilities were issues which also featured prominently during the interviews with the male partners, who stated very clearly that the long periods they have to spend at the health facilities to obtain treatment and services is a problem because they are forced to leave their household activities unattended for this time:

"*One has to stay there for quite a long time waiting to be served."*

"*Like right now I cannot even count them, they even more than maybe 70 people here."*

"*So you take one person in there now you're trying to hurry up, you don't do a good job."*

"*If you want to do a good job you take, take time Hum ... and then you don't finish this entire people in a limit time."*

"*Wait for quite a long time in those long queues at the ante-natal clinics."*

Nurse participants:

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

"*Counselling it is having a very long process and most cases three nurses are counselling more than 200 hundred a day."*

"*We are requesting for the additional staff and especially for the school leavers who can play a vital roles in the health sectors."*

"*The majority of us we are going to be retired, and we need the government to participate fully as well the nation."*

"*Nurses are become few."*

"*We are having more clients than staff, which does not go hand in hand with the word "counselling."*

All the participants (male and female partners and nurses) emphasised that involving the male partner in RH is not an easy task because it requires adequate resources – human and material – and also sufficient time for the programme to succeed. Based on the participants' responses it is obvious that, in order for this process to succeed, the following is needed: adequate, effective and efficient human resources such as well-trained nursing staff, adequate, effective and efficient materials, including buildings, and the effective utilisation of time.

The use of scarce resources came to the fore in interviews with the male partner participants. The most important issues raised included the professional training of nurses to enable them to provide proper information to all stakeholders in RH services. In respect of human resources, the male partners expressed themselves as follows: "*And there should be also government nurses, trained specifically to suit for the programme related to RH."*

In terms of material resources the male partners stated the following:

"*I suggest there should be a clinic, specifically for them (men) to guarantee their sense of freedom."*

"*Well, hmm … to talk what I expect is first of all for the infrastructure to be upgraded, for this building (showing on the roof of the building) to be at least expanded."*

"*Room they call the ANC department is very small."*

"*Hmm … you can't even put two beddings in this department to at least limit your time hmm … to get time as a factor in here and I think that if they expand it a little bit more like make it a little bit bigger."*

The male participants further advised that the facilities needed to be upgraded and that they needed to include more services. One participant stated: "*Need to add something like to build health and social facilities/training centres directly for males." "Because in some cases the male partners can get information from his partner saying that he is sick, or the chid is very sick and they need to go then they can go."*

3.2.2.2 Category 2.2: Management principles and structures to facilitate male involvement in RH

This category focused on policy and legislation pertaining to male involvement in RH; buildings and structures; the human resources needed for rendering the services; and networking. These are the

crucial aspects that influence male partners not to become actively involve in the RH services and may be described as follows:

3.2.2.2.1 Subcategory 2.2.1: Inadequate policy and legislation pertaining to male involvement in RH

Inadequate policies and legislation on male involvement in RH were also mentioned by the participants as stumbling blocks in respect of male partner involvement. The participants indicated that policy is sometimes not clear on the way in which to involve male partners both in terms of the health care provider and also in terms of stakeholders in RH. Policies are sometimes unilateral which means that the mothers and children only are favoured by the government when it comes to resource distribution. Al-Sabir, Alam, Hossain, Rob and Khana (2004) suggest that, in order for RH to be successful, it is essential to have in place an appropriate intervention and action plan for effectively involving male partners in RH, for sustaining their participation in RH and for encouraging them to accept services from the existing government.

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

"*How do we are surviving because we are not going neither for investigation or physical examination, and after the pension we leave for a short time."*

"*… woman they are having many health services, for example, immunization start until they get old."*

"*… for us it end up at the age of 15 years, some of this thing discourages male partners."*

"*Yes, what we have observed there is no proper care for males, it just start here then it end there but woman it end up until they get old."*

The female partner participants were of the opinion that policies and legislation needed to be put in place to encourage male partners to participate. One participant stated that:

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

"*Yes, there are no policies; if it is there then they will participate. If there is nothing then they will stay away from this."*

The nurse participants were of the belief that the lack of proper strategies to encourage male partners to participate in the RH process was a major problem and needed to change as a matter of urgency. In this regard they had this to say:

"*We do not really have such a policy at this clinic but" (policies).*

"*No, we do not have these strategies on how to approach them."*

"*Perhaps a person is coming to the hospital with his problems, so that one is easy to have a discussion with. But if I go at different building and call them to come, I might not get anyone."*

3.2.2.2.2 Subcategory 2.2.2: Poor and inadequate buildings and structures for RH services

Resources such as buildings and the facilities to offer RH services were felt to be inadequate. The stakeholders cited factors such as the fact that most of the health facilities lack sufficient space (not enough buildings) and also that there is insufficient staff to attend to their needs as well as a lack of privacy, as contributing to the lack of male involvement in RH. In this respect male and female partners and the nurses expressed themselves as follows:

"*Buildings are not enough or they do not have private rooms where a husband and wife can get treatment together."*

"*We usually go there but it seems that doctors do not have enough time because of the overcrowding."*

"*Yes, they do not have time because the hospital* is always very full."

The male partner participants felt that the equipment and the buildings where the women were attended to needed to be upgraded. They were of the opinion that more facilities needed to be built in order to accommodate more women. They insisted that privacy was not possible when the rooms were so overcrowded and that this overcrowding sometimes led to unhygienic conditions. In this regard they the following to say:

"*This departments is (pausing) a little bit downgraded what I mean by that is that the infrastructure is not really up to standard."*

"*I have also experienced that the place is very small – it's so small that the women can be from up to seventy women a day even (pulling his face again) I see things are not well organised or placed."*

"*We only have a common building, where all the people get their treatment, so we need assistance in this regard."*

"*And again this place needs more facilities."*

"*There is no privacy at all."*

The nurse participants also expressed concern about the lack of privacy in the buildings used for RH

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

"*Hospital is the place with limited freedom for some the people."*

"*But if we are having a place outside the hospital which is separated then a person can freely ask and request without the interference from a female partner."*

"*Sometime one may have good feelings of accompanying his partner but he does not know where will be stay."*

"*I think to strengthen this education I know that we will assist many male partners."*

"*There is a lack of training material such as posters and so on …"*

Issues here include the lack of privacy in buildings, the time spent waiting about, the lack of equipment and the idea that RH buildings were found to be offensive by male partners. The health facilities that provide RH services were observed as being accessible for female partners only. These factors all constituted serious obstacles to male participation in RH.

3.2.2.2.1 Subcategory 2.2.3: Inadequate human and material resources to render RH services

Shortages of staff and increased numbers of clients in the health facilities were cited by the male and female partners as well as the nurses as factors which could contribute to the lack of male involvement in RH. The lack of sufficient staff to take care of clients was a matter of grave concern to the nurse participants, as it relates to the quality of nursing care provided. The nurses expressed concern especially in cases where the nurses were rushed when seeing clients. They had this to say:

"*In regard to the hospital, we have a lack of enough staff, by this way, it will also discourage people."*

"*When people are coming in need of assistance, nurses will not be enough for all the people to be treated."*

"*This does not mean it's our wish, but it is a testimony that the staff complement in hospital is very low."*

"*Sometimes, I have to attend to clients at the ante-natal clinic, giving them their prescription, and sometimes I would even fail to attend to them and they will go back."*

A shortage of staff results in poor health care, as it means that health care workers, even though willing to complete their tasks diligently, have limited time and resources at their disposal despite the increasing demands of their patients and partners tend to become discouraged. Some of the nurse participants expressed their feelings as follows:

"*Nurses are become few."*

"*We are having more clients than the staff."*

"*We are having a shortage of staff."*

On the category of human resources one of the male partner participants expressed himself as follows:

"*There should be nurses trained specific to suit for the programme related to the RH."*

The health facilities that render RH are predominantly staffed by female healthcare workers and, according to the participants this could have a negative effect on the involvement of male partners in RH. Should the male partner decide to go to a health facility it would not be possible for him to be open and to divulge his problems as, culturally, the male does not respect females and, whether or not what the females were doing or saying was correct, the males would not appreciate it.

In view of the fact that the male partner, with his African culture, regards the female as inferior, the dominance of the female health caregiver is not likely to appeal to the male partners. In order to involve the male partner, McGinn, Maine, McCarthy and Rosenfield (1996) suggest that government and institutions that provide RH services should pay more attention to the planning of their activities, especially in respect of the management of human and material resources in order to support the facilitation of male partner involvement in RH.

3.2.2.2.2 Subcategory 2.2.4: Poor networking and partnerships between stakeholders and health facilities that provide RH services

In this subcategory poor networking and partnerships between the stakeholders (male partners, female partners and the nurses), as well as between the significant stakeholders in the community and the health facilities that provide RH services, were regarded as contributory factors in respect of the poor participation and involvement of male partners in RH. These factors may be described as follows:

(a) Networking

Networking refers to the process in which individuals, institutions and organisations in both the public sector and the government sector form a support system in order to pave the way for involving male partners in RH. The aim of networking is both to gather information and also to provide information within work groups in order to encourage the exchange of ideas as organisations grow. Networking is employed in the decision-making process and also in handling conflict within or between groups. Networking also involves the sharing of ideas and information and is aimed at offering support and providing direction to stakeholders. It also refers to the sharing of expertise and services and helps to extend political influence **(**Barker & Gaut, 1996; Wikipedia 2007).

The nurse participants expressed the following:

"*Networking should be strengthened.*

"*We need a good networking with women who already are trained."*

"*Intersectoral collaboration between government and nongovernment organisations."*

"*Incorporate it (male involvement in the RH process) within the school curriculum."*

Networking is a means of sharing information and providing support to partners in RH. This support is essential in encouraging favourable involvement on the part of couples involved in RH.

(a) Partnership

A partnership is a legal contract entered into between two or more persons – persons are bound by such a contract. A partnership establishes a relationship between individuals or groups that is characteristic of mutual cooperation and responsibility (American Heritage Dictionary, 2007).

In terms of the RH programme there needs to be a partnership between, for example, the male and female partners, and between the male and female partners and the nurses. Partnerships are also essential between the institutions that are providing RH services, for example, at government level (community level, district level, regional level and national level), others such as Line Ministries, and NGOs. This study revealed that a partnership (relationship) between the male partners, the female partners and the nurses is lacking:

In this respect the participants stated the following:

"*There should be a strong relationship between male and female partners" (relationship).*

"*Government institution and nongovernmental organisation should work together" (working together).*

"*Good communication is needed for male partners to participate in the RH."*

"*There should be policies and regulations on how to involve male partners in the RH."*

Strong input from both partners is essential if a partnership is to be successful. O'Neil (2006) suggested significant points in respect of partnerships which could be applied to the stakeholders in the RH programme, since a partnership is an ongoing, flexible and dynamic issue which needs strong input from all stakeholders. O'Neil (2007) suggests the following strategies which may be implemented in order to strengthen the partnerships between the stakeholders in respect of male partner involvement in RH. These strategies include:

- *Time*. Male and female partners and other stakeholders need to take the time to establish and build their relationships in order to achieve a successful outcome. In this regard one of the female partners stated:

"*Male partners do not have time to go to the hospital husband is just there for travelling."*

- *Joint decisions*. Decisions need to be made jointly in order to establish a good relationship and to minimise conflict and blame.
- *Unequal benefit*. Partners and stakeholders should understand that, although they might not benefit equally, each should realise a value-added benefit.
- *Collective action*. The stakeholders in RH need to take collective action in case of any problems or should any amendments be needed in respect of the RH programme.
- *Mission to accomplish together*. Stakeholders in the RH programme should realise that, for the male partner to be involved in RH, effort is needed on all sides. For example, the eradication of RH diseases such as HIV/AIDS needs a major effort on the part of all the stakeholders, including community members, and government and nongovernmental institutions. In respect of this, one of the female partner participants stated:

"*It's important and needed in the sense that men do not know that whenever a woman is pregnant and do need to have proper care, during some months closer to delivery" (lack of mission to accomplish).*

- *The sharing of resources, benefits and recognising success*. O'Neil (2007) suggests that, for partnerships in RH to thrive, the male partners who are targeted by this programme must find it worthwhile for them to assist their partners and to share their resources with these partners, that is, pay their partners' transport to go to hospital, fees and all other necessary expenses. In order to avoid the conflicts that might occur as a result of a negative attitude which is observed in one of the male participants in health facility C, who stated as follows:

"*I cannot wasting my money on the kids is not mine is belong to the mother family" (no benefit or sharing of resources).*

"*A woman is pregnant, a man regard it as their own business or woman's rights not theirs" (no recognition).*

In addition, this aspect of the *sharing of resources and recognition* should also apply to government and nongovernmental institutions which need to share their resources in order to strengthen this process.

Develop and adopt the shared vision: For example, the vision that involving male partners in RH could bring about a change in the partners' relationship. A shared vision might also make it easier for the health sectors that provide RH services not to provide fragmented services when treating RH diseases and conditions. This is possible only if all the stakeholders have a common and shared vision. Lastly, this vision should reflect in all the activities relating to RH.

In conclusion, partnerships in the RH programme need the full engagement and mutual interest of all the partners and significant stakeholders. Secondly, good communication between the partners; commitment, honesty, respect, courtesy, collaboration, trust, willingness and the utilisation of the strengths and capabilities of the partners and significant stakeholders are essential ingredients for successful partnerships.

Finally, partnerships in RH should be built step by step, that is, built incrementally by starting at the

beginning, growing gradually and tackling more complex initiatives as competence increases. This, in turn, needs involvement, hard work, effective practice and consistency across the entire programme.

3.2.3 Main category 3: Lack of or limited knowledge and skills on the part of the stakeholders in RH

Anderson (2003) suggests that the "meaningful involvement of males must be based on skills, not just status". In other words, for the male partners to participate they need to possess knowledge and skills and this knowledge will be acquired only if the male partners are empowered with such knowledge and skills through an awareness of the RH services available (McGinn, Bamba & Balman, 1989). This could be facilitated by community members such as youths, parents, traditional healers and traditional leaders (Bwalya, 2003; Mabote, 2003).

It would appear that, while not all male partner participants would agree to be involved in RH services, nevertheless, there were others who were positive about it. The latter expressed themselves as follows:

"*It is important to us males, to be assisted t do things in a correct way."*

"*If I had enough knowledge I could have planned my children."*

However, lack of knowledge on the part of the male partners should not be generalised because, in a study on the issues of RH which was conducted in Botswana, it was found that the level of knowledge of the husbands was 99% as compared with that of their wives (93%) (Bwalya, 2003). In their study on RH, Zambrana, Reynaldo and McCarrher (1998) revealed that male partners are knowledgeable about RH issues.

Accordingly, on the basis of the above statement, it may be assumed that, if males do indeed possess sufficient knowledge about RH issues, then it is other factors which are playing a role in their reluctance to become involved in RH.

Nurse participants also indicated that they do not have adequate knowledge and skills to train or educate male partners to participate in RH services. While some were confident that they could impart information others did not know what information to give. One may conclude that this could be the result of either a lack of training or else of unsuitable training in respect of the nurses. In this regard some of the nurse participants indicated the following:

"*We did not get training which included RH, for men to participate."*

"*In our training as a nurse we were not taught how to work with male partners especially in this regard (RH)."*

"*We ourselves we lack of these skills of attracting men to come to the RH context."*

This study revealed it would be difficult to facilitate male partner involvement in RH services because of factors such as a lack of education and inadequate dissemination of information.

3.2.3.1 Category 3.1: Lack of education and training to facilitate male involvement in RH

One of the problems identified was a lack of education and training on the part of the male partners, female partners and nurses in respect of up-to-date knowledge and skills of RH. The participants felt that information, education and communication are tools that could aid the process of involving male partners in RH. "Absence of adequate reproductive health education could lead to a lack of awareness on RH diseases. RH (RH) requires knowledgeable and skilful health service providers who are have proper practical experiences and training" (Danforth & Jesowski, 1994). Education and training in respect of male involvement in RH encompasses three groups – the male partners, the female partners and the nurses. At the same time, the nurses who are providing the services should be knowledgeable and skilful enough to provide an adequate service. If people are educated and informed then they are empowered and they will cooperate and facilitate.

All the participants (male and female partners and nurses) emphasised that involving the male partner in RH is not an easy task because it requires adequate resources, both human and material, and sufficient time for the programme to succeed. Based on the responses of the participants it is clear that this process will be achieved only by providing adequate, effective and efficient human resources such as well-trained nursing staff, and adequate and effective such as buildings, and the efficient utilisation of time.

The prudent use of scarce resources was an important issue which came to the fore during the interviews with the male partner participants. The most important issue raised by the male partner participants was the training of nurses to enable them to provide proper information to the stakeholders of RH.

In respect of the category pertaining to human resources the male partners expressed themselves as follows:

"*And there should be also government nurses, trained specifically to suit for the programme related to the RH."*

In terms of material resources, the male partners had the following to say:

"*I suggest, there should be a clinic, specifically for them (men) to guarantee their sense of freedom."*

"*Hmm … you can't even put two beddings in this department to at least limit your time Hmm … to get time as a factor in here and I think that if they expand it a little bit more like make it a little bit bigger."*

The male partners further recommended that facilities be upgraded and that they include more services. One participant stated:

"*Need to add something like to build health and social facilities/training centres directly for males."*

Female partner participants:

The female partners did not have anything to say about this category.

Nurse participants

In respect of the facilities the nurses were of the opinion that building health and social facilities and training centres would be an advantage. They also maintained that the nurses should, preferably, be

male nurses and that the programme should be an ongoing process. The nurse participants stated:

"*Need to add something like to build health and social facilities/training centres directly for males."*

"*And I think that this will be solved in a way that if the centre consisting of different programme can be established, it can give information. In case of inadequate information he can go for the male centre."*

3.2.3.2 Category 3.2: Unavailability of training and education resources to facilitate male involvement in RH

As regards the dissemination of information, the participant male partners, female partners and nurses indicated that they did not receive sufficient information on RH. The male participants specifically expressed concern that the lack of information for male partners had contributed to the unsuccessful attainment of goals in terms of the RH programme. They were, thus, of the opinion that information ought to be disseminated to the requisite audience. This issue was referred to by all the participants.

Male partner participants

The male partners indicated that the reason why they had not visited either the department or the centre (health facilities providing reproductive health) was due to ignorance and inadequate information and education, which had, in turn, contributed to their lack of knowledge and understanding in respect of RH. The following statements were made:

"*If we had enough information we would attend."*

"*If we are given such opportunity …"*

"*If I get correct information, like how to plan my children so that it is not always responsibility of a woman to plan the family."*

The above findings indicate the reluctance on the part of the male partners to take ownership, which could be attributed to the lack of information on RH which had, in turn, led to a feeling of disempowerment in the process of involvement in reproductive health.

The male partners regarded education as an important instrument or tool to be used in this regard. They expressed the following:

"*I think all those who are coming to the hospital should get information because the couple may be married a man can be the one who is having a problem with fertility."*

"*Yaa, simple to say, those whom I found here, they got information and they should not keep this information to themselves, they should share information with others."*

Female partner participants:

The female partner participants were in agreement that more information needed to be disseminated to the male partners so as to enable them to assume the required roles in the reproductive process. This is clearly borne out by the following statement made by one of the female partner participants:

"*Even those who come to the hospital will be given information."*

In addition, the female partner participants expressed their desire to have open discussions on RH with their male partners as this would strengthen the family unit and create a stronger bond between couples. This, in turn, would ensure that proper care from both partners would be offered in times of need.

One of the female partners expressed the following:

"*Married couple become inseparable, they will discuss openly, and care for one another and their love will be much stronger. If one is in ailing health, and the other is taking care for the other then it is a good thing indeed."*

"*We want men to be at the same level with women, walk the walk, talk the talk."*

"*If we understand one another, we can then follow the policy of RH as partner."*

The female partners strongly expressed the need for the male partner to be involved in RH services and, specifically, in the personal care aspect during the final day of delivery of the baby. This involvement would also be perceived as a form of commitment and it would demonstrate the acceptance of responsibility.

Nurse participants:

Despite the fact that the nurses did not provide information on RH issues, they did, nevertheless, realise the importance of sharing information. This is evident from the following statements:

"*Through the information sharing they (male partners and female partners) would be able to live and build productive health lives."*

"*… programmes for information should be created in order to give the information to male partners."*

"*We have just to start giving information."*

"*I have noticed it myself that the reason why men do not come , it is due to the way they are informed , which is done in a spiteful way, because these things create feelings of shyness in them."*

3.3 CONCLUSION

The results of the study were discussed in the light of the relevant literature in order to contextualise the findings and highlight the trustworthiness of the results. It became evident from the findings of this study that the reasons why male partners are not involved in RH include poor interaction (partnership) between male partners, female partners and nurses, as well as between other significant stakeholder such as members of both the community and the health facilities. Secondly, the context (environment) in which the RH services are provided is not favourable in terms of accessibility to and utilisation of resources. Thirdly, the way (process) in which the RH services are managed by the nurses is inadequate. This is as a result of the unavailability of resources, policies and legislation, and also the fact that these resources, policies and legislation are deficient.

In short, one may conclude that there is poor interaction (partnership) between the male partners and female partners as well as between partners and the nurses in RH facilities because of negative perceptions, poor interpersonal relationships between the stakeholders, the personal attributes of the male partners, female partners and nurses and also sociocultural barriers. These poor partnerships could also be the product of a lack of knowledge and skills which has resulted from inadequate education and training and the deficient dissemination of information to agents, recipients and other stakeholders in RH services.

In terms of the *environment,* it emerged that facilities are poor and inadequate for optimising the functioning of RH care delivery systems in order to facilitate male involvement in these systems. It would seem that RH is often inaccessible to the male and female partners because of long distances and

the unavailability of transport. Higher costs in respect of the RH treatments provided and the lengthy periods of time spent by the female partner at the health facilities that provide these RH services also play a role.

In terms of *management,* the lack of management principles, inadequate policies and legislation, as well as the unavailability and poor utilisation of human and material resources to facilitate male involvement in the RH services, were all cited as problems in respect of the facilitation of male partner involvement in the RH context. Poor management was manifest in terms of the inadequate buildings and poor infrastructure of those health facilities that provide RH services, as well as in poor networking.

In the light of the poor partnership between the stakeholders within the turbulent environment that provides RH – a poor partnership which had resulted from inadequate management principles, policies and legislation – one may conclude that the nurse, as agent, faces challenges in managing this partnership environment in order to facilitate male partner involvement in the RH context.

Accordingly, the challenges of the "management of the partnership environment" will be adopted as the central statement of this study and this topic will be discussed in detail in chapter 4.

Table 3.2: Summary of the findings, conclusions and central concepts

FINDINGS IN CHAPTER 3	CONCLUSIONS	CENTRAL CONCEPTS
• Negative perceptions • Poor interpersonal relationships • Personal attributes • Sociocultural barriers • Lack of knowledge and skills • Lack of education and training	Poor interaction between male partners, female partners and nurses in facilities and institutions rendering the services	**Partnership**
• Inaccessibility of health facilities o Long distances and inadequate transport o Lengthy periods of time spent at facilities o Poor and inadequate buildings o Inadequate human and	Poor and inadequate optimisation of the RH facilities to facilitate male partner involvement in RH	**Environment**

material resources ○ Higher costs involved		
• Inadequate policies and legislation • Poor and inadequate buildings and infrastructure • Inadequate human and material resources • Lengthy periods of time spent at facilities • Higher costs involved • Lack of education and training	Poor management principles and infrastructure	**Management**

CHAPTER 4

DEFINITION, CLASSIFICATION AND CONSTRUCTION OF RELATIONSHIPS BETWEEN CONCEPTS AND STATEMENTS (STEP 1.2)

4.8 INTRODUCTION

Chapter 3 contained a discussion of those factors that influence male involvement in RH as revealed by the findings of the study. The data were analysed and presented in the form of main categories, categories and subcategories. The aim of chapter 4 is to conceptualise the main concepts of the central statement as identified in chapter 3 in order to describe the conceptual definitions of these main concepts which are needed to develop a model to facilitate male partner involvement in the RH context. For the purposes of the development of this model, the concepts need to be clear, precisely defined and explained in such a way that the end product will always, however, be tentative. This approach is necessary in view of the fact that, if two individuals were presented with the same concept, they would usually come up with different attributes, interpretations and connotations. Walker and Avant (1983, p. 35) are in strong agreement that what is true today will not necessarily be true tomorrow. The central *concepts and statements* were synthesised and deduced from the empirical and literal (literature) data obtained in chapter 3. The aim of this step of synthesis was to

- generate new ideas/ways of thinking
- provide a method for examining the data for new insights that could add to the development of relevant theory
- enrich the vocabulary and highlight a new area in terms of the topic of the study
- refine the ambiguous concepts in the theory and clarify all overused or vague concepts (Walker & Avant, 2004, p. 40–64).

4.9 IDENTIFICATION OF THE MAIN CENTRAL STATEMENT, DEFINITION OF THE CENTRAL CONCEPTS AND REDUCTION OF THE IDENTIFIED CRITERIA OF THE CENTRAL STATEMENT.

The identification of the central statement and the concepts was done on the basis of the results of the fieldwork. The fieldwork was conducted by a thorough examination, clarification and analysis of the concepts. The identification and clarification of the concepts was discussed in detail in chapter 2.

4.9.1 Identification of the main central concepts

As concluded in chapter 3, the data revealed that there was poor interaction (partnership) between the male partners and the female partners, as well as between them and the nurses in the RH facilities. This poor interaction was the result of negative perceptions, poor interpersonal relationships between stakeholders, personal attributes on the part of the male partners, the female partners and the nurses,

and sociocultural barriers. It was also concluded that this poor partnership may have resulted from a lack of knowledge and skills, which had, in turn, come about because of inadequate education and training and the insufficient dissemination of information to agent, recipient and other stakeholders in the RH services.

Secondly, it emerged that resources such human, material and health facilities are inadequate in ters of optimising the functioning of the RH care delivery system (environment) to facilitate male involvement in RH care. This was viewed as being the result of the inaccessibility of the RH facilities (to both the male and female partners) because of long distances and the unavailability of transport. The costs involved in RH treatment and the lengthy periods spent by the male and female partners at the RH facilities also played a role.

Lastly, a lack of management principles, inadequate policies and legislation, as well as the unavailability and poor utilisation of human and material resources to facilitate male involvement in RH services were also cited as problems in respect of this facilitation. Poor management was manifest in the inadequate buildings and the poor infrastructure of the RH facilities, as well as in poor networking.

In the light of the importance of the role of male partners in the RH system there has been an urgent call to involve them in the process. In view of the fact that RH is a complex and dynamic issue, both the International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994, and the United Nations Fourth World Conferences on Women held in Beijing, China, issued the challenge for countries to place this involvement of male partners at the centre of development. These two conferences called on different countries and organisations to readdress gender imbalances and to respect the reproductive rights of both women and men as necessary conditions for improving sexuality and RH.

Accordingly, based on the above facts, the researcher is of the opinion that the men in Namibia could play an important role in RH. This might be feasible if male partners were empowered with the necessary knowledge and skills to understand the importance of their involvement in RH services. On the other hand, this involvement of male partners requires both a joint venture and active participation not merely on the part of the male partner alone, but in terms of all the stakeholders, including male partners, female partners and nurses, as well family members, and community members, together with other stakeholders from the line ministries and NGOs.

In light of the poor *partnership* (resulting from inadequate *management* principles, policies and legislations) between the stakeholders in RH within a turbulent *environment*, one may conclude that the nurse, as agent, will face challenges in managing the partnership environment to facilitate male partner involvement in the RH context.

Based on these findings, the researcher concluded that the involvement of male partners in the RH context would require a well-managed partnership environment that could facilitate this process. Accordingly, the central statement of this study of the “management of a partnership environment” to

facilitate male partner involvement in the RH context is extremely relevant.

In order to identify the concepts needed for the development of the model, information was gathered during the research process in terms of the steps described in chapter 2. In the conclusion to the data analysis in chapter 3 a central statement was formulated as indicated in the paragraph above.

However, the structure of theory development requires the identification of those concepts that will form the building blocks of the theory. Therefore, for the purposes of this study, the meanings of the concepts of *management, partnership* and *environment* are extremely important in order to arrive both at a theoretical definition that will direct the description of the facilitation of male partner involvement in RH and also to describe guidelines for the operationalisation of the model. Accordingly, these concepts of management, partnership and environment will be described as follows:

4.9.2 Definition of the concepts of the central concepts

After the identification of the central concepts of "Management of partnership environment" a detailed conceptualisation was carried out. Firstly, the concepts of management, partnership and environment were examined separately. This was followed by an exploration aimed at finding a common meaning for the full concept of "Management of partnership environment".

In this process, dictionaries, books, a thesaurus, journal articles, internet exploration, models and theories in respect of the identification of the uses and interpretations of "management partnership environment" were used to obtain synonyms that would convey the commonly accepted usage of the relevant concepts (Chinn & Kramer, 1995).

4.9.2.1 Examination of the concept of management

The examination of the concept of management was carried out as follows, namely, dictionary definition, subject definition, reduction of the identified criteria of the concept, reduction process of the criteria identified and, finally, a definition of the term "management".

4.9.2.1.1 Dictionary definition of the concept of "management"

According to the *American Heritage Dictionary* (2008) the term "management" refers to

- the act , manner or practice of **managing, handling, supervisor, control**
- person or persons who **control** and **direct**
- skill of managing and executive ability.

According to Leadership 501 (2008) the term refers to

- the art of conducting and **leading**
- and includes strategic **planning**, setting objectives, managing **resources,** deploying the **human** and **financial assets.**

According to the *Business Encyclopaedia* (2008) the term refers to

- **art**
- **organisation**
- **people to be led.**

According to the *Merriam Webster Online Dictionary* (2008) the term refers to

- act and art to manage
- conducting or supervising of something to **accomplish** something
- handling or directing
- exercising executive administration, and supervisory direction, to work upon or try to alter for a purpose
- directing or carrying on a business affair.

According to the *BNET Business Dictionary* (2008) the term refers to

- use of **professional skills** for identifying and achieving organisational **objectives** through the deployment of appropriate **resources**
- and involves identifying what **needs** to be done and organising and supporting others to perform the necessary task
- a manager has complex and overhanging **responsibilities.**

4.9.2.1.2 Subject definition of the concept of "management"

Luft (2008 in Nickel, McChugh & James, 1987) and Pierce and Dunham (1990) state the following:

- Manager leads by assigning the task to be achieved – the organisationally desired goal.
- Planning (setting goals and strategic planning); organising (allocating and assigning tasks); directing (supervision, leading others to accomplish the task) and controlling (evaluation of whether the goal has been attained) (Fottler, Hernandez & Joiner, 1994).
- Requires managerial skills such as
  - **communication skills** (oral communication in order to give direction and appraisal, written communication in the form of reports, letters, memos, and policy statements and listening skills in order to identify the needs of the client)
  - **human skills** (temperament, diversity in the workplace , understand different personalities and cultures,
  - **time management skills** (allocation of time, managing uncontrollable factors **computer skills (keep** pace with rapid changes in technology)
  - **technical skills how to perfo**rm tasks)
  - **behavioural management** (influential strategies based on knowledge, skills and

leadership skills; human relationships, advocacy of human relationship (Floyd & Wooldridge, 1996).

According to the *Business Dictionary* (2008) management refers to

- the **organisation** and **coordination** of activities in accordance with policies in order to achieve clearly defined goal.

According to Booyens (1998, p. 135), management is a participative process which includes

- dynamic interactive decision making ,problem solving, shared governance, ownership, accountability
- the **organising of transformation**
- **empowerment** of stakeholders with **knowledge** and **skills**
- communication inside and outside of the health care setting to increase: **responsibility,** foster better **relationships**, increase trust and mutual support between the stakeholders; improve **attitudes**; **decision making** and **problem solving and** develop **mature,** healthy, **self-directed personalities** among the stakeholders
- full and **active participation**
- possession of relevant **knowledge**, **willingness** to participate
- helping stakeholders to understand their **responsibilities**, and **accountability** and their authority inherent in the system
- decisions being clearly defined and accurate estimation of the **resources** needed for implementation
- **monitoring** and **evaluation**
- **shared authority** and **responsibility** in the entire process
- interpersonal **relationships**; interactive decision making and problem solving **involvement** an**d participation** of the stakeholders
- level of participation and **involvement** of **the stakehold**ers is based on the nature of the decision or problems, the **abilities** of the stakeholders as well as their **desires** and **expectations**
- decision making such as **participating, delegation, testing, consultation**, **consensus decision making, democratic decisions, negotiation, shared governances and organisational transformational (**Booyens 1998, p. 434**).**

According to Muller, Bezuidenhout and Jooste (2006, p. 19) management is

- a process whereby **human**, **material** , f**inancial**, **physical** resources and information are deployed to facilitate the **attainment** of the organisational **goals**, **objectives** and outcomes by applying fundamental management activities such as **planning, organising, leading and control.**

According to Del Bueno and Vincent (1986, p. 16, in Booyens, 1998, p. 195) and Huber (1996, p. 106) **management** includes**:**

- **Planning**
  - **Investigation** of **externa**l and **internal** factors that have an impact on the programme or the organisation and forecasting.
  - **Forecasting** the current **personnel** and availability of s**taff** involved in the organisation or

receivers (clients) of the services; action planning: (*structure*, *process and* outcomes).

- **Planning** the policy, human resources, process, management approaches and strategies.

▪ **Organising**

- **Chain of command** and **chain of reporting, unity of command span of control; requisite authority and continuity responsibility**.
- The *organisational **culture:*** **values** and **norms,** behaviour, personal appearance, dress, physical environment, communication, ritual and rules of the organisation which reflect in its policies and practices
- A mission statement which outlines the organisation's philosophy, **goals** and **objectives.**
- Formal organisational structure which outlines the **responsibilities** of departments and individuals.
- Informal **networking** structure or relationship.
- Political structure which presents the distribution of power within the organisation.
- **Skills**: ability to **communicate** effectively – both orally and in writing – and good listening skills in order to understand.

▪ **Directing and leading:**

- According to Sullivan and Decker (1992, p. 181) a leader requires leadership skills, *traits* and *behaviour*

▪ **Control and monitoring (evaluation)**:

Controlling and monitoring

- should be based on standards and **objectives**
- should have the active participation of the stakeholders (MoHSS, 2001, p. 15–21)
- based on **behaviour** rather than personal traits
- carried out in accordance with the set of characteristics required for the programme (specific indicators) (La Monica, 1990, p. 307)
- evaluation should be based on job-related **behaviour** rather than on personal traits or characteristics (Hellriegel & Slocum, 1989, p. 765)
- people to be involved in the programme evaluation should be taught beforehand how to use the tools of evaluation and the way in which the programme is operated (McConnell, 1984, p. 765)
- **feedback** should be given immediately after evaluation
- stakeholders to be evaluated should be given **recognition** when they have performed well (Riley, 1983, p. 33)
- feedback should be **explained** carefully so that the stakeholders understand the process of evaluation.

4.9.2.1.3 Reduction of the identified criteria of the concept of "management"

The following criteria were deduced from both the dictionary and the subject definition of the concept of "management"**:**

- planning
- organisation
- directing/leading
- control
- human resources
- material resources
- time

- financial
- physical
- information
- objective/goal /outcome

4.9.2.1.4 Reduction process of identified criteria of "management"

The reduction process for the concept management is illustrate in table 4.1

Table 4.1 Characteristics of essential and related criteria in respect of management

ESSENTIAL CRITERIA	OTHER RELATED CRITERIA
Effective management of **human**, **financial**, **physical** and **material** resources as well as **information** and **time** to facilitate male involvement in RH	❑ **Planning includes:** ▪ goal setting ▪ action plans ▪ implementation strategy ▪ evaluation strategy ❑ **Organising includes:** ▪ designing the structure ▪ assigning responsibility and authority ▪ establishing the command structure ▪ establishing a coordination mechanism ❑ **Directing and leading involve:** ▪ Implementing leadership principles and strategies in order to manage the dynamic interaction between the stakeholders. ❑ **Control and monitoring (evaluation) involve:** ▪ setting standards ▪ measuring actual performance ▪ evaluating deviations ▪ rectifying deviations ▪ feedback

4.9.2.1.5 Definition of the concept of management

The definition of the concept of management was formulated on the basis of the criteria identified in table 4.1.

- Management is a process whereby **human**, **material**, **financial**, and **physical** resources as well as **information** and **time** are deployed to facilitate **goals**, **objectives** and **outcomes** by utilising management principles such as **planning**, o**rganising**, **leading** and **controlling**.

4.9.2.2 Examination of the concept of "partnership"

The data analysis in chapter 3 indicated the acceptance on the part of the majority of participants of the need to strengthen the partnerships between the stakeholders in order to facilitate male partner involvement in RH. In particular, the partnership between the male partners, female partners and nurses should be strengthened although stakeholders such as community members, Line Ministry and NGOs which should also be a part of this partnership. The aim is to facilitate this process of strengthening partnerships. The concept of "partnership" may be analysed as follows:

4.9.2.2.1 Dictionary definition of the concept of "partnership"

According to the *American Heritage Dictionary* (2007a) a partnership is

- **a contract** entered into by **two or more individuals**
- **an agreement**
- **shares**
- **a relationship** between individuals groups that is characterised by **mutual co-operation and responsibility** for the achievement of specified goals

According to the *Compact Oxford Thesaurus for Students* (2007) a partnership entails

- **cooperation**
- **association**
- **collaboration**
- **alliance**
- **union**
- **coalition**
- **affiliation**
- **relationship**
- **connection**

According to the *Investment Dictionary* (2007) a partnership consists of

- **two or more** individuals managing and operating a business
- with both owners being **equally and personally liable**

According to the *Financial & Investment Dictionary* (2007) a partnership is

- a contract between **two people or more** people in a joint business all of whom **agree** to pool their funds and talents
- **a sharing** of responsibility
- **an agreement of partnership**

According to the *Real Estate Dictionary* (2007) a partnership is

- an agreement **between two** or more entities to go into business or to invest
- partners **bind** each other
- **scope** of partnership

According to the *Catholic Encyclopaedia* (2007) a partnership is

- an incorporated **association** of two or more persons
- having **objectives**
- **shared** responsibilities

4.9.2.2.2 Subject definition of the concept of a " partnership"

According to O'Neil (2006) partnership includes:

- **a joint decision** to establish begins with the **belief** that an important need may best be fulfilled through a partnership
- a partnership is the best way to **accomplish** an important body work
- a person who is **able to help**
- being and thriving for a clear **understanding**, that **mutual benefits**
- partners may not benefit equally but each must realise a **value added benefit**
- **collective action** to meet a specific need
- **mission to accomplish** together
- **sharing of resources**, **benefit** and recognition of successes
- **shared vision**
- **collaboration**
- **developed** and c**ontinued** refinement of shared vision of the work to be accomplished is the key to the success of any partnership
- **full engagement of** all partners in the relationship
- **vision** should reflect in all the activities – **culture** of full engagement from the very beginning that leads to a collective enthusiasm and attaining of goals,
- c**lear accountability** in terms of work and **responsibility**
- frequency of quality **communication** between the partners, **collaboration** and resolving of issues, **trust** is an essential ingredient for a successful partnership
- **willingness** and ability of partner to **share** power and control,
- understand the **mission** and the **culture** of individual
- utilisation of **strength** of each partner's capabilities, unique authority and differing flexibilities ;
- **networking**
- **flexible** approach to the need and to responsibility;
- ability to overcome the challenging **barriers;**
- a partnership should be built **step by step** (built incrementally by starting

at the beginning, growing gradually

According to Kennon (2007) a partnership encompasses

- **joint** ownership
- participation in gross return
- collaboration between stakeholders
- **sharing** of profits and losses (**networking**)
- exercise of the partners' **rights to** participation, and **confidentiality**
- **flexibility** in partnership agreement
- **reliability** and **responsibility** in terms of the relationship (legal and financial)

According to the *Business Encyclopaedia* (2007) a partnership involves

- **participating** in gross return
- an incorporated **association** of two or more person
- **objectives**
- collaboration between stakeholders

4.9.2.2.3 Reduction of the identified criteria for the concept of "partnership"

The following criteria were deduced from the dictionary and subject definitions of the concept of partnership:

- a relationship /interpersonal
- a joint agreement (communication)
- cooperation
- full engagement in collective action
- an agreement
- joint decision making
- sharing of resources
- setting a mutual, consensual goal
- respect
- trust
- sharing responsibility
- confidentiality
- collaboration
- networking
- active participation
- active involvement

4.9.2.2.4 Reduction process of identified criteria of the concept of " partnership"

The identified criteria for the concept "partnership" are illustrated in table 4.2.

4.9.2.2.5 Definition of the concept of "partnership"

The definition of "partnership" was formulated on the basis of the criteria identified in table 4.2

Table 4.2 Characteristics of essential and related criteria in respect of a partnership

ESSENTIAL CRITERIA	**OTHER RELATED CRITERIA**
Establishment of **partnership** between male partner, female partner, nurses and significant stakeholders to facilitate male partner involvement in the RH context	▪ Satisfactory **interpersonal relationship** between the stakeholders based on **mutual cooperation, trust, respect** and **confidentiality** (**communication**) ▪ Active **participation** and **involvement** of the stakeholders in all activities ▪ **Collective action, agreement** and sharing of resources **to accomplish** objectives together ▪ Adopting the **shared vision** ▪ Joint **decision making** ▪ **Sharing of responsibility** ▪ **Networking** between the stakeholders. ▪ **Collaboration** between stakeholders

❑ A partnership is a **interpersonal relationship** between stakeholders which is based on a **joint agreement** and a **decision making** founded on **shared vision**, **mutual cooperation**, **trust**, **respect** and **confidentiality** to **cooperate** in **sharing responsibilities** through **full engagement**, **participation**, **involvement**, **collaboration**, **networking**, **collective action** and to **share resources** for the interests of all partners.

4.9.2.3 Examination of the concept of "environment "

The concept "environment is examined as follow:

4.9.2.3.1 Dictionary definition of the concept of "environment"

According to Allen (1990) environment refers to

▪ **physical** surroundings and conditions especially those affecting the lives of people

According to Brown (1993) environment refers to

- **the conditions** in which a person or a community lives and works
- a region surrounding a place, **context** or **setting**, **structures** and **conditions** within which an organism can operate and a system enables a person to operate

According to Schwarz (1994) environment refers to

- **surrounding**, **external** conditions influencing growth of living and work conditions

According to Matthew (1997) environment refers to

- a **context** within or a word or sentence in which a change or process takes place

According to Robinson (1999) environment refers to

- the combination of **external** conditions that surround and influence a living organism

According to Davidson, Seaton and Schwarz (1999) environment refers to

- **surrounding conditions**, especially as **influencing** a person's development or growth and the natural conditions in which we live

According to Neufeldt and Guralnik (1994) environment refers to

- something that **surrounds** and all the conditions, circumstances and **influences** surrounding and affecting the development or growth

According to Soukhanov (1992) environment refers to

- **circumstances** and c**onditions** surrounding one having a combination of **external,** physical condition that affects and **influences** the growth, development and survival of an organism

According to Kahn (1989) environment refers to

- network, the **context** in which something develops

According to Cullen, Davidson, Flackett, Grandison, Marshall, Munro and McGovern (2000) environment refers to

- the **surroundings** or **conditions** that surround and **influence** a living organism
- **conditions** within which something or someone exists

According to Lindberg, Hunter and Kruszewski (1994) environment refers to

- the **physical surroundings that affect** an individual's wellbeing

4.9.2.3.2 Subject definition of the concept of "environment"

According to the Rand Afrikaans University Department of Nursing (2002):

- The environment includes both an **internal** and an **external** environment.
- The **internal environment** consists of dimensions of **body, mind and spirit.**
- The **external environment** consists of **physical, social, and spiritua**l dimensions.

According to Simpson and Weiner (1989) the concept of environment refers to

- the **conditions** under which any person or thing lives or develops
- the sum total of influences which modify and determine the development of life or character

According to Schaefer, Artique, Foli, Johnson, Tommey, Poat, *et al*. (1998) the concept of environment refers to

- the **context** in which we live

According to Freese, Beckman, Boxley-Harges, Bruick-Sorge, Harris, Hermiz, *et al*. (1998) the concept of environment refers to

- all the **internal** and **external factors** that surround and interact with human beings

According to Waite (2002) the concept of environment refers to

- territory, **surrounding**, background and framework

According to Howell (2002) the concept of environment refers to

- existing f**orces** outside the organism and in the **context** of culture

4.9.2.3.3 Usage of the concept of a "conducive environment"

According to Voght and Murrell (1990) a conducive environment

- provides **support**
- **is a no threatening** environment
- people feel **safe** interest
- creates ideas
- **cooperate**
- **is characterised by vision**
- **is characterised by commitment**

According to Hellriegel, Jackson and Slocum (1999) a conducive environment characterised by

- **recognition**
- **praise**
- **reward**
- **resources** for attaining goals
- a facilitator who patient with team members
- **listening** and **encouragement**
- two way **communication**
- **involvement of followers in decision making**

According to Howell (2002, p. 7) facilitating a conducive (partnership) environment involves

- **involvement**
- continuous **support**
- promoting of efficiency in terms of **time, cost and impact**
- **less bureaucracy**
- **clear policies and guidelines**
- recognition of and respect for humanitarian nature
- human , technical and financial recourses **(resources)**
- **sense of ownership**

According to Douglas, Martin and Krapels (2003, p. 2) a conducive environment is one that requires a relationship of positive communication characterised by

- t**rust**
- **mutual respect**
- **openness** between superiors and, subordinates as well as between co-workers
- **teamwork** and **cooperation** characterised by **fairness, openness**, and **trust**

According to Robbins, Odendaal, and Roodt (2003, p. 413) an enabling environment characterised by

- **trust**
- **authenticity**
- **openness**
- **supportiveness**

According to Ellis and Hartley (2000, p. 188–189) facilitating a conducive environment provides

- **praise** and **recognition**
- **sharing of** knowledge, skills and resources

According to Williams (2002, p. 301) new ideas from workers are

- **welcomed**
- **valued**
- **encouraged**

4.9.2.3.4 Reduction of the identified criteria of the concept of "environment"

The following criteria were deduced from the dictionary and subject definitions of the concept of "environment":

- Internal and external
- Factors
- Conditions:
  - Provide **support and a non-threatening** environment.
  - Ensure that the stakeholders feel **safe, interested** and **not apprehensive.**
  - Ensure that the environment promotes encouragement, **commitment**, **recognition**, **praise and reward** (motivation).
  - **Openness**
  - Adequate **resources** for attaining goals
  - Facilitator should demonstrate **patience** with team member.
  - Promote continuous **support** in terms of **time, cost** and impact.
  - Less bureaucracy, clear **policies** and g**uidelines**
  - **Humanitarian** in nature in terms of which individual feels **recognised** within the partnership.
  - **Adequate human**, **technical** and **financial** resources

4.9.2.3.5 Reduction process of identified criteria of the concept "environment"

Table 4.3: Characteristics of essential and related criteria in respect of a conducive environment

Essential criteria	**Other related criteria**
Maintaining a conducive **internal** and **external environment** by eliminating **factors** and **conditions** that would hinder the facilitation process of male partner involvement in the RH and maximise positive conditions	▪ **Create safe, interested** and not apprehensive environment. ▪ Encourage **commitment**, **recognition**, **and praise and reward** (motivation**).** ▪ Demonstrate **patience** with stakeholders. ▪ Demonstrate **respect** ▪ Effective management **resources and time** ▪ **Networking**

4.9.2.3.6 Definition of the concept of "environment"

The definition of the concept of "environment" was formulated based on the criteria identified in table 4 .3

- The environment is **internal** and **external factors** and **conditions** that influence

individuals.

4.9.3 Final reduction process of identified criteria of the main concept of "management of partnership environment to facilitating male partner involvement in the RH context"

In order to arrive at an adequate and workable definition of the main concept, the essential criteria will be further reduced in an attempt to refine them so that the intended meaning may be reflected as suggested by Chinn and Kramer (1995).

Table 4.4: Characteristics of essential and related criteria

ESSENTIAL CRITERIA	OTHER RELATED CRITERIA
Management Effective management of human, financial, physical and materials resources as well as information and time to facilitate male involvement in RH	▪ **Planning** (situational analysis, goal setting, action plan, implementation strategy, and valuation strategy) ▪ **Organising** (designing the structure, assigning responsibility and authority; establishing the command structure and coordination mechanism) ▪ **Directing and leading** (leadership, policies, guidelines and strategies in order to manage the dynamic interaction between the stakeholders ▪ **Control and Monitoring (evaluation)**(setting standards, measuring actual performance, and feedback
Partnership Establishment of partnership (interpersonal relationship) between male partner, female partner, nurses and significant stakeholders to facilitate male partner involvement in the RH context	▪ Satisfactory **interpersonal *r*elationship** between the stakeholders based on **mutual cooperation, trust, respect** and **confidentiality** (**communication**) ▪ Active **participation** and **involvement** in all activities ▪ **Collective action, agreement** and sharing of resources **to accomplish** objectives together ▪ Adopting the **shared vision** ▪ **Joint decision** making ▪ Sharing of responsibility

	▪ **Networking** ▪ **Collaboration** between stakeholders
Environment Maintaining a conducive environment by eliminating factors and conditions that would hinder the facilitation process and minimise positive conditions.	▪ **Create safe, interested** and not apprehensive environment. ▪ Encourage **commitment**, **recognition**, **and praise and reward** (Motivation**).** ▪ Demonstrate **patience** with stakeholders. ▪ Demonstrate **respect** ▪ Effective management **resources and time** ▪ **Networking**

4.9.4 Definition of related concepts

The concepts related to the main concept of the management of a partnership environment to facilitate male partner involvement in the RH context will be now be defined according to their application in the current study.

- **Management**

Mnagement here entails the effective management of human, financial, physical and material resources, and information and time in order to facilitate male involvement in RH. The senior registered nurse in collaboration male partner, female partner, nurses and significant stakeholders carries out the planning in terms of which goals are set, action plans developed, and implementation and evaluation strategies formulated. The act of organising implies that the registered nurse working in the RH facilities designs the structure, assigns responsibilities, and establishes the command structure and coordination mechanism for the stakeholders (male partners, female partners, nurses and significant stakeholders). Through leadership the registered nurses manage the dynamic interaction between stakeholders. Managing include evaluating the outcome by setting standards against which to measure actual performance, to evaluate deviations, to rectify deviations and to give feedback to stakeholders.

- **Partnership**

Partnership is an interpersonal relationship between male partners, female partners, nurses and significant stakeholders to facilitate male partner involvement in the RH context. Partnership implies that the registered nurse promote the joint agreement and decision making founded on shared vision, mutual cooperation, trust, respect and confidentiality to cooperate in sharing responsibilities through full engagement, participation, involvement, collaboration and networking in order to attain a mutual, consensual goal which is in the interests of the partners. Through a partnership, the stakeholders take collective action in sharing resources to address challenges and barriers in matters concerning RH.

- **Environment**

The environment comparises the internal and external factors and conditions that influence individuals, thus the facilitation of male partner involvement in RH requires conducive environment. A conducive environment can be maintained by eliminating factors and conditions that would hinder the facilitation process of male partner involvement in RH and maximising positive conditions. Maximising positive conditions implies that the registered nurse creates a safe, interested and secure environment; encourages commitment, recognition, and praise and reward (motivation), demonstrates patience with respect to stakeholders; manages resources and time effectively and encourages networking.

4.9.5 Definition of the concept of "management of the partnership environment"

The definition of the concept of "management of the partnership environment" was formulated on the basis of the criteria identified in table 4.2.9.

- Management of the partnership environment

The management of the partnership environment by senior registered nurses is a process of managing human, material, financial, physical, information and time effectively by establishing partnerships (interpersonal relationship) between male partners, female partners, nurses and significant stakeholders. The management of a partnership environment may be achieved by maintaining a conducive environment in which factors and conditions that would hinder the facilitation process are eliminated and positive conditions enhanced.

4.10 DEVELOPMENT OF MODEL CASE

According to Walker and Avant (1988, p. 40) a model case is actually a real-life example of the use of concepts that includes all the critical attributes of those concepts. Accordingly, a model was identified and described for the identification of the critical attributes and their related connotations for the meaningful utilisation of a partnership model to facilitate male partner involvement in the RH context. The scenario will be described first and the application will follow.

4.10.1 The construction of a model case

The model case represents a further approach to the development of conceptual meaning. It enables the researcher to construct a case that represents the experience which is being explored. The following scenarios are used to illustrate the concepts identified.

A four-day conference for registered nurses and midwives was held from 24–26 March, 2009 at the Kunene Hotel in the Oshikoto region. The participants came from different clinics, health centres and hospitals. The aim of this conference was to devise strategies to mitigate the impact of maternal deaths, diseases and the problems that may affect mothers and children during antenatal and postnatal care.

The chairperson of the conference welcomed the participants from the different clinics, health centres and hospitals in the Oshikoto Region. The agenda of the meeting was explained and adopted. The participants were urged to participate actively so that they could put forward effective recommendations and strategies to address the abovementioned issues.

All the representatives from the different health facilities were given the chance to present those problems that affect their daily work in RH services during antenatal and postnatal care. The major problem which was identified from all the reports was the lack of involvement of male partners in RH.

On the second day the participants were divided into groups to study possible causes for the reluctance on the part of male partners to become involved in RH. The following problems were identified.

- The first problem identified was the *negative perceptions of male involvement on the part of community members and significant stakeholders*. The following factors were identified as influencing these perceptions: interpersonal relationships, poor communication, negative attitudes, a lack of trust and confidentiality on the part of the male partners, personal attributes, shyness and embarrassment on the part of the by male partners in respect of participation in the RH services and sociocultural barriers including polygamy, myths, gender disparity, migration, alcohol abuse by male partners and household duties and responsibilities.

- The second problem identified was *the lack of optimum functioning of the health care delivery system in facilitating male partner involvement in RH*. The main contributory factor to this problem was perceived as the inaccessibility of those health facilities that provide the RH services. This inaccessibility was seen in terms of the long distances the male and female participants had to travel to the heath facilities together with the unavailability of transport and the high transport costs involved. In addition, the delegates to the conference emphasised that the main problem behind the

male partners not accompanying their female partners could be that the expense such visits incurred. Other reasons could be staff shortages, inadequate buildings and infrastructure, the unavailability of the resources, and a lack of policies and legislation on male involvement in RH. Poor networking and unsatisfactory partnerships between stakeholders in the community and as well as in the RH facilities, for example, clinics, health centres and hospitals,

- The third factor affecting male partner involvement in RH was *the lack of dissemination of information as well as the lack of education and training* in respect of the male partners, female partners and nurses in order to update their knowledge and skills.

On the third day of the conference the chairperson provided feedback and the delegates were given the opportunity to scrutinise and come up with the core problems that could be affecting the process. In discussion with two consultants from South Africa the major problem was identified as being threefold:

1. Poor management of human, material, financial, time and information. This was perceived in terms of planning, organising, directing, and supervision.
2. Poor partnerships between male partners, female partners and the other stakeholders who could play a vital role in the facilitation of male partner involvement in RH.
3. Deficient environment to promote the active participation, collaboration and involvement of stakeholders.

During the meeting of the nurses the main theme of the conference was adopted as the "management of the partnership environment" to promote male partner involvement within the RH context.

On day four the chairperson suggested that the participants divide into three groups in order to come up with a strategic plan on the way in which to promote the effective management of the partnership environment. The first group dealt with the theme of "management", the second group "partnership" and third group the "environment". Each group was given an opportunity to formulate both the central theme and related themes to support the central concept for the main themes which had been identified.

Group1 – management. This group came up with the central theme of the effective management of the human, financial, physical, and material resources and of information and time in order to facilitate male partner involvement in RH. The realization of this central theme would mean that the managers or the senior registered nurse would have to **plan** the way in which to manage the above factors. This planning would include: **goal setting**, **action planning**, **and implementation of strategies** and **evaluation of strategies.** Accordingly**,** the senior registered nurse manager would have to take responsibility for **designing the structure**, **assigning responsibility** and **authority**, and establishing the **command structure** and the **coordination** mechanism. In directing the senior registered nurse

manager would have to implement **leadership** principles and strategies in order to manage the dynamic interaction between the stakeholders. In her controlling and monitoring the senior registered nurse would have to devise strategies in respect of setting **standards**, **measuring actual performance**, **evaluating deviations** and **rectifying any deviations**.

Group2 – partnership. This group came up with the central theme of an adequate partnership between stakeholders to facilitate the active participation and involvement of male partner in RH together with sound **interpersonal relationships** between the stakeholders based **on mutual co-operation, collaboration, communication, the sharing of responsibility,** joint **decision-making, trust, respect and confidentiality.** Accordingly**,** it would be incumbent on the senior registered nurse to promote the active participation and involvement of the stakeholders in all activities, c**ollective action,** the sharing of recourses **to accomplish** together , the adopting of the **shared vision, a sensitised cultural** realisation on the part of the stakeholders, the setting up clear accountability and responsibilities in respect of all the stakeholders, the utilisation of the capabilities, and unique authority of each partner, the ability to meet the challenges affecting the progression of male involvement**,** and, finally, to promote the rights to participate in the reproductive health and the **accessibility** of all the stakeholders .

Group3 – environment. This group came up with the central theme of creating a conducive internal and external environment to promote the active participation and involvement of all the stakeholders to facilitate male partner involvement in RH. Accordingly, it would be incumbent on the registered nurses to provide **support and a no threatening** environment in order to ensure that the stakeholders felt **safe,** and not apprehensive**.** The environment should promote encouragement, **commitment**, **recognition**, **praise and reward** (motivation) and also have access to adequate **resources** for attaining the goals of involve male partner in the reproductive health. The facilitator should demonstrate patience with team members, and promote continuous **support** in terms of **costs** and impact. There should be less beaurocracy, clear **policies** and g**uidelines; a humanitarian** attitude in terms of which the individual would feel **recognised** and **respected and** adequate **human**, **technical** and **financial** resources.

In conclusion, the participants recommended that the steering committee come up with tools or model strategies that could assist the registered nurses in health facilities in their managing of these reproductive health facilities. This would help overcome problems such **conflict management** arising from poor interpersonal relations and attitudes, poor **management of time**, staff shortages and overcrowding. These strategies would also help provide clinic staff with information to give to the clients in order to motivate and to encourage the male partners to attend the health facilities.

In terms of the second aspect, the senior registered nurses decided to establish a sound partnership between the stakeholders (recipient) by establishing and strengthening the interpersonal relationship between the stakeholders based on **mutual cooperation**, **collaboration**, **communication**, the sharing of responsibility, joint decision making, trust, respect and confidentiality .

Thirdly, the nurses who participated in the conference urged management to come up with a model that could create or facilitate a conducive internal and external environment, that is, an environment characterised by s**afety**, **interest, patience, an absence of apprehension**, **adequate resources**, **commitment**, **recognition**, **praise and reward (motivation),** in order to facilitate active participation and involvement on the part of stakeholders to facilitate male partner involvement in RH.

Lastly, it emerged that the participants wanted this model to articulate clearly the way in which the nurses should establish a relationship (partnership) between male and female partners that would facilitate **openness and awareness** and **motivate the male partners to participate** in RH. The second step involved empowering the partners with **knowledge and skills** about their roles, responsibilities and accountability in terms of RH. The aim of empowering the stakeholders to understand and realise their roles, responsibilities and accountabilities is that this empowerment could lead to **behavioural changes** which would move them to accept their **responsibilities**. The final product would, then, be the **active partnership and involvement** of male partners in the RH context which would, in turn, need to be monitored and evaluated.

The Minister of Health and Social Services closed the conference and urged all the stakeholders to view this matter of involving male partners in reproductive health in a very serious light. He suggested that the next conference should embark on formulating the **model and guidelines to facilitate male partner involvement in the RH context.**

4.11 THE RESEACHER'S MENTAL MAP

The concepts identified in terms of a partnership to facilitate male partner involvement in RH are classified according to the practice model as described by Dickoff *et al.* (1968) using the elements of practice theory. The following section focuses on the conceptualisation of elements such as *context (environment), agent, recipient, procedure, dynamics and terminus.* The detailed conceptualisation of these elements will be discussed fully in chapter 5. These concepts are presented in figure 4.1.

4.12 RELATIONSHIP STATEMENTS

The relationship statements were formulated from essential and related criteria, the researcher's mental map and other concepts.

- An effective management of human, financial, physical, material, information and time to facilitate male involvement in RH.

- The senior registered nurse in collaboration male partner, female partner, nurses and significant stakeholders carries out the planning in terms of which goals are set, action plans are developed, and implementation and evaluation strategies are formulated.

- A partnership is an interpersonal relationship between male partner, female partner, nurses and significant stakeholders to facilitate male partner involvement in the RH context.

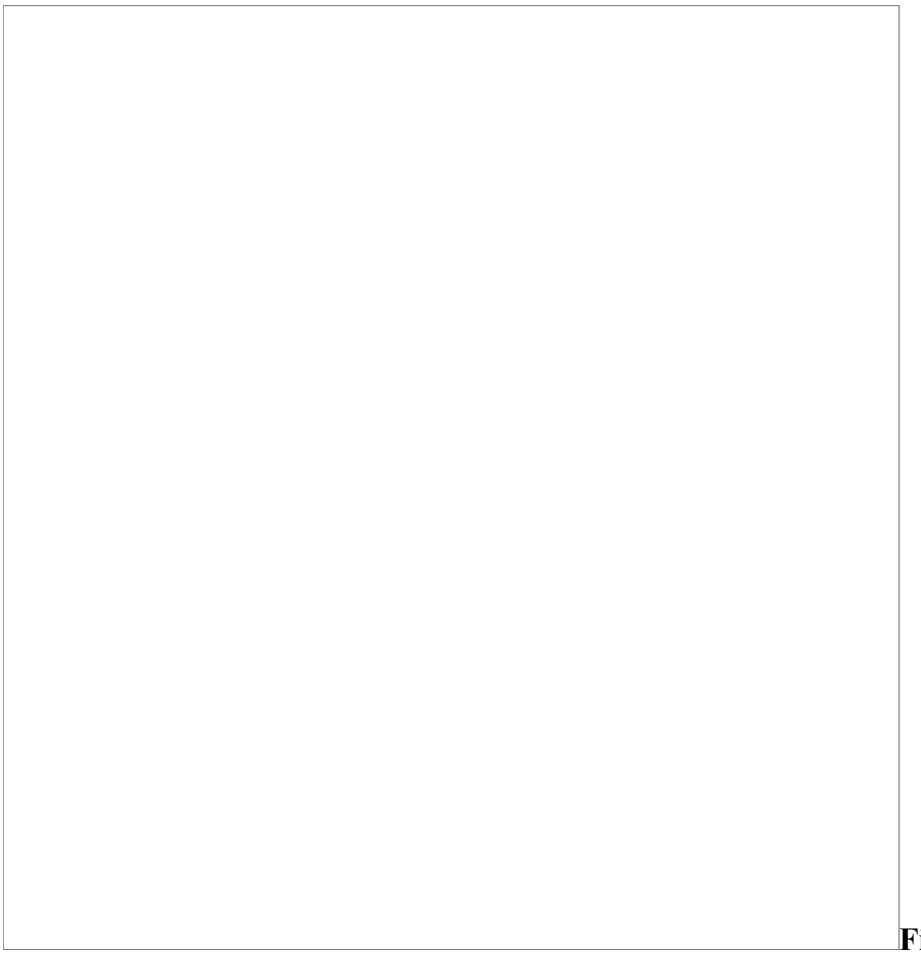

Figure 4.1 Researcher's mental map

- A partnership implies that the registered nurse promote the joint agreement and decision making founded on shared vision, mutual cooperation, trust, respect and confidentiality to cooperate in sharing responsibilities through full engagement, participation, involvement, collaboration, networking, in order to attain a mutual, consensual goal which is in the interests of the

partners.

- Through partnerships, the stakeholders collectively share resources and act to address challenges and barriers in matters concerning RH.

- A conducive environment can be maintained by eliminating factors and conditions that might hinder the facilitation process of male partner involvement in RH and maximising positive conditions.

- Maximising positive conditions implies that the registered nurse creates a safe, interested and secure environment; encourages commitment, recognition, and provides praise and reward (motivation), demonstrates patience and respect towards stakeholders; and manages resources and timeeffectively, as well as encouraging networking.

4.13 PROPOSED STRUCTURE TO BE USED IN THE DEVELOPMENT OF THE MODEL

The proposed structure to be used in the development of the model was derived from the main categories, categories and sub-categories of data analysis (chapter 3) and the central concepts of management, partnership and management, and environment (chapter 4), as well as the elements of theory practice. These structure the categories in terms of five phases, namely, situational analysis, establishment of partnership, management process, maintaining the conducive environment and control and terminus/outcome

4.13.1 Elements of theory practice

The elements of the theory illustrated in figure 4.2 include context, agent, recipient, procedure, dynamic and outcome within the context of facilitation.

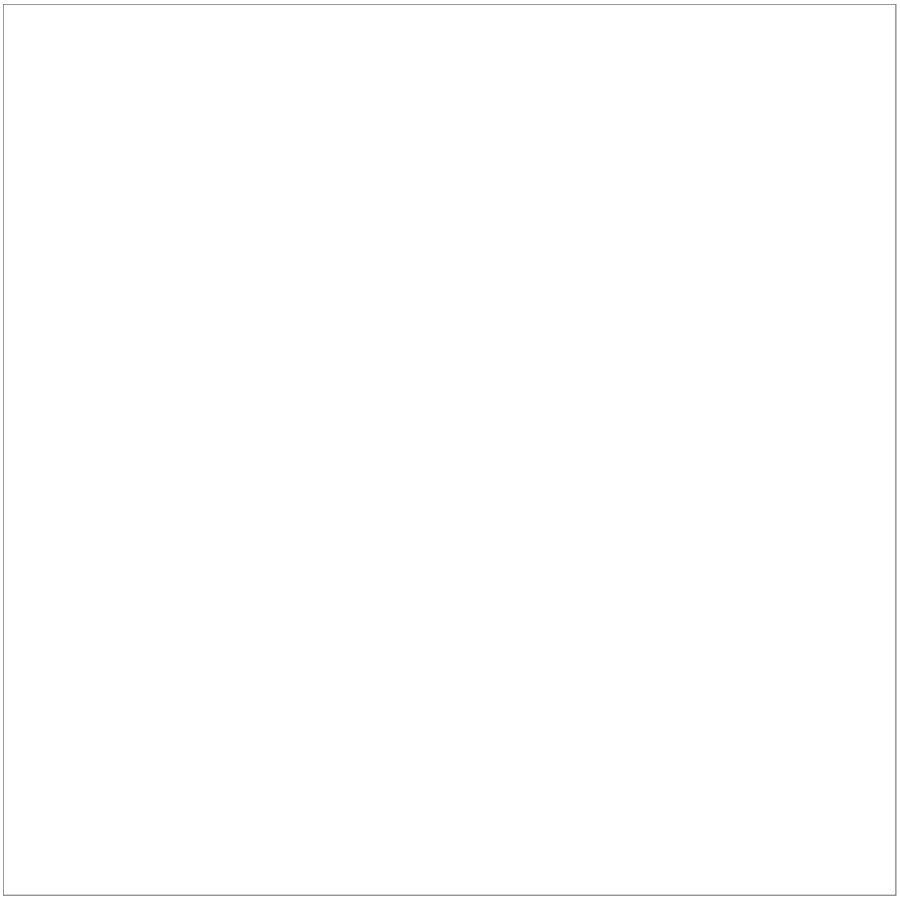

Figure 4.2: Integration of the elements of theory practice in the facilitation process

4.13.2 External and environmental factors

The figure 4.3 below presents aspects of both the external environment (community) and the internal environment (health facilities) to be analysed during situational analysis.

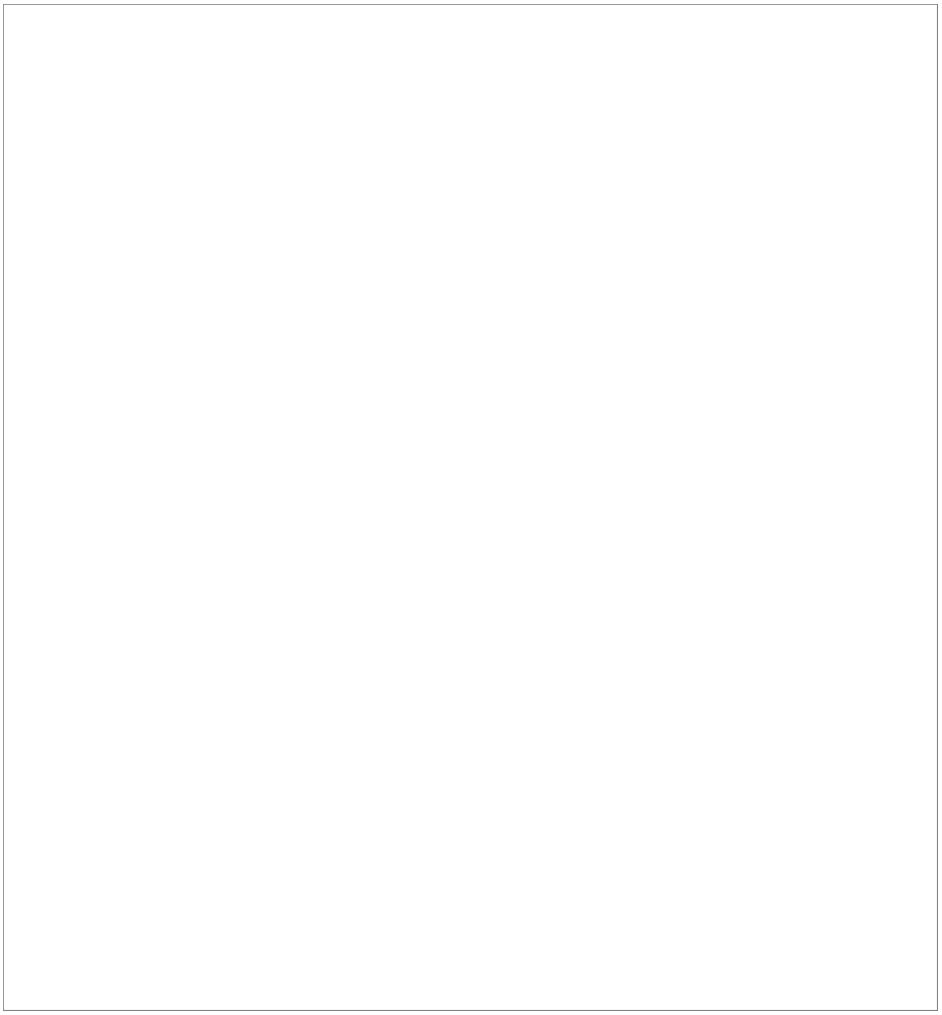

Figure 4.3: The external and internal environments as components of situational analysis

4.13.3 Establishment of a partnership environment

Figure 4.4 illustrates the interpersonal relationship (partnership) between the stakeholders – agents (significant others, nurses and the researcher) and recipients (male partners, female partners). The concepts involved in the establishment of a partnership include shared vision, networking, mutual cooperation, collaboration, communication, the sharing of responsibility, joint decision making, participation and involvement.

4.13.4 Process for the "management the partnership environment"

Figure 4.5 illustrates the process of managing human, material, and physical resources, and time and information through planning, organising, directing and control.

4.13.5 Maintaining a conducive environment

The concepts for maintaining a conducive environment are illustrated in Figure 4.6.

4.13.6 Management of the partnership environment

The concepts “management”, “partnership” and “environment” are illustrated in Figure 4.6.

4.14 SUMMARY

In this chapter the central concept of the management of the partnership environment and related concepts were defined. Based on this definition, the relationship statement was formulated. A mental map to illustrate agent, recipient, dynamic procedures, context and outcome was drawn up. Acoordingly, a model case was developed from the characteristics of the main concept which had been identified. The mental map as well as the proposed structure to be used for theory development was illustrated. In the following chapter the concepts identified will be used to construct a model together with input from both experts in model development and the nursing specialist who supervised this study.

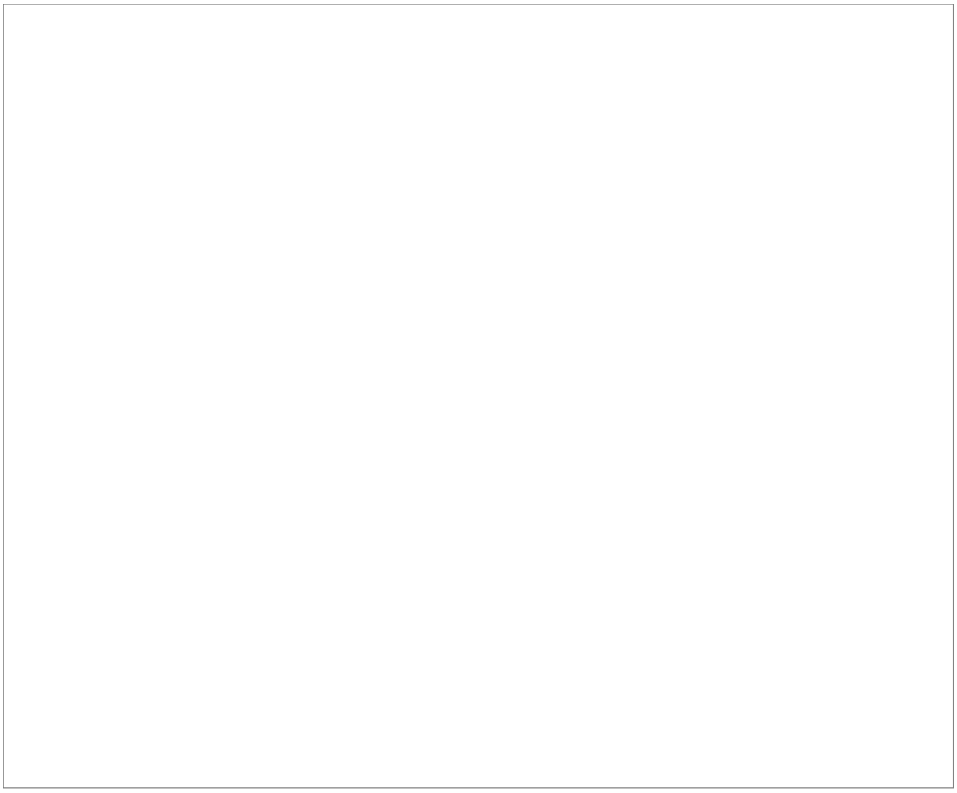

Figure 4.4: The relationship between stakeholders – agents (registered nurses, significant stakeholders) and recipients (male and female partners) in partnership

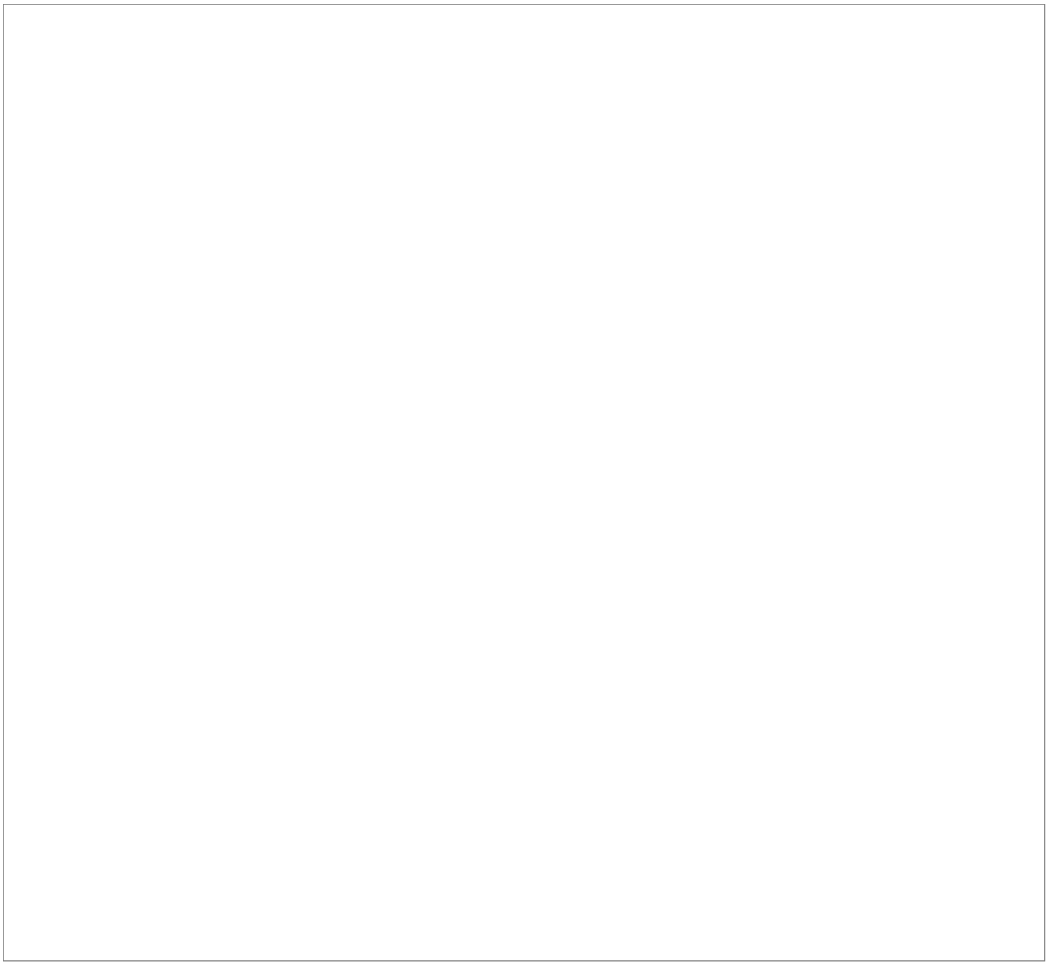

Figure 4.5: The components of the management process,

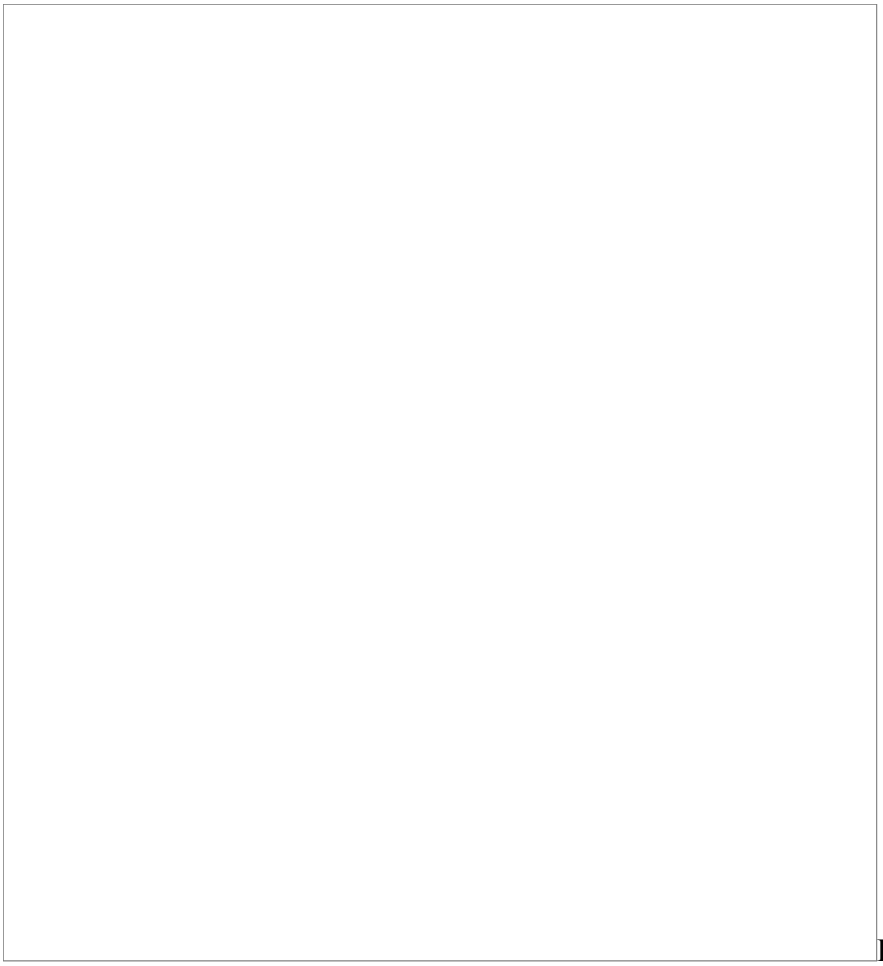

Figure 4.6: Illustrates the central concept of partnership environment

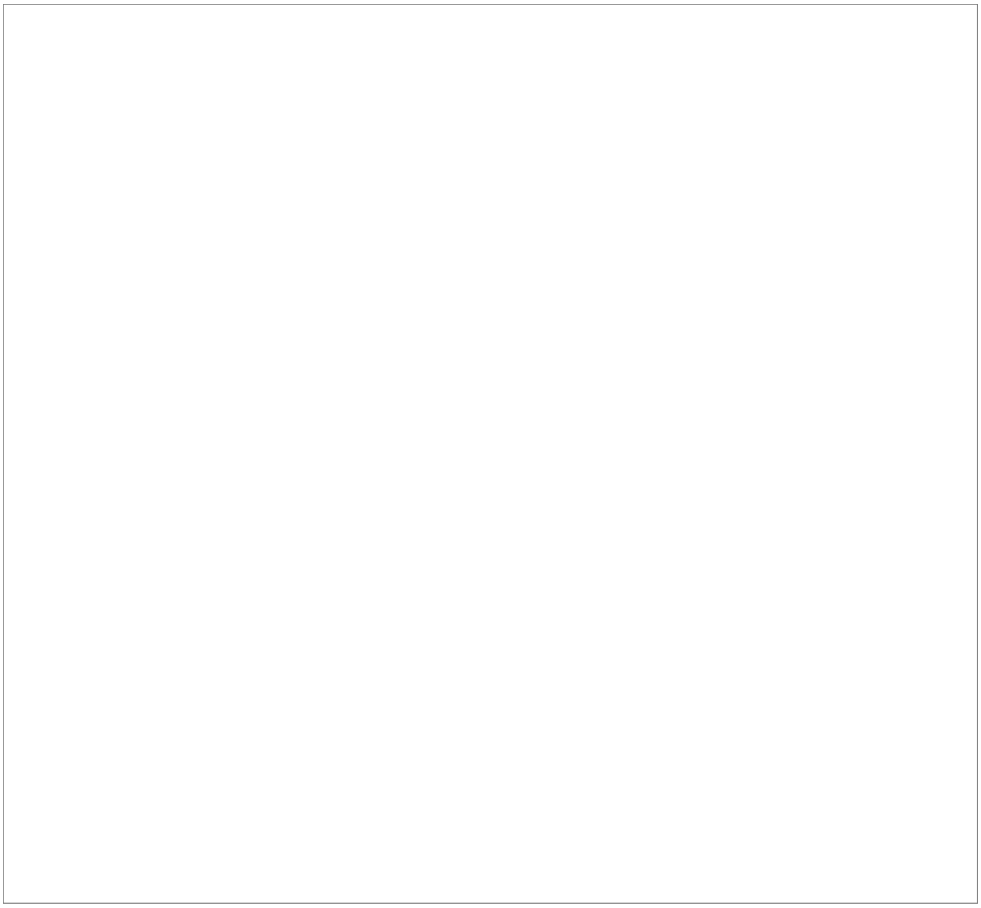

Figure 4.7: Relationship between the central concepts of management, partnership and environment

CHAPTER 5

DESCRIPTION OF A MODEL TO FACILITATE MALE PARTNER INVOLVEMENT IN THE REPRODUCTIVE HEALTH CONTEXT IN THE OSHIKOTO REGION IN NAMIBIA

5.5 INTRODUCTION

The aim of this chapter is to describe a partnership model to facilitate male partner involvement in the RH context. The findings in chapter 3, step1 – concept analysis – which comprised the identification, definition and classification of concepts and the construction of an relationship between concepts and statements (chapter 4) formed the basis for the development of this model.

This model to facilitate male partner involvement in RH is based on the theory generation of Chinn and Kramer (1991). The central concepts are defined by using the rules described by Rossouw (2000/1,) and Copi and Cohen (1996). Lastly, the model evaluation will be done in accordance with the method of Chinn and Kramer (1991).

5.6 MODEL DSCRIPTION

In the description of the model, the researcher will use the following headings and subheadings – an overview of the model, the purpose of the model, and the structure of the model. The latter comprises components such as assumptions on which the model is based, and the definition of concepts, which consists of theoretical definitions of the central statement and related concepts, as well as other related definitions as they appear in the five phases illustrated in the development of the model. These are followed by a discussion of the process and an evaluation of the model

5.6.1 **An overview of the model**

A schematic presentation in figure 5.1 illustrates a model to facilitate male partner involvement in RH. Each component of the model will be explained in terms of the way in which it contributes to the model as whole. This schematic presentation illustrates the way in which the registered nurses as agents in a partnership with other significant stakeholders manage the partnership environment in order to facilitate male partner involvement in RH.

FIGURE

Figure 5.1: A model to facilitate male partner involvement in the reproductive health

The RH environment comprises both an external environment (community) and an internal environment (health facilities). The internal environment consists of health facilities such as clinics, health centres, and hospitals at the different levels – community level, district level, regional level and national level – at which RH services are being offered.

Each environment is characterised by interrelated dynamic factors and challenges that both influence and hinder the involvement of male partners in RH. The factors and challenges in respect of each environment may be described as follows:

The *external environment (community)* in this study comprises the external and internal factors within the community that influence male partner involvement in RH. The challenges (dynamic) in respect of the internal community environment in this study may be expressed in terms of *poor interpersonal relationships* between the stakeholders, poor communication, negative attitudes, a lack of confidentiality and trust, and *personal attributes* including shyness and embarrassment on the part of

both the male and female partner. The challenges in respect of the external community environment that hamper male partner involvement in RH include sociocultural aspects such as polygamous practices, myths about male involvement in RH, gender disparity, migratory labour and abuse of alcohol by male partners.

The internal environment (health facilities) comprises both the external and internal factors that influence male partner involvement in RH. The internal factors include the challenges (dynamics) inherent in the health facility environment and issues such as poor management principles (inadequate policies and legislations); poor infrastructure; staff shortages; poor networking in the health facilities that provide RH services and the lengthy periods of time spent by the partner at the health facilities. The challenges within the external health facility environment in this study may be expressed in terms of, firstly, the inaccessibility of the health facilities arising from long distances and the shortage of transport available to partners wishing to visit the RH facilities. Secondly, the high costs of reproductive treatments and services as well as poor networking in, for example, the wards or departments, also constitute challenges within the external health facility environment.

The *agent* refers to the researcher, senior registered nurses and other significant stakeholders in either the community or in the health facilities. The primary agent is the researcher who developed a model and strategies for the facilitation of male partner involvement in RH. The co-agent is the senior registered nurses (primary health supervisor) within the health context (environment) in collaboration with influential (significant) people within the community, line ministries and NGOs.

The *agents* (researcher and registered nurses) in this model possess scientific knowledge and skills (competencies) that will enable them to manage the partnership environment in such a way as to facilitate male partner involvement in RH. This knowledge and skills refer to the following:

- The research conducted that will enable the agent (the researcher) to explore and to describe the needs and challenges that are hampering the process of involving male partners in RH services. These challenges will form a basis to support the agent during the *partnership* and *management* phase in order to facilitate the involvement of both the male and female partners in RH.
- Nursing skills will enable the registered nurse, as the agent, to promote the active participation and involvement of the male partners, female partners, nurses and significant stakeholders in, *inter alia*, adopting a shared vision, making joint decisions, and sharing responsibility, collective action and agreement. However, for the stakeholders (male and female partners and the nurses) to achieve the partnership in totality it is essential that communication, networking, motivation and collaboration be strengthened.
- Management skills will enable the agent to manage both the external and the internal environment in terms of human, financial and physical resources, information, time and material through planning, organising, directing and controlling. The underlying *dynamic* of facilitation of male partner involvement RH is carried out in four phases, namely, situational analysis, partnership, management and control, and outcome phases. The end product in terms of the involvement of the male partner in RH is the core and fundamental facet within the RH context.

5.6.2 **The purpose of the model**

The purpose of the model is to provide a theoretical framework for nurses and significant stakeholders within the health facilities to facilitate male partner involvement in the RH context. However, this is possible only if the process takes place through the management of the partnership environment in five phases within the framework of the management process. These phases comprise situational analysis, partnership, management of the human, financial, physical and material resources, information, and time spent planning organising, directing and control in order to attain the outcome – "male partner involvement in RH".

5.6.3 **The structure of the model**

The structure of the model comprises the assumption on which the model is based, concept definitions (central statement and related concepts), relationship statements and the nature of the structure (Chinn & Kramer, 1991). These may be described as follows:

5.6.3.1 The assumptions

The Theory for Health Promotion in Nursing (THPN) (Department of Nursing Science, Rand Afrikaans University, 1999) is used as the theoretical framework. This theory views male partners, female partners, nurses and other stakeholders as spiritual beings who function holistically in an integrated, interactive manner within the environment. The primary assumption of this model is based on facilitating male partner involvement by managing the partnership environment. Using the THPN as a basis, the following assumptions were derived by means of deductive reasoning.

- Male partners, female partners and nurses are perceived holistically in interaction with both the internal and the external environment.
- The internal (community) and external (health facilities) environments exert an influence on the involvement of male partners in the RH context.
- The nurse (registered nurse), as agent, requires
  - research knowledge and skills in order to explore and describe the factors that influence male partner involvement in the RH context and to conduct a situational analysis
  - interpersonal skills such as communication, networking, collaboration and motivation in order to facilitate the partnership between the stakeholders through shared vision, mutual cooperation, the sharing of responsibility, and joint decision making
  - knowledge of management principles and strategies in order to plan, organise, direct and control human, financial and material resources, information, and time effectively so as to facilitate male partner involvement in RH
- Male partner involvement in the RH context is dynamic, is a partnership and is an interactive process that requires input from partners, individuals, families, communities and the government at large.
- Male partner involvement in RH is an ongoing process which requires monitoring, evaluation and the provision of feedback to the stakeholders.

5.6.3.2 Theoretical definitions of the central and related concepts

The central statement – "management of the partnership environment" – will be defined first and this will be followed by definitions of the other related concepts as they emerge in phases 1, 2, 3 and 4.

5.6.3.2.1 Definition of the central statement

The central statement which comprises statement and concepts may be described as follows:

Management of partnership environment: The management of the partnership environment by senior registered nurses is a process of the effective management of human, material, financial and physical resources, information and time by establishing partnerships (interpersonal relationship) between male partners, female partners, nurses and significant stakeholders. The management of the partnership environment may be achieved by maintaining a conducive environment by eliminating factors and conditions that would hinder the facilitation process and minimise positive conditions. During this process the registered nurse would apply fundamental management processes and principles such as planning, organising, leading and control.

Management: The effective management of human, financial, physical, material resources, information and time to facilitate male involvement in RH. The senior registered nurse in collaboration with male partners, female partners, nurses and significant stakeholders carries out the planning in terms of which goals are set, action plans are developed, and implementation and evaluation strategies are formulated. The act of organising implies that the registered nurse working in RH facilities designs the structure, assigns responsibilities, and establishes the command structure and coordination mechanisms for the stakeholders (male partner, female partner, nurses and significant stakeholders). Through leadership the registered nurses manage the dynamic interaction between the stakeholders. Managing includes evaluating the outcomes by setting standards against which to measure actual performance, evaluate deviations, rectify deviations and give feedback to the stakeholders.

*Partnership***:** A partnership is an interpersonal relationship between male partner, female partner, nurses and significant stakeholders to facilitate male partner involvement in the RH context. A partnership implies that the registered nurse promote joint agreement and decision making founded on a shared vision, mutual cooperation, trust, respect and confidentiality to cooperate in sharing responsibilities through full engagement, participation, involvement, collaboration, networking, in order to attain a mutual, consensual goal which is in the interests of the partners. Through a partnership, the stakeholders take collective action by sharing resources to address challenges and barriers in matters concerning RH.

Environment: The environment comprise the internal and external factors and conditions that influence individuals, thus the facilitation of male partner involvement in the RH requires an environment favourable to such involvement. Such an environment can be maintained by eliminating factors and conditions that would hinder the facilitation process of male partner involvement in RH and maximising positive conditions. Maximising positive conditions implies that the registered nurse creates a safe, interested and secure environment; encourages commitment, recognition, and praise and

reward (motivation), demonstrates patience and respect for stakeholders; and effectively manages resources and time as well as encouraging networking.

5.6.3.3 Relationship statements

According to Chinn and Kramer (1995, p. 96), a relationship statement refers to a description, explanation, or prediction of the nature of the interaction between the concepts of a model. The following relationship statements were formulated in respect of the model to facilitate male partner involvement in the RH context in the Oshikoto Region:

- An effective management of human, financial, physical and material resources, and information and time, to facilitate male involvement in RH.

- The senior registered nurse, in collaboration with male partners, female partners, nurses and significant stakeholders, carries out the planning in terms of which goals are set, action plans are developed, implementation occurs and evaluation strategies are formulated.

- A partnership is an interpersonal relationship between male partner, female partner, nurses and significant stakeholders to facilitate male partner involvement in the RH context.

- A partnership implies that the registered nurse promote of the joint agreement and decision making founded on a shared vision, mutual cooperation, trust, respect and confidentiality to cooperate in sharing responsibilities through full engagement, participation, involvement, collaboration, networking, in order to attain a mutual, consensual goal which is in the interests of the partners.

- Through the partnership the stakeholders share collective resources and action to address challenges and barriers in matters concerning RH.

- A conducive environment can be maintained by eliminating factors and conditions that would hinder the facilitation process of male partner involvement in RH and by maximizing positive conditions.

- Maximising positive conditions implies that the registered nurse creates a safe, interested and secure environment; encourages commitment, recognition, and praise and reward (motivation), demonstrates patience and respect for stakeholders; and manages resources and time effectively, as well as encouraging networking.

5.6.3.4 Nature of the model

The structure of the model includes the central element of the model, concepts, statements and

relationships between the concepts. The model consists of the context in which the RH services are delivered, the agent (the facilitator of the process), the recipient (male in partnership with female partner), and the dynamic challenge that hinders male partner involvement in RH procedures, processes, and purpose. The following colours were used during the development of the model. The rationale behind using these colours is described as follow:

- Green – symbolises life as well as prosperity, healing, cooperation and growth (*environment*).
- Purple – symbolises healing, peace, royalty, patience and happiness (*outcome of facilitation*).
- Blue – symbolises healing, understanding, tranquillity, protection, peace, happiness, mediation, sharpness, the power to perceive, spiritual awareness and patience (*partnership*).
- Dark blue – symbolises changeability (*situational analysis*).
- Orange – symbolises encouragement, strength, ability to concentrate, attraction, adaptability and stimulation (*management*).
- Pink – symbolises the overcoming of evil, love, friendship, compassion, and relaxation (*relationship between male and female partner*) (see Figure 5.1).

The model consists of two rectangles in green (light and dark), which depict the context as the dynamic environment that occurs within the legal and professional boundaries which exert an influence on male involvement in RH. The dark green depicts the external environment while the light green depicts the internal environment.

The community environment (external) signifies that, when the male partner, female partner and the nurses enter the health facilities, it is, in the main, the external community environment that influences

their perceptions about RH. These influences may be in terms of either accepting or rejecting the services, roles and responsibilities in the RH context.

Within the blue block there are three blue circles which depict the recipient (male partner and female partner) and the agent. The two green circles depict the agents (researcher and nurses). The circle which represents the male partner is larger than the other circles as this symbolises the negative attitudes, dominant behaviour over female partner, poor communication, aggression and lack of responsibility towards the female partner. The female partner is depicted by a smaller circle in order to symbolise the oppression and voicelessness of women in terms of RH decision making.

The dotted, interlinked line between the male partner, female partner, nurses, researcher and significant stakeholders signifies the poor interpersonal relationships, which include negative attitudes and poor communication.

The two green circles inside the blue rectangle of the partnership phase represent the agents – the researcher and the senior registered nurse. The green colour symbolises the growth of the agent in terms of knowledge and skills in the fields of nursing, management and research in order to manage the partnership environment and carry out a situational analysis.

The blue rectangle depicting the partnership contains a light pink rectangle which embraces the two circles depicting the recipients – the male and female partners – with an arrow to indicate the both the partnership and the bond that required in the RH context. Pink was used to symbolise the future relationship between the male and female partners, which would be characterised by love, friendship, compassion and repose. This relationship would come about once they had utilised the RH services together.

The underlying dynamic, namely, facilitation, is indicated by a solid line at the bottom of the model in order to symbolise the fact that this dynamic underlies both the partnership and the management phases.

The management process is depicted by an orange rectangle which contains four lines and four circles. The purpose of this is to represent the management process of planning, organising, leading and control of human, material, financial and physical resources (environment) and time within a partnership and in collaboration with the other stakeholders, either in the health facilities environment or in the community environment. The phases such as situational analysis; establishment of partnerships; management processes; maintaining a conducive environment andtermination and evaluation outlined as follows are integrated in the management process (detailed description of these phases in 5.2.4.):
Phase 1 – situational analysis. In this phase the agent utilised research skills to identify the needs and challenges that affect or influence the stakeholders (male partners, female partners, nurses, and significant stakeholders) within the community and the health facilities environments. The challenges identified in this phase form the basis on which the agent will deploy the management process in order to manage the partnership environment (see figure 5.1).

Phase 2 – establishment of partnership: In this phase the agent utilised interactive facilitation processes, such as communication, involvement, participation, collaboration and networking. The facilitation of a partnership between the stakeholders so as to promote male partner involvement in RH implies the adoption of a shared vision, cultural realisation and knowledge, and sound interpersonal relationships which are based on mutual cooperation, collaboration, networking, communication, the sharing of resources and responsibilities, joint decision making, trust, respect and confidentiality. Through the partnership the stakeholders engage in collective action by sharing resources, addressing challenges and barriers and participating actively in matters concerning RH (see figure 5.1).

Phase 3: – management process. In this phase the actual process of facilitation is fully implemented by the agent using management steps such as planning, organising directing/leading and control, as well as leadership policies and guidelines in order to manage the dynamic interaction between male partners, female partners and nurses during the facilitation process. The facilitation process is implemented on four levels which are indicated with four oval circles joined by a continuous line to symbolise the continuity and ongoing aspect of the facilitation process. The four levels on which the facilitation process takes place may be described as follow:

1. Planning in terms of which goals are set, action plans developed, and implementation and evaluation strategies formulated by the senior registered nurse in collaboration with other stakeholders.
2. The act of organising implies that either the registered nurse or the nurses working in RH facilities design the structure, assign responsibility to subordinates, and establish the command structure and coordination mechanism in order to facilitate male partner involvement in RH.
3. Through the implementation of leadership and management principles and strategies, such as time management, conflict management and the management of change, the registered nurses manage the dynamic interaction between the stakeholders.
4. By setting the standards by which to measure actual performance, evaluating deviations, rectifying any deviations and providing feedback to the partners, a registered nurse will be able to determine the degree of male partner involvement in RH (see figure 5.1).

Phase 4 –maintaining a conducive environment. In this phase the registered nurse perpetuates a conducive environment by ensuring that the environment is safe and interesting and that it is characterised by commitment, motivation, patience, support, respect, adequate resources and networking. See figure 5.1.

Phase 5 – termination and evaluation. In this phase the agent utilises controlling strategies which include setting standards, measuring actual performances, evaluating deviations and rectifying any deviations. The provision of sufficient feedback to the partners by the registered nurses is one of the most important measures used to eliminate deviations and to improve the active participation of male partners in RH. Such feedback assists the agent to formulate specific goals, set measurable targets which must be met at specified times and describe the way in which to attain these targets. As indicated by Levenstein (1984), involving all the partners in the feedback process produces the best results (see figure 5.1).

5.6.4 **Process description of the model**

The process of the model to facilitate male partner involvement in RH takes place in four interdependent phases within the RH context. These five phases are as follows:

Phase 1: Exploratory and situational analysis

Phase 2: Establishment of the partnership

Phase 3: Management process

Phase 4: Maintaining the conducive environment

Phase 5: Control and terminus/outcome

5.6.4.1 Phase 1: Exploratory and situational analyses

This phase involves conducting both an exploratory and a situational analysis in order to explore and describe those factors that are impeding male partner involvement in RH. The aim of the situational analysis is, firstly, to determine the feasibility of the facilitation process aimed at promoting male partner involvement in RH. Secondly, the aim of the situational analysis is to assist the registered nurses to establish a partnership and to manage the human, financial and material resources, and time so as to facilitate male partner involvement in RH.

The situational analysis will be conducted by the registered nurse in collaboration with the other stakeholders in the health facilities, as well as with significant stakeholders from the community, the line ministries or NGOs.

The situational analysis may be conducted in those health facilities that provide RH services at community, district, regional or national level. The health facilities may include clinics, health centres and hospitals at district, regional and national level. The factors to be analysed include infrastructure, availability of human and material resources, policies and regulations.

The stakeholders to be analysed include the male partners, female partners, nurses and significant stakeholders in the community. The situational analysis can be conducted in two sections – the community environment and the health facilities environment. The findings may be presented as was illustrated in chapter 3.

The identification and selection of the key stakeholders will be followed by the joint appointment of the task team to conduct the situational analysis.

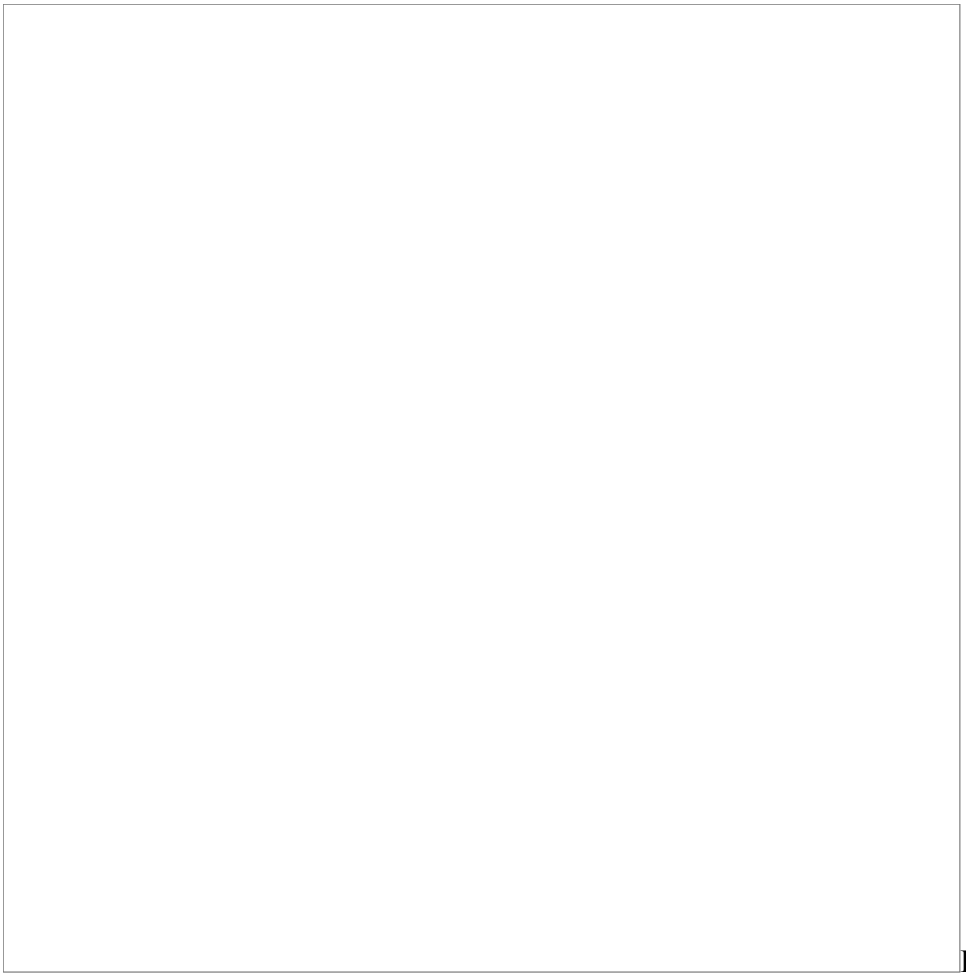

Figure 5.2: Phase 1 Situational analysis and Phase 2 Establishment of the partnership

The function of the task team is to identify the scope of the information required for the situational analysis. The ambit of the analysis includes examining the operational requirements of both health facilities that provide RH services, analysing the information (data) collected by the researcher in the Oshikoto Region, and scrutinising legislation/policy on both RH and gender issues, Nursing Acts, and Nursing regulations (scope of practice of nursing, since the nurse will be a major facilitator of male partner involvement in RH).

In light of the results which emerged in chapter 3 one may conclude that the findings of this study may be used as a guide for a situational analysis either in the external or internal environments.

In terms of the external environment the following factors may be analysed – perceptions; interpersonal relationships (attitudes, communication, respect, secrecy, confidentiality, trust, responsibility, and support mechanism), personal attributes (fear, shyness and embarrassment) and sociocultural barriers (polygamous practices, myths about male involvement in RH, gender disparity and alcohol abuse by male partners, migratory labour practices, and household duties).

In terms of the internal environment the following factors may be analysed – accessibility of RH facilities (distance, availability of transport, costs involved in the RH services and treatments, time spent at the health facilities), policy and legislation, buildings and infrastructure providing RH services,

availability of human and material resources to deliver RH services and mechanisms, networking/partnerships between stakeholders and within RH facilities, and, lastly, the mechanism of information sharing to empower the stakeholders with the necessary competencies (knowledge, skills and attitudes).

Based on the information uncovered by the researcher in collaboration and in partnership with the other stakeholders, the following emerged: the necessity of conducting a resources inventory, and of auditing the capacities, strengths and weaknesses of the human resources, as well the knowledge and skills available to implement facilitation strategies in respect of male partner involvement in RH.

A framework of the findings should provide a structure for presenting the information in a logical way. This framework should identify the outcome of the stakeholders; resources and characteristics; and the nature of the health facilities that provide RH. The findings of the situational analysis should include recommendations on the way in which the agent will manage the partnership environment so as to facilitate male partner involvement in RH. This aspect will be discussed in detail in phase 2 (partnership) and phase 3 (management process).

5.6.4.2 Phase 2: Establishment of the partnership

After the situational analysis has been conducted the partnership between the stakeholders needs to be established before the management process commences (see figure 5.2). The agent has a primary responsibility to facilitate this process of this interaction (interpersonal relationships) between the stakeholders. The stakeholders in phase 2 include the nurses, and the male and female partners, as well as other significant stakeholders who are involved in the RH services in collaboration with the nurses. These other significant stakeholders may either be from the line ministries, NGOs or the community. The aim of establishing a relationship between the male partner, female partner and the nurse in this phase is to create and strengthen the interpersonal relationships between stakeholders by increasing self-awareness, openness, trust, communication, and receptiveness and to motivate male partners to understand the significance of RH.

In phase 2, the agent utilised the interactive facilitation process to establish the partnerships. According to Charlton (2000), there are two essential purposes for a vision. Firstly, a vision creates an attractive future and motivates people both to find their own roles in a specific programme and to work purposefully towards the defined goals. Secondly, a vision serves to focus attention on the direction in which the programme is going. According to Barker (1990) a vision provides a framework for both decision making and conflict. If the vision is explicitly communicated to the individuals then they will tend to change their negative attitudes and behaviour, and to become committed to and optimistic about the programme. Thus, a shared vision among the partners may facilitate male partner involvement in RH. However, the registered nurse as agent is able to foster the partners' commitment to the shared vision only by effectively communicating this shared vision to the partners. The shared vision should always be stressed enthusiastically on a day-to-day basis whenever the agent encounters the partners. The vision statement should be discussed with the partners, and not simply announced to them, and the values inherent in the statement should be clarified. The partners should be encouraged to voice their own opinions about the vision statement as, by doing so, the partners may contribute to the shared

vision. Communicating the shared vision serves as intellectual stimulation to the partners. It makes them aware of the problems and, by stimulating thought and imagination and by stressing certain values and beliefs, it enables them to find solutions to the problems that they have in respect of involvement in RH.

The aim of networking is to gather and provide the information across work groups – encourage the exchange and sharing of ideas, offer support, and foster and share expertise and services. Poor networking between RH facilities has resulted in the RH environment becoming both a complex and challenging one. The registered nurse, as agent, possesses the management skills to create an environment that will provide the partners with the opportunity to make use of the resources available. During this stage of networking, it is essential that the registered nurse create and develop an environment in which the stakeholders share information and advice, and also support the partners should they need help (Barker & Gaut, 1996).

Networking requires the active participation of the stakeholders in the community (youth leaders, political leaders, traditional leaders and church leaders) and in the health facilities environment (medical doctors, social workers, psychologists), all of whom are identified for the purpose of networking. Secondly, intersectoral collaboration between government ministries, NGOs and other organisations should be identified and encouraged during the networking process.

Mutual cooperation may be defined as the state of doing something together or of working towards a shared aim (*Oxford Dictionary,* 2000). This type of cooperation is essential between the agent (registered nurse) and the recipient (male partner and female partner), both of whom have the common goal of facilitating male partner involvement in RH. This cooperation is possible only if agents and recipients understand their respective roles in the RH environment.

Collaboration is an interactive mechanism that encompasses inquiry and reflection as approaches to the development of collective thought and coordinated actions. Through collaboration different perspectives are examined, new ideas and possibilities explored and common knowledge derived from the integration and synthesis of those ideas that are relevant to the facilitation of male partner involvement in RH (Senge 1993; Bohm, 1996).

Communication may be regarded as a process involving the transmission of information/messages from the sender (agent) to the receiver (recipient) in such a way as to be received in an acceptable manner (Daniels *et al.*, 1997, p. 92). Effective communication promotes the sharing of information and the enhancing of decision making which may be relevant to the stakeholders during the development of strategies to promote male partner involvement in RH (Clark & Maas, 1998, p. 218). It is essential that the registered nurse possess positive attitudes in order to facilitate this process. These attitudes include c*ongruence* (the ability on the part of the nurse to be aware of the way in which the male and female partners interacts with the nurses, as well the ability to communicate this awareness to the participants), acceptance (the ability to avoid making judgements, either covert or overt) and empathy (not sympathy but the capacity of the agent to perceive the nature of the participants' frames of reference accurately).

Sharing responsibility – a responsibility refers to the duty to take care of something (*Oxford Dictionary,* 2000). In this study the sharing of responsibilities means that the male partners and the female partners share responsibilities in terms of those activities that are related to RH. Both the male and the female partners are jointly responsible for participating in RH services for the benefit of both their health and that of any siblings. The registered nurse also engages the male and female partners in discussion in order to encourage each partner to share his/her experiences with the other partner. The partners may discuss their stories and experiences in respect of their involvement in RH. Through this interchange of information and experiences they will come to understand their responsibilities and their expected roles in RH. In addition to the above strategies for fostering a greater understanding of their responsibilities in respect of their involvement in RH, the registered nurse, as agent, must strengthen this understanding by empowering both the male and female partners with knowledge and skills about RH and their roles in respect of promoting the active participation of males in RH.

Joint decision-making within the RH context must be rational and informed so as to enable the partner to play a crucial part in this context. Beyer (1988) defines decision-making as a process of selecting from among a number of alternatives in order to achieve a specific goal. A decision refers to a choice or judgement that is made after consideration of the best possible option (*Oxford Dictionary*, 2000). Joint decision-making in the context of this study refers to the fact that male partners, female partners and nurses should make decisions together. This process of decision making should be based on justifiable evidence to support the decision made through logical reasoning (Botes, 2000). The registered nurse is responsible for creating an environment that will provide the partners with the opportunity to share in decision-making.

Trust and respect are the foundation of male partner involvement in RH. Trust and respect for the self and for the dignity of others' values, ideas, thoughts and feelings enhance human interaction and social transformation (Pamela & Loriz, 1998). A lack of trust and respect among the stakeholders (male and female partners and nurse) emerged as a major determining factor influencing the decision of the male partner not to become involved in RH. It is essential that the agent make use of leadership skills in order to establish a trusting and respectful relationship. Trust must be earned and carefully nurtured over time if the male partner is to build such an interpersonal relationship. However, this type of relationship requires patience, consistency, dependability and endless attention over a relatively long period of time.

In this study, trust refers to the fact that the stakeholders, such as the male partner, female partner and the nurse, should trust one another in order to facilitate male partner involvement in RH. It is not merely a case of the nurse being trusted by the partner, as the nurse, as agent, must also trust the partner. The greater the trust that the agent places in the partner and the greater the belief that the partner will change, the greater the possibility that the male partner will participate actively in RH services (Booyens, 1998). If the agent is trusted he/she will find it easier to facilitate male partner involvement in RH. It is to be expected that the registered nurse will possess knowledge and skills in the field of RH, and will be willing to admit mistakes and weaknesses, will to be able to trust his/her subordinates, to spend time listening to the partners, to interpret their body language, to be sympathetic and to respond to problems on the part of subordinates, to be honest, to be open about the programme, and to treat the partners with respect, courtesy, care and concern.

Confidentiality may be defined as **a** situation in which the registered nurse is expected to keep secret any information with which he/she is entrusted by the partners (*Oxford Dictionary*, 2000; Muller *et al.,*

2006). This information may include information provided to the registered nurse during the visit of partners to the RH facilities. It may relate either to an interpersonal problem or to the reproductive disease itself. Ehlene and Springer (1998 in Jooste, 2003) describe confidentiality as a situation of support in respect of the protected relationship between caregivers and patients and the guarding of the use of private information. It is vital in the context of the RH services that the nurse maintain the highest standards of professionalism by keeping confidential any information given to him/her by the client in respect of any diseases or problems on the part of the client.

Motivation refers to the concept which is used to describe both the extrinsic conditions that stimulate certain behaviour and the intrinsic responses that make human beings the way they are. The registered nurse, as agent, in his/her role of facilitating male partner involvement needs to motivate the male partner by ensuring thatthat the following:

- *The need* for the male partner to be involved in RH should be clearly indicated – the needs include any deficiencies and actions taken to remedy these deficiencies. These latter actions could include achievement motive, power motive, affiliation motive, security motive (drive or reason) and status motive.

- *Incentive motive* refers to the alleviating of a need and the subsequent reduction of a drive.

- *Manipulation motive:* Male partner should also have manipulative motives in order to manoeuvre the culture, beliefs and norms that are hindering the slow pace of male involvement in RH. However, it must be borne in mind that it is not easy to change culture.

- *Activity motive*: The male partners must be made to realise that active involvement in RH services, for example, attending RH facilities with their partners, will be of benefit to both partners as this attendance could assist the partners to understand their problems and needs in totality and also lead to a greater understanding of their families and the community at large. Attending RH facilities could also enhance the partners' knowledge and skills in respect of RH issues, and this would, in turn, enable them to solve and manage problems affecting their health and that of their families.

- *Achievement motive**:*** The male partners should believe that their involvement will make a difference, for example, those male partners who attend RH facilities should feel that this attendance will be beneficial for their own health and that of their families, that they will gain knowledge and skills, that they will be enabled to solve the complex problems that are affecting their health and that of their families, that they will be able to complete a challenging assignment successfully, and develop a new way of doing something, for example to involve RH where it is needed.

- *Power motives:* The male partners should believe that their involvement in RH will influence other people to change their attitudes and behaviour, for example, transform the negative attitudes of other males towards RH issues. Their involvement in RH should also enable them take control of their own activities in respect of RH, to develop the ability to exercise authority especially as regards those activities that affect their own health, although power motives should be addressed in a shared manner.

- *Affiliation motive:* The male partners should believe that their involvement in RH will be admired by the majority of community members, and that they will be accepted by the community and by the family. The community should gain the impression that these men are friendly and cooperative.

Their involvement in RH should enable them to maintain harmonious relationships and to avoid conflict within the family and the community. Finally, the male partners should be given the opportunity to participate in pleasant social activities such as home-based care and AIDS-awareness initiatives.

- *Security motive:* The male partners should be able to believe that their involvement in RH will be kept confidential and that their needs will be cared for in a holistic manner. They must feel protected by the caring nurses to whom they are able to divulge their problems. It is essential that they are able to afford the RH programme and services that could protect them against the illnesses and disabilities that may occur as result of reproductive diseases and complications.
- *Status motive:* The male partners who are actively involved in RH need to receive recognition and acknowledgement, for example, a token of appreciation for their involvement in RH should be awarded to these male partners in the form of the opportunity to be treated first or an introduction during the health education programme which the nurses conduct at the commencement of their duties.

5.6.4.3 Phase 3: Management processes

After the situational analysis in phase 1 and the establishment of the relationship between the stakeholders in phase 2, the management phase commences. During this phase the agent endeavours to address different perceptions such as negative attitudes, poor interpersonal relationships, inferior communication, the personal attributes of the male and female partners, and the nurses and, sociocultural barriers that might lead to conflict (conflict management), and the lack of optimum functioning of the health care delivery system in terms of inaccessibility of RH facilities, poor or inadequate management principles and structure (poor or inadequate legislation and policies), inadequate buildings and infrastructure, inadequate human and material resources, poor networking and, lastly, lack of knowledge and skills on the part of the stakeholder. In order to address these problems the agent employs the management principles of planning, organising, leading and control as follows:

- **Planning**

After the situational analysis of both the external and the internal environment followed by the establishment of the partnership between the agent and the recipients, the nurse, as agent, has to plan the facilitation process of involving male partners in RH services. Accordingly, the nurse puts into practice the planning steps of goal-setting, developing an action plan and an implementation strategy, as well as evaluation strategies to assess the attainment of the goal and the outcomes. During this stage the registered nurse should consider whether this action plan is achievable, quantifiable and time bound. The nurse should also take into account the financial implications and the human resources available.

During *goal-setting*, the vision, mission and value statement for male involvement in RH should be clearly formulated. The aim of the vision, mission and value statement provides the framework for the

resolution of any conflicts which might arise between the stakeholders, as interpersonal relationships (negative attitudes and poor communication) play a vital role in RH.

The aim of the vision is to give direction to the stakeholders (male partner, female partn and nurses) on future developments, for example, involvement of male partner in RH. Charlton (2000) indicates that, once the stakeholders have understood the vision, they tend to become motivated and to gain clarity in respect of their roles in the programme. This also allows the stakeholders to choose those activities that would enable them to attain the envisioned goal and to avoid wasting time on actions that are not relevant. Vision provides a frame of reference for decision making because the decision makers know the direction in which the programme is going.

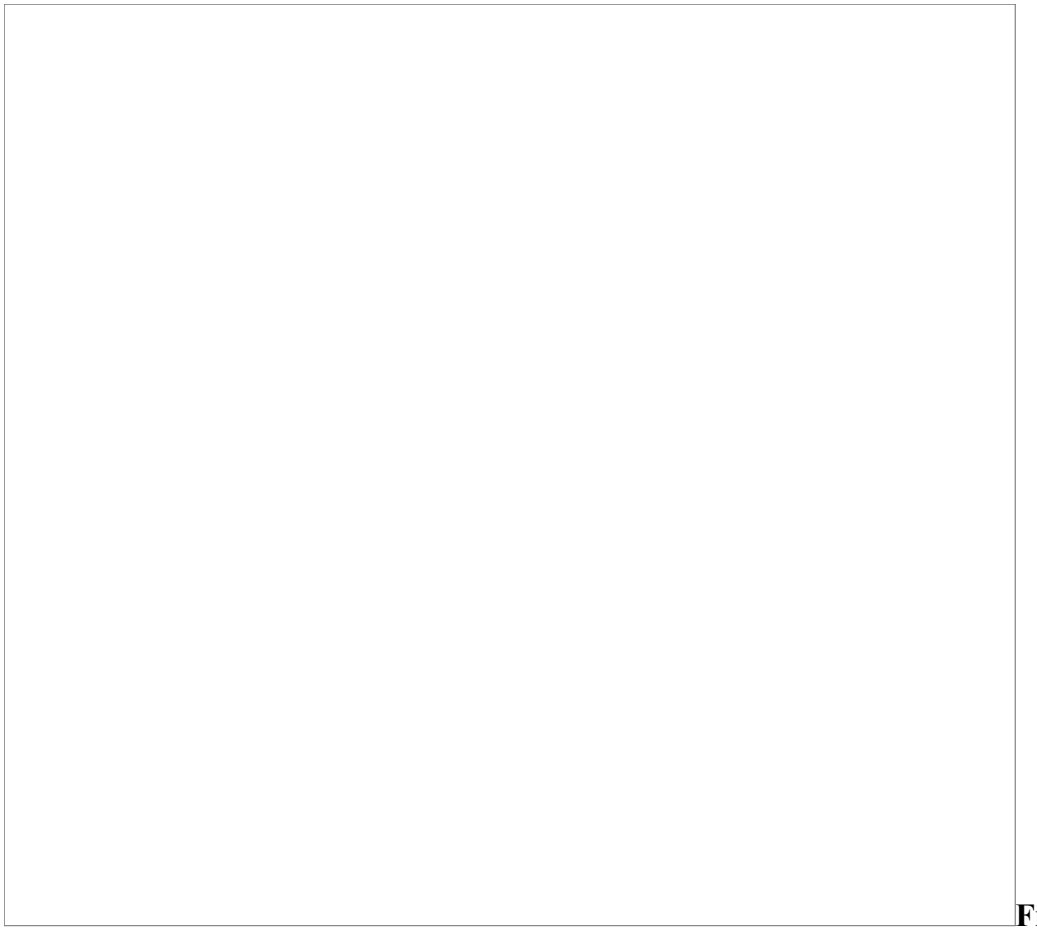

Figure 5.4: Phase 3 Management process

In developing the action plans it is essential that the registered nurse identify the key performance areas (KPAs) based on the need identified in the situational analysis. Firstly, the objectives for each identified KPA must be set. Secondly, the activities or action required in respect of each KPA and the attainment of each objective must be drawn up in partnership with the stakeholders. Apart from dealing with the KPAs, the registered nurse must assign duties, tasks and responsibilities to the partners – this includes the due dates for the attainment of each objective. Each action plan should be executed in accordance with these due dates.

Development of implementation strategies: In this step the registered nurse plans the task (KAP) indicated in the action plan in terms of who, how, when and with what. The registered nurse should come up with polices and guidelines in respect of the execution of each task. These guidelines and policies include:

- situational analysis policies and guidelines to facilitate male partner involvement in the RH male facilities
- partnership policies and guidelines to facilitate male partner involvement in the RH male facilities
- management process policies and guidelines to facilitate male partner involvement in the RH facilities
- control and outcome policies and guidelines to facilitate male partner involvement in the RH male facilities

The implementation strategies, such as policies and guidelines to facilitate male partner involvement in RH, need to be formulated in collaboration with the researcher who played a major role in developing both the model and the strategies for this model.

- **Organising**

Organising, as the second step in the management process, needs to be implemented after the goal and the actions plans have been determined, the key performances areas identified, and the policies and guidelines formulated. During this step key performance areas are structured and human, financial and physical resources, as well as time and information, are allocated and deployed in a logical and formalised way in order to facilitate optimal utilisation and the attainment of goals, asd well as the outcome, namely, male partner involvement in RH.

Designing the structure – this refers to the logical grouping of the key performances areas (KPA), and the detailing of the way in which the activities will be performed and by whom.

Assigning responsibility and authority – once the structure has been designed, the assigning of responsibilities and the authority for each activity will follow. This includes the creation of the organisational relationship between the nurse and the male and female partners, for example, from whom and where to obtain information (directive/instruction), to whom they report and to whom and for what they are responsible.

Establishing the command structure – after assigning the responsibilities and the authority to stakeholders, the establishing of a command structure will follow. This step includes the establishment

of a *reporting line* in case problems or needs are either identified or arise between the male partners, female partners and the nurses. This establishment of a reporting line entails determining who will report to whom (chain of command), from whom the partner should receive the order (unit of command), and the assigning of the responsibility to perform activities based on the KPAs identified (requisite authority). This step also includes establishing the authority which the partner may need in order to obtain and utilise the available resources necessary for the accomplishment a given task. The registered nurse who delegates the responsibility for the performance of a task to a particular partner should bear in mind that this delegation does not mean that the nurse is absolved from being finally responsible for the successful completion of the task (continuing responsibility).

Coordination mechanism – refers to the process of linking and integrating those activities which were indicated in the designing of the structure, the assigning of responsibility and authority and the establishing of the command structure into a single integrated unit in order to facilitate the realisation (goal and outcome) of male involvement in RH.

- **Directing and leading**

After the planning and organising activities in respect of the management of the partnership environment in order to facilitate male partner involvement in RH, the third management step of leading and directing will follow. This step represents an important management activity because it is concerned with the dynamic interaction between the nurse, the male partner and the female partner. As indicated in the situational analysis, the dynamic that prevailed mostly between the nurses, male partners and female partners includes poor interpersonal relationships, negative perceptions of male involvement in RH, inferior communication, negative attitudes, a lack of trust and respect, and fear of the unknown as result of the social and cultural factors which were indicated in chapter 1. Muller *et al.* (2006) suggest that, in order to manage this dynamic so as to attain the goal and the outcome of male partner involvement in RH, the registered nurse, as agent, can facilitate this process by means of leadership principles and strategies. As indicated in chapter 4, the leadership strategies of *conflict management*, *decision making, problem solving*, *time management* and the *management of change,* may be employed. The strategies pertainingto each principle of leadership needed in the facilitation process of male partner involvement in RH are discussed in detail in chapter 6.

5.6.4.4 Phase 4: Maintaining a conducive environment

After the management process phases, the phase of maintaining a conducive environment commences. The aim of this phase is to strengthen and maintain the interpersonal relationships within the environment that provides RH services. A conducive environment is characterised by safety, interest, commitment, motivation, patience, support, respect, adequate resources and networking.

Safety refers to the state of being protected from any danger or harm (Hornby, 2000). Health facilities encompass several physical and psychological factors that may influence or affect the decisions of life partners either to become involved or not to become involved in RH services (Perry, 1997). Safety, in this study, is expressed in terms of the privacy and confidentiality of both information and treatment. It is essential that the registered nurse identify those factors that threaten the safety of the partners in RH

facilities. In this study a lack of privacy and a lack of confidentiality are among the main factors that negatively affect male partner involvement in RH. The vision, mission and value of the health facilities that provide RH should clearly indicate the way in which safety will be guaranteed in terms of privacy and confidentiality.

The word "interesting" means attracting attention as a result of a special, exciting or unusual quality (Hornby, 2000). The environment in which RH services are delivered should attract the attention of the partners in terms of the availability of adequate resources, safety, privacy and recognition of the partners' presence at the health facilities. Networking, mutual cooperation, collaboration, communication, the sharing of responsibilities, joint decision-making, trust, respect and confidentiality will make it possible both to promote and maintain the highest professional standards and this will, in turn, help ensure confidentiality in respect of the information given to clients about their diseases or problems regarding RH.

Commitment refers to a promise to support or to do something (Hornby, 2000). In this study the RH facilities and institutions should be committed to providing quality services in order to facilitate male partner involvement in RH. The agent is expected to ensure that the human, material, and physical resources, as well as time and information, are managed properly.

Motivation is the term used to describe both the extrinsic conditions that stimulate certain behaviour and the intrinsic responses that make human beings what they are. The "intrinsic" is described in terms of needs, wants and drive (*Oxford Dictionary*, 2000). In this fourth phase, motivation is expressed in terms of recognition, praise and reward. For example, the needs and deficiencies of the partners are identified and action taken to meet these needs and resolve the deficiencies. In terms of the affiliation motive, the male partner should feel that his involvement in RH will be regarded with approval by most members of the community. As regards the security motive, the male partner should be in no doubt that he and his partner's problem(s) will remain confidential and that their needs will be cared for in a holistic manner.

Hornby (2000) describes support as the act of helping or encouraging by saying or showing agreement, while respect may be defined as a feeling of admiration which arises in response to positive qualities. In the RH environment the agent should be able to spend time with the partners and be visibly involved in listening, interpreting their body language, showing sympathy and responding to their problems. In his/her communication with the partners the registered nurse must establish a trust relationship by being honest, open and respectful in terms of both their problems and their presence. Any information which is in the interests of the partners should not be withheld, but it is essential that personal secrets and confidential information is not divulged (Barker, 1990). In order to build such a relationship (interpersonal relationship) the registered nurse must treat the partners with respect, courtesy, care and concern (Barker, 1990). The registered nurse must also be consistent in her behaviour and keep any promises made. If a leader is to be trusted that leader needs to be mature wise, autonomous, competent, goal directed, empathetic and have a solid sense of ethics (Booyens, 1998).

Hornby (2000) and Muller *et al*. (2006) define adequate resources as assets that may be used to help achieve the aims of the organisation. These resources may be human, physical or material. In this study

adequate resources, whether human, material or physical, are maintained through planning, organising, leading and control.

Networking is a process that includes the establishing and use of contacts for information, advice and support. The aim of networking is to gather and provide information across work groups, to encourage the exchange and sharing of ideas, to offer support, and to foster and share expertise and services (Barker & Gaut, 1996).

5.6.4.5 Phase 5: Control and terminus/outcomes

After the phases of planning, organising and leading it becomes incumbent for the registered nurses to implement control as the fourth step in the management process in order to ascertain whether all the activities suggested in the previous three steps have been implemented in accordance with the strategic intent and subsequent strategies and plans. Accordingly, the aim of controlling is to ensure that the goals and the outcome as suggested are accomplished. Muller *et al*. (2006) suggest the following four steps in terms of control in order to guide the registered nurse during the process: setting the standard, measuring actual performance, evaluating deviations, rectifying deviations and feedback (see figure 5.1).

Setting the standard may be defined as a written description or statement of the expected level of performance with reference to the structure process and the outcome. In this respect, standards may be situational analysis standards, developing partnership standards, management standards and control and outcome standards. The standard(s) should be relevant, realistic, attainable and measurable. Thus, these standards function as a foundation for the goals that were formulated during the planning phase.

Measuring actual performance, during the facilitation process – from phase 1 to phase 3 – information was collected, collated and presented in order to identify any disparities between performance standard and actual performances based on the activities identified during each phase. The aim of this step is to enable the registered nurse to identify any deviations and problem.

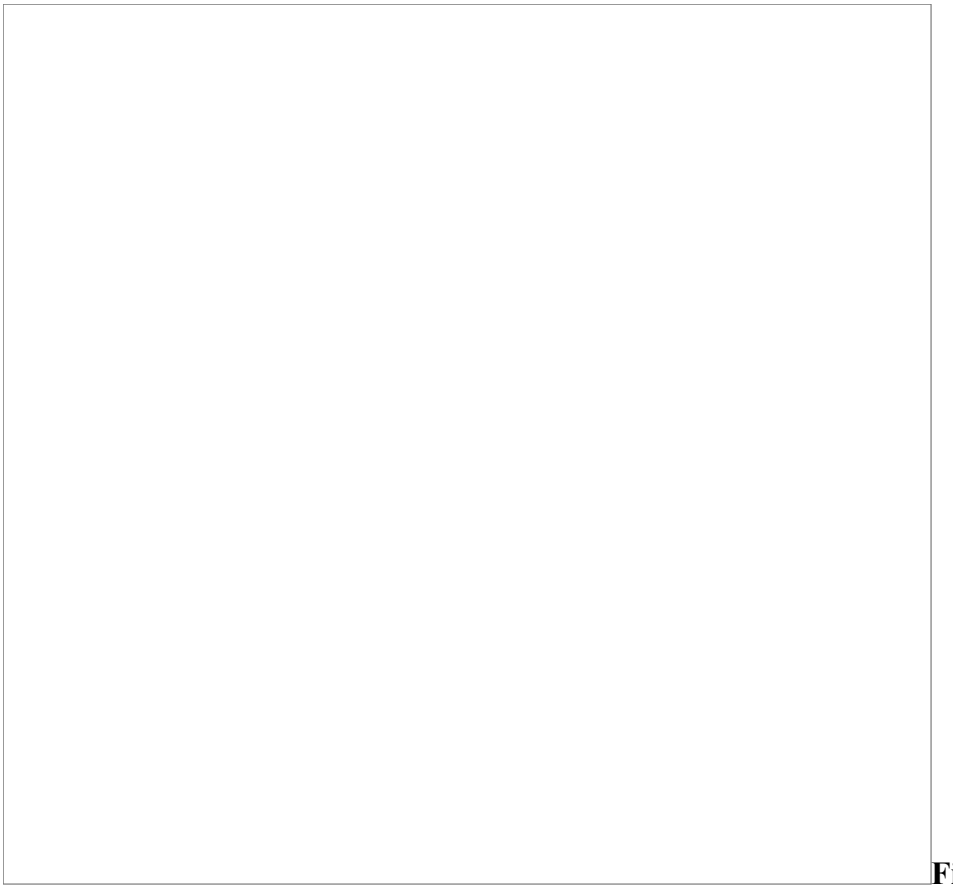

Figure 5.3: Phase 4: Maintaining a conducive environment

However, the registered nurse is expected to collect valid, quantifiable and absolutely reliable data. Each standard indicated in "setting standards" will determine the type of information that must be collected and also the way in which this information should be collected.

Evaluating deviations: This step comprises the determination of the performance gap between the performance standard and the actual performance. The registered nurse, as agent in the facilitation of male partner involvement in RH, should ensure that the deviation/disparity is trustworthy (reflects the truth). In addition, non-compliance should be determined and evaluated with reference to its impact; contributory factors should be investigated in order to guide the nature and the scope of any corrective/remedial action which may be required; the extent of the deviations should be determined and a decision taken as to whether these deviations justify further investigation.

Rectifying deviations: The aim of this step is to determine the need for collective or remedial action and to ensure that deviations do not occur. The rectification of any deviation proceeds in accordance with the problem identified. Consultation and counselling are vital in this regard.

Feedback: Sufficient feedback for the partners from either the registered nurse or the enrolled nurse is one of the most important measures to improve productivity and outcomes. This feedback should be planned in such a way that the registered nurses should be able identify the key areas in terms of which

feedback should be given, for example, the registered nurse must decide the details of the topic to be conveyed, and this might include deficiencies, successes, problems or acknowledgement. The receiver (partners) should be able to understand the situation fully and also what he/she is expected to do after the feedback. However, in order to accomplish this it is essential that there be mutual respect between stakeholders.

The person providing the feedback should be specific, timely, descriptive, non-judgemental, diligent, constructive, positive and aware of emotional status of the client. The person(s) receiving the feedback must clarify the type of feedback which he/she is seeking in order to benefit from this feedback. The atmosphere should allow for open-mindedness, friendliness, respect, trust and justice. Attentive listening skills are also essential if the feedback is to be successful.

5.7 EVALUATION OF THE MODEL

This study was conducted under the supervision of five independent experts, namely, two experts in model development and qualitative research, two experts in qualitative research and education, and one expert in education, management, model development and qualitative research.

During the year of study, consultations were held with the researcher, two supervisors and two experts (professors) in research and model development in order to clarify the model. Various stakeholders, such as experts in model development, peer group members and staff members from the nursing profession were also given the opportunity to make their inputs into the model.

The model was also evaluated in accordance with the criteria for theory generation of Chinn and Kramer (1991), in terms of which the following questions are posed:

- How clear is the model?
- How simple is the model?
- How general is the model?
- How accessible is the model?
- How important is the model?

5.3.1 How clear is the model?

The concepts and statements used in model development were explored and described using the protocols and steps described by Wilson (1989) in Walker and Avant (1998). An intensive literature review was conducted in order to identify the attributes and connotations of a partnership and the

facilitation of male involvement in RH. The major related concepts which had been identified were defined and described so as to enhance the clarity of the model.

Throughout the study both the major concepts and the related concepts were used in a consistent fashion. The conceptual map derived from the conceptual analysis provided a framework for collecting the empirical data in the form of focused groups which comprised the male and female partners as well as the nurses.

The identification of the concepts and statements used in this model for facilitating male involvement in RH were carried out systematically; for example, the researcher commenced with an exploration and description of the empirical data using different research methods and techniques. This was followed by the concept analysis and conceptualisation using the various methods described by Walker and Avant (1988) – the researcher used the methods of synthesis, derivation and analysis strategies for the formulation of concepts and statements and for the model development. The researcher also used qualitative synthesis (data synthesis from empirical data) and literal synthesis (data synthesis from literature).

The following procedures for concept derivation were used – the researcher identified the concepts and familiarised himself with existing literature relating to the topic of interest. This involved not only reading the literature but also critiquing the level and usefulness of the existing concepts to be found in the literature. The researcher read widely in order to identify relatedness and dissimilarities to the concepts identified and then chose parent concepts or sets of concepts from other fields to use in the derivation process. Finally, the researcher redefined the concepts or sets of concepts from the parent field in terms of the topics of interest.

5.3.2 How simple is the model?

The concepts used in a model include simple and specific concepts which are supported by the diagram (sketch) in all the phases, while core concepts only are used. There is evidence of simplicity, for example, the model is easy to understand and to implement because it indicates, firstly, the context in which RH delivery should be taking place (health context, male and female partner context), secondly, the agent or the facilitators of the process, and, thirdly, the recipients (male and female partners) and the procedures to follow in order to involve male partners in RH.

5.3.3 How accessible is the model?

There is evidence of empirical accessibility in the model due to the fact that the definitions generated for the model are specific and also because related concepts have been defined, therefore, there is conceptual meaning.

5.3.4 How important is the model?

The importance of this model lies in the fact that the model may be used in nursing practice, nursing education and research. In terms of nursing practice this model, which aims at facilitating male involvement in the RH context, could be suitable for all the stakeholders at all levels, namely, community, district, national and regional level. In terms of nursing education, the strategies and approaches in the model may be utilised in the training and educating of the male and female partners and in the community at large on ways in which to participate in RH and also on ways in which to involve, promote participation in, and motivate male partners to become involved in RH.

The model was carried out in five phases, namely, situational analysis, development of the partnership, management process, conducive environment and control and outcome. A model also indicated the significant factors that the facilitator needs to consider, for example, the mobilisation of resources as well as the management of these resources, empowerment of the stakeholders as well as partnerships and the development of networking. The model may also provide essential for in training nurses during their initial basic training. In terms of management, the model clearly outlines the process of management, that is, planning, organising, leading and control, within the RH context. These management approaches in the RH context may be applied not only within a health environment, but in any organisation which wishes to involve the male partner. In terms of research the model may be used as a paradigm for those who wish to conduct further studies on males and RH.

5.4 SUMMARY

This chapter dealt with the framework of a partnership model to facilitate male partner involvement in RH. An overview of the model was provided as well as a description of the purpose and structure of the model. The structure of the partnership model was described using the assumptions on which the model is based and the concept definitions. Related statements are inherent in both the assumptions and definitions the nature of the structure and the process of the model.

This process of facilitating male partner involvement in the RH is carried out in five phases: phase 1 which deals with the situational analysis; phase 2 which is concerned with the development of a partnership between the agent and the recipients through shared vision, networking, mutual cooperation, collaboration, communication, sharing of responsibility, joint decision-making and

motivation; phase 3 involves the management process which comprises planning, organising directing and controlling; while phase 4 deals with the promoting of a conducive environment through safety, interest, commitment, motivation (recognition, praise and reward), support, adequate resources and networking; phase 5 involves control and the outcome in terms of which the registered nurse sets the standard of monitoring, measuring performance, rectifying deviations and providing feedback to the stakeholders. The outcome of the entire programme is male partner involvement in RH.

The model was evaluated in accordance with the following set of criteria prescribed by Chinn and Kramer (1991, p. 129): clarity, simplicity, generality, accessibility and importance of the model.

CHAPTER 6

DESCRIPTION OF GUIDELINES TO OPERATIONALISE THE MODEL TO FACILITATE MALE INVOLVEMENT IN THE REPRODUCTIVE HEALTH CONTEXT

6.4 INTRODUCTION AND RATIONALE

In the previous chapter the researcher described the development and evaluation of the model to facilitate male partner involvement in the RH context. The purpose of this chapter is to describe the guidelines for operationalising a model to facilitate male partner involvement in RH.

Guidelines were developed for the implementation of the model to facilitate male partner involvement in RH through the management of a partnership environment. These guidelines may be implemented in those health facilities that provide RH services, namely, clinics, health centres and hospitals. The nurses, in collaboration with significant stakeholders from the community, representatives from the line ministries and NGOs, will be able to facilitate male partner involvement in RH.

These guidelines were derived from the conceptual framework which was generated using deductive reasoning and analysis. The guidelines and strategies at each level are aimed at facilitating male partner involvement in RH through the management of the partnership environment by enabling male partners to become actively involved and to eliminate those factors that impede the full participation of male partners in the RH context. The chapter will focus on these guidelines which are expressed in terms of the aims and strategies of each of the four phases in facilitating male partner involvement in RH.

6.5 GUIDELINES FOR THE FACILITATION OF MALE PARTNER INVOLVEMENT IN RH

Guidelines were developed for the implementation of the model for facilitating male partner involvement in RH through the management of a partnership environment. The guidelines are written in the form of a series of phases from 1 to 5. The guidelines for each phase consist of the aim and activities relevant to that phase. These phases include the following:

- Phase 1: Situational analysis
- Phase 2: Establishment of the partnership
- Phase 3: Management process
- Phase 4 : Maintaining a conducive environment

- Phase 5 : Control and terminus/outcome

6.5.1 Guidelines for phase 1: Situational analysis

The aim and activities for situational analysis may be described as follows:

6.5.1.1 The aim

The aim of this guideline is to provide the registered nurse (agent) with assistance on the way in which to conduct a situational analysis of both the external environment (community) and the internal environment (health facilities) in order to identify factors that affect the facilitation of male partner involvement in RH.

6.5.1.2 Activities for the phase of situational analysis

Situational analysis refers to the process of exploring the capabilities of the healthcare services in order to identify unfulfilled client needs. The needs of the client must be understood in terms of the capabilities and the environment in which client is functioning (Muller *et al*., 2006). The strategies for situational analysis in this study focus on the external environment (community) and the internal environment (health facilities). These strategies may be described as follows:

MODEL

Figure 5.4 Five Phases for a model to facilitate male partner involvement in the reproductive health context.

❑ **Activities for the situational analysis phase of the external environment**

In this study the external environment refers to the community. This external environment – the community – represents the male partners, the female partners and significant stakeholders, as well as factors which influence male partner involvement in RH. The following activities may be used to analyse the external environment:

- The senior registered nurse, in collaboration and in partnership with nurses and significant stakeholders in the community, is responsible for conducting the situational analysis.
- The following research methods should be employed: formulation of the problem statement and the aim and objectives of the study, designation of the population and the sample, sampling, data collection, data analysis and validation of the trustworthiness of the study.
- The stakeholders in the external environment to be analysed include male partners, female partners and other significant stakeholders such as youth leaders, church leaders, politicians and traditional leaders in the community who exert an influence on male partner involvement in RH. The following aspects need to be analysed:
  - perceptions about male partner involvement in RH
  - interpersonal relationships (practices) including aspects such as attitudes, communication, respect, secrecy, confidentiality, trust, responsibilities, and support mechanism
  - personal attributes such as fear, shyness and embarrassment
  - networking/partnerships between stakeholders in RH facilities
  - Influences/pressure of social and cultural norms and standards on the male partner and other stakeholders
- Accessibility of the health facilities that provide reproductive health services:
  - distances and the transport system available for the male and female partners who wish to visit the RH facilities
  - costs involved in the RH services and treatments
  - time spent at the RH facilities
- Sociocultural barriers to be analysed include

- polygamous practices
- myths about male involvement in RH
- gender issues and practices
- alcohol abuse by male partners
- migratory labour practices
- household duties of the stakeholders

❑ **Activities for the situational analysis phase for the internal environment**

In this study the internal environment refers to those health facilities that provide RH services. This internal environment comprises the male partners, female partners and nurses within the health facilities and also those factors that influence male partner involvement in RH. The following strategies may be used to analyse the internal environment:

- The senior registered nurse, in collaboration with other stakeholders, is responsible for conducting the situational analysis.
- The environment to be evaluated comprises the health facilities that provide RH services, for example clinics, heath centres and hospitals.
- The factors in respect of the stakeholders (male partners, female partners and nurses) to be analysed include:
  - perceptions of the nurses in respect of male partner involvement in RH
  - interpersonal relationships including aspects such as attitudes, communication, respect, secrecy, confidentiality, trust, responsibilities, and support mechanisms
- management principles and structures to facilitate male partner involvement in RH
  - availability of policies and legislation on male partner involvement in RH
  - the nature and structure of the buildings used for the RH services
  - availability of human and material resources with which to deliver RH services
  - nurses' knowledge and skills in terms of RH and, specifically, in respect of the facilitation of male partner involvement in RH

6.5.2 Guidelines for phase 2: Establishment of a partnership

The aim, objectives for the guidelines for the development of a partnership may be described as follows:

6.5.2.1 The aim

The aim of this guideline is provide the registered nurse (agent) with assistance on ways in which to strengthen the interpersonal relationship (partnership) between the male partners, the female partner and the nurses in both the external environment (community) and the internal environment (health facilities) in order to facilitate male partner involvement in RH services. This aim may be realised through a shared vision, networking, mutual cooperation, collaboration, communication, motivation, shared responsibility and joint decision making.

6.5.2.2 Activities for the establishment of the partnership

The strategies for the establishment of a partnership to facilitate male partner involvement in RH through shared vision, networking, cooperation, collaboration, shared responsibility, joint decision making and motivation include the following:

- **Activities in respect of shared vision**

In terms of this study the *vision* is a written statement relating to the future intent, aspiration, uniqueness and identity of the programme in respect of male partner involvement in RH. In this study it is essential that all the partners share the vision of male partner involvement in RH. Activities for developing a shared vision may be described as follows:

- The vision should be specific, measurable, achievable, realistic and time-bound.
- The vision should be formulated by the registered nurses in collaboration with other stakeholders and it should be clear in its mission.
- The stakeholders should work together to identify possible obstacles in the way of reaching goals and devise strategies to overcome these obstacles.
- There should be a mechanism in place with which to evaluate the vision.
- The vision should be acceptable to all stakeholders.

- **Activities in respect of networking**

Networking is a process that includes developing and using contacts for information, advice and support (Barker & Gaut, 1996). Activities in respect of networking include the following:

- The registered nurse should facilitate the networking process. The stakeholders in the community (youth leaders, political leaders, traditional leaders and church leaders) and the stakeholders in the health facilities environment (nurses, medical doctors, social workers and psychologists) should be identified for the purpose of networking.
- Intersectoral collaboration between government ministries, NGOs and other organisations should

be identified and encouraged during networking.

- Networking should be made known to the stakeholders. It should aim at both gathering and providing information across workgroups.
- During the process of networking decision making and the handling of conflict within or between groups should be dealt with.
- During networking exchanges the sharing of ideas and information should be encouraged.
- Networking should aim at offering support and direction to the stakeholders. It should also encourage the sharing of expertise and services.
- Stronger political, religious and cultural influences within the community should be encouraged in order to facilitate male partner involvement in RH.

❑ Activities in respect of cooperation

Cooperation refers to the state of doing something together or of working towards a shared aim, while the concept "mutual" describes the feeling that two or more people have for each other or actions that affect two or more people equally (*Oxford Dictionary,* 2000). In this study it is expected that the male and female partners should work together to promote the involvement of the male partner in RH. Activities in respect of cooperation include the following:

❑ Activities in respect of collaboration

Collaboration refers to interactive mechanisms that inquire into and reflect on approaches in developing collective thought and coordinated actions. Through the collaboration in this study different perspectives were examined, new ideas and possibilities explored and common knowledge derived from the integration and synthesis of those ideas that were relevant to the facilitation of male partner involvement in RH (Senge, 1993; Bohm, 1996). Activities in respect of collaboration include the following:

- The agent should facilitate this process of collaboration.
- The views and conclusions of the stakeholders in respect of the direction and future of collaboration should constitute a shared vision.
- There should be a clear platform on which the partners may come together to share ideas.
- The stakeholders should all be involved in all the activities from planning, organising, implementation and evaluation.
- All the activities should be appropriate.
- The participation and involvement of the stakeholders in the RH decision-making process should be supported by sufficient resources (human, material, financial and time) so as to produce positive outcomes for the stakeholders involved.
- The following principles should be employed during the collaboration of the stakeholders in RH issues. *Respect* for, and affirmation of, the diversity and the breadth of the partners' knowledge – an understanding that people may make varied and important contributions to help shape the decisions that affect their lives. Equitable access as a commitment to ensure equal opportunities for all stakeholders to participate and to be involved in RH. *Inclusiveness as* a commitment to the development of

participation and involvement strategies for all stakeholders, especially those stakeholders who are needed or who play a vital role in RH services. *Responsiveness* as a commitment to listening to and taking action in relation to the views, concerns and experiences of the stakeholders in RH. Integrity as a commitment to open, transparent and accountable participation and involvement in practices that enhance trust and confidence.

- It is recommended that accurate and comprehensive records be maintained of the stakeholders' participation and involvement initiatives, including planning, implementation, and evaluation.
- The privacy and confidentiality of all stakeholders should be maintained during the collaboration process.
- The participation and involvement of stakeholders in the RH plan should include:
  - a description of the purpose of the stakeholders' participation and involvement in the RH
  - details about the scope of decisions to be made
  - an outline of the extent and nature of stakeholder influence in subsequent decision making in respect of RH
  - details of the way in which stakeholders will be provided with feedback and also of the way in which the initiative will be evaluated and reported upon (Government of Western Australia, 2008)

❑ Activities regarding respect and trust relationships

Trust must be earned and carefully nurtured over time. It takes patience, consistency, dependability and endless attention over a relatively long period (Booyens, 2004). It is not sufficient that the registered nurse be trusted or that the male partner be trusted by the female partner; the registered nurse, the male partner and the female partner all need to trust and respect one another. The greater this mutual trust and respect the more efficient will be the facilitation process. On the other hand, it is also essential that the degree of trust in the registered nurse be the greater trust because this will make it easier to facilitate the changes needed to motivate the male partner to move in the right direction and to be committed to this endeavour. The activities for building trust and respect include the following:

- In order to gain trust and respect the registered nurse must exhibit knowledge and skills in both the theory of RH as well as in practice. This will help the registered nurse to be of assistance to the partners when they present their problems in respect of RH issues.

- During interaction with the male and female partners it is essential that the registered nurse be able to understand and to describe the nature of their problem(s) from a social, psychological and economic perspective. At the same time the registered nurse must be able to help the male and female partner holistically, as this will enable the nurse to create a positive, trusting and respectful relationship between them. The registered nurse should be able to admit his/her mistakes and weaknesses as this will also enable the partners to acknowledge their own problems. It is in this way that trust is built.

- It is vital that the registered nurse spend time with the partners and be visible by being involved, listening, interpreting their body language, showing sympathy and responding to their problems.

- When communicating with the partners the registered nurses will establish a trust relationship by being honest, open and respectful about both their problems and their attendance at the RH facilities. Any information which is in the interests of the partner(s) must not be withheld, while, on the other hand, personal, secret and confidential information is not to be divulged (Barker, 1990).

- In order to establish trust and respect in the partnership relationship it is essential that the registered nurse plan all actions carefully and anticipate the implications of any action taken.

- The registered nurse, in building a trusting and respectful relationship, must treat the partners with respect, courtesy, care and concern (Barker, 1990). He/she must be consistent at all times in his/her interactions with the partners and ensure that any promises made are kept. According to Booyens (1998), for a registered nurse to be trusted he/she needs to be mature, wise, autonomous, competent, goal directed and empathetic and have a solid sense of ethics

❑ Activities for sharing responsibilities

Responsibility refers to the duty of taking care of something (*Oxford Dictionary,* 2000). In this study the sharing of responsibilities means that both the male partners and the female partners should share responsibilities in terms of all activities related to RH issues. These activities include the following:

- The agent as coordinator will plan ongoing workgroups with all stakeholders; for example in this study this means that all the stakeholders from the community and health facilities environments must be involved in ongoing workgroups in order to ensure their active involvement in both planning and in working towards consensus.
- The coordinator will formulate the guidelines for the programme to be followed by the workgroups and set a date for initiating and implementing the programme.
- During this stage of sharing responsibility the strengths, weakness, opportunities and threats related to the programme will be determined from the results of situational analyses of the external and internal environment of both the community and the RH facilities.

❑ Activities for joint decision making

Decision making constitutes an integral part of the problem-solving process and might be necessary during the facilitation of male partner involvement in RH. The effectiveness of this facilitation process may be measured by the quality of the decisions that the partners make jointly (joint decision making). It is essential for the smooth running of the facilitation process that the decisions made be appropriate and rational (Booyens, 2004). The following activities may be implemented in order to promote joint decision making:

- *Selling*. The senior registered nurse should sell the ideas or decision/solution to the stakeholders (male and female partner) who are to make the decision.
- *Testing*. The facilitator should present the ideas and decision to the partners for debate. This debate should then be followed by feedback.
- *Consultation*. The senior registered nurse should ask for the opinions and inputs of other stakeholders in respect of these decision/ideas.
- *Consensus decision making*. The stakeholders should be allowed sufficient time to debate and to reach agreement on the actions to be planned and implemented.
- *Negotiation*. There should be a platform on which individual stakeholders deliberately come together in order to reach a jointly acceptable agreement.
- It is essential that both the registered nurse and the partners be able to recognise the problem because failure to identify the problem correctly could lead to either faulty decision making or else no solutions. The definition of the problem should be neither too general nor too specific because both of these would effectively restrict the number of alternative solutions possible. During this process of joint decision making it will be incumbent on the stakeholders to gather the information needed before making any decisions. They will also be expected to develop and to evaluate alternative solutions by

identifying both the advantages and the disadvantage of the steps that they choose in making a decision. Lastly, the stakeholders need to select the appropriate solution and implement it.

❑ Activities for communication

Communication refers to a process involving the transmission of information/messages from the sender(s) (agent) to the receiver(s) (recipient) in such a way that the information/messages are received in an acceptable manner (Daniels *et al.*, 1997). Effective communication promotes the sharing of information and effective decision making, which may in turn be relevant to the stakeholders during the development of strategies to promote male partner involvement in RH (Clark & Maas, 1998). Activities for communication include:

- The communication process should be a two-way process in terms of which all the stakeholders actively participate and are involved in the discussions until consensus is reached.
- An effective communication process should involve the comprehensible and productive exchange of information, thoughts, ideas and emotions.
- The content should be clear, simple and open in order to facilitate the mutual understanding and interpretation of the message.
- During the communication process any disturbance should be controlled and managed effectively.
- The sharing of ideas should be encouraged during the communication process.
- The use of common language facilitates continuous, interpersonal dialogue, shared meaning, understanding, interpretation and an accurate analysis of the information communicated.
- The communication process should be relevant, comprehensive and timely.
- It is essential that the facilitator communicate the quality of *caring* to both the male and female partners during their visits to the health facilities, for example the nurses need to demonstrate warmth, caring and non-judgemental behaviour and understanding of the culture, problems, values and the attitudes of the partners.

- The basic or positive attitudes include *congruence* – an ability on the part of the nurses to be aware of the way in which the partner experience interacts with the partner participants as well as the ability to communicate this awareness to the partners themselves; *acceptance* – the avoidance of making any judgements, either covert or overt, in respect of the participants; and *empathy* (not sympathy) which, in this study, refers to the facilitators' capacity to perceive the nature of the frames of reference of the participants accurately.

- Good communication is essential in order to facilitate the learning environment and to strengthen communication between partners so as to enhance the participation and involvement of the partners;

- During the communication process the agent should consult families and other stakeholders in order to identify resources, facilitate access to these resources and promote the needs of the partners in the RH context.

- During the communication process the registered nurse should avoid *interruptions* and preconceptions, as well as bias and argumentativeness.
- During the communication process it is essential that the registered nurse is sensitised to the culture of the partners. Cultural sensitisation includes *cultural sensitivity* – the ability to recognise cultural factors that may affect the effective involvement of the male partners in RH; *cultural relativism* – the ability to view beliefs and behaviours in the context of the culture in which they

originated and to find ways in which to deal with these beliefs and behaviours; *cultural accommodation* – the ability to accommodate the client's culture as well as the ability to modify health care delivery in the light of cultural factors; and *culture brokering* – mediation between individuals or groups from different cultures. It must be borne in mind that there is no culture that is superior to any other culture (cultural ethnocentrism).

❑ Activities for motivation

The concept of motivation is used to describe both the extrinsic conditions that stimulate certain behaviours and the intrinsic responses that make human beings what they are. The intrinsic is described in terms of needs, wants and drives (*Oxford Dictionary*, 2000). As indicated in chapter 3, the male partner may be discouraged from participating in the RH context as a result of both external and internal influences. The following activities may serve the purpose of meeting the needs, wants and drives in terms of male partner involvement in RH:

- The needs for the male partner to be involved in RH should be clearly indicated.
- *Drive motive.* Deficiencies or problem identified should be made known by the stakeholders and directions or actions established to diminish these deficiencies.
- *Incentive motive.* To alleviate a need and reduce a drive and, in this way, establish an incentive will tend to restore physiological or psychological imbalances.
- *Manipulation motives*. The male partners should also have manipulative motives in order to maneuver the culture, beliefs and norms that are impeding male partner involvement in RH. It must, however, be borne in mind that, despite the fact that culture is not easy to change, motives may make this possible.
- *Activity motive*. The male partner should take into account that active involvement in activities pertaining to RH, for example attending RH facilities with their partners, will be of benefit to both themselves and their partners because they will come to understand their problems and needs in totality. They will also come to a deeper understanding of their own families and of the community at large. This will, in turn, enhance their knowledge and skills in respect of RH issues, and enable them to manage and to solve the problems affecting their health and their families.
- *Achievement motive.* The male partners should believe that their involvement will make a difference, for example those male partners who attend the RH facilities should believe that their attendance will be of benefit to their own health and to that of their families.
- *Power motives.* Male partners should believe that their involvement in RH will influence people to change their attitudes and behaviours, for example change the negative attitudes of males towards RH issues.
- *Affiliation motive.* The male partners should believe that their involvement in RH will be regarded with admiration by most members of the community, and lead to their being accepted by both the community and the family. The community, in turn, should gain the impression from this involvement that the men are being friendly and cooperative. In addition, their involvement in RH should help the male partners maintain harmonious relationships and avoid conflicts within the family and the community.
- *Security motive.* The male partners should feel secure in their involvement in RH and they should know that their problems will be kept confidential and that their needs will be catered for in a

holistic manner. In other words the male partners should feel protected in the certainty that the nurses who are caring for them will not divulge their problems. They should also know that they are able *t*o afford the service being provided, and that the RH programme and services could protect them against the illnesses and disabilities that could occur as result of reproductive diseases and complications.

- *Status motive.* It is essential that the male partners' active involvement in RH be recognised and acknowledged, for example, they could be given a token of their involvement in the form of either being given precedence and not having to wait or else being introduced during the health education programme which the nurses conduct at the commencement of their duties.

6.5.3 Guidelines for phase 3: Management process

The objective of these guidelines is to empower registered nurses in terms of ways in which in to manage the partnership environment in order to facilitate male partner involvement in RH through planning, organising, leading, and control/evaluation.

6.5.3.1 The aim

The aim of these guidelines is to advise the registered nurse (agent) on ways in which to manage the partnership environment (external and internal) through planning, organising, leading and control (discussed in phase 4) in order to facilitate male partner involvement in RH.

6.5.3.2 Activities for the management process

The management process consists of four phases. The activities in respect of each phase may be described as follows:

6.5.3.2.1 **Activities for planning**

The planning phase comprises the following activities: goal-setting and the development of action plans, and implementation and evaluation strategies for assessing the realisation of the outcomes.

- During the planning stage it is essential that the registered nurse take into account the fact that the activities planned should be achievable, quantifiable and time bound.
- The financial implications and human resources available should also be considered during this phase.

- **Activities for goal setting**

In *goal-setting* the vision, mission and value statement for male involvement in RH should be clearly formulated.

- The vision, mission, and value statement should provide the framework for the resolution of any conflicts which might arise between the stakeholders, as interpersonal relationships (negative attitudes and poor communication) play a vital role in RH.
- The vision, mission and value statement should give direction to the male and female partners in terms of possible future happenings, for example involvement RH.
- The vision should aim at highlighting those activities that could lead the stakeholders to attaining the envisioned goal and avoid wasting time on actions which are not relevant. The vision provides a frame of reference for decision making because the stakeholders have been made aware of the direction in which the programme is going.
- The mission statement should indicate the core business-related service delivery to concretise the vision of the programme.
- The value statement reflects the beliefs, principles and moral statements that must guide the behaviour of the stakeholders during the facilitation process. This value statement should indicate both the intent and the quality of the programme, the male and female partner and the output orientation.

- **Activities for the development of action plans**

- The registered nurse has to identify the key performance areas which will be based on the needs identified in the situational analysis.
- The objective for each identified KPA and the activities or actions required in terms of each KPA must be set in partnership with the other stakeholders.
- The registered nurse must assign accountability as well as the subsequent duties, tasks and responsibilities of the male and female partners. This includes the due dates for the attainment of each objective; therefore, each action plan must be executed in accordance with these due dates.

- **Activities for the development of implementing strategies**

In terms of the KPAs indicated in the action plans the registered nurse must plan who, how, when and with what he/she is intending to implement the KPAs.

- The registered nurse must devise the policies and guidelines for the execution of the tasks needed to facilitate male partner involvement in RH. These guidelines and policies could include a situational analysis, the development of the partnership, the management process, the maintaining of a conducive environment and control and outcome.
- It is essential that the strategies – policies and guidelines to facilitate male partner involvement in RH – be implemented in collaboration with the researcher who has played a major role in developing both the model itself and the strategies for the model.
- Goals must be set by the registered nurses in collaboration with other stakeholders.
- The goal-setting should indicate both the goal of the programme (male partner involvement in the RH context) and the goals of each stakeholder (male partners, female partners, nurses, significant and influential people from the community).
- The goal of the stakeholders should be set in collaboration with the senior registered nurse.
- The goal programme should indicate the outcomes, the way in to achieve these outcomes, and

how it will contribute to the realisation of the programme.

- During the setting of the goal the senior registered nurse and the other stakeholders should work together to identify any possible obstacles in the way of attaining the goals and devise strategies to overcome these obstacles.
- There should be a mechanism to evaluate the goal against the agreed-on performances standards. This evaluation should serve as a measure of the stakeholder performance.
- The goals should specific, measurable, achievable, realistic and time-bound.
- Goals should be formulated in the affirmative.
- The goals should be in a sequence in terms of the timeframe (short, medium and long term).
- The participatory process of consultation should ensure that the goals are acceptable.

6.5.3.2.2 **Activities for organising**

The organising phase comprises the following steps: design structure, assigning of responsibility, and the establishing of the command structure and the coordination mechanism*,* all of which should be performed by the registered nurse in collaboration with other significant stakeholders.

- **Activities for designing the structure**

The designing of the structure refers to the logical grouping of the KPAs, the way in which the activities will be performed and by whom these activities should be performed. These activities should all be clearly articulated (Muller *et al.,* 2006).

- The registered nurse would have identified the needs and problems during the situational analysis.
- The key performance areas need to be identified in order to solve these problems and meet these needs.
- The stakeholders in the RH context need to be identified and defined, for example the male partners, female partners and registered nurses. This also involves identifying and defining the roles and responsibilities of each stakeholder.
- The division of tasks and the assigning of responsibilities need to be done in order to determine who will do what and when it will be done.
- Rules and regulation need to be formulated in order to guide the stakeholders on the way in which they are to fulfil their tasks and carry out their responsibilities. These rules and regulations may take the form of procedure manuals which, for example, may prescribe the communication process between the stakeholders and ways in which to manage deviant behaviours.
- The stakeholders must be provided with a clear statement of what is expected in terms of appropriate behaviour.

- **Activities for assigning responsibility and authority**

The structure of the design will be followed by the assigning of the responsibilities and the authority pertaining to each activity. This will include the establishment of the organisational relationship between nurse and both the male and female partners, for example, from whom and where to obtain information (directive/instruction), to whom partners report and to whom and for what they are

responsible

- The assigning of responsibilities should be carried out by the registered nurses in consultation with the other stakeholders.
- It is essential that the responsibilities and authority pertaining to each stakeholder be clearly defined in order to avoid conflict.
- Education and training in respect of their roles is vital if the stakeholders are to understand their responsibilities clearly.
- These responsibilities need to be reviewed and monitored in order to identify the possible problems and needs of male partner and female partner and find the appropriate way to manage such problems and needs.

❑ **Activities for establishing the command structure**

The establishing of the command structure refers to the establishment of a reporting line in case any problems or needs are identified or manifest between the male partners, female partners and the nurses.

- Establishing the command structure entails determining who will report to whom (chain of command), and from whom the male and female partner should receive the order (unit of command).
- The responsibility for performing activities based on the KPAs identified (requisite authority) needs to be assigned, and it also needs to be determined whose authority the male and female partner may need in order to obtain and to utilise the available resources needed to accomplish a specific task.
- The registered nurse who delegates the responsibility for performing a specific task to a male and female partner should bear in mind that the act of delegating does not mean that the registered nurse is absolved from being held ultimately responsible for the successful completion of the task (continuing responsibility).

❑ **Activities in respect of the coordination mechanism**

The coordination mechanism refers to the process of linking and integrating those activities which were indicated in designing the structure, assigning responsibility and authority, and establishing the command structure into a single, integrated unit in order to facilitate the realisation (goal and outcome) of male partner involvement in RH (Muller *et al*., 2006). In view of the complex and dynamic process of involving the male partners in RH it is essential that a meeting be organised between the different categories of nurses and significant stakeholders in the community in order to discuss the way in which to manage the partnership environment in order to facilitate male partner involvement in RH.

- A formal coordination structure (committee) within the reproductive health facilities must be established.
- The committee should have the following: the purpose and objective of the committee; the composition of the committee; roles and functions within the committee; the scope of authority of the committee including the power of the committee to make the decision; meeting procedures and reporting mechanisms.
- The role of the committee is to identify the KPA and the way in which they intend to manage the programme.

6.5.3.2.3 **Activities for leading**

The activities of conflict management, time management and decision making and the management of change and leadership, which form part of the facilitation process of male partner involvement in RH, will be discussed below:

- Activities for conflict management

Conflict may be defined as a situation in which two or more parties became aware of the facts that what each party wants is incompatible with the wishes of the other part (Hein & Nicholson, 1990). Conflict may be seen as part of the process of testing and assessing oneself and may be perceived as positive in the sense that it allows one the opportunity to make full use of one's reasoning capacity. It may also provide the opportunity to bring about change and avoid stagnation (Cavanagh, 1990). Conflict may benefit group behaviour as cohesiveness is often enhanced during periods of conflict (Cavanagh, 1990). Accordingly, conflict should not always be perceived as negative, but it must be borne in mind that, wherever people interact with each other, the potential for conflict exists (Hein & Nicholson, 1990).

- There should be clear rules, policies and guidelines in the RH facilities and these should be made known to every stakeholder.
- There must be appreciation of the efforts of the stakeholders and the registered nurse be genuine when approaching the male and female partners. The partners must feel that they are of some worth in terms of the facility where they obtain the RH services.
- There should be a conducive environment in which the stakeholders feel free to be innovative. This will, in turn, encourage the stakeholders to make suggestions. Such a situation promotes creative thinking which leads to better solutions for problems.
- It is essential that the registered nurse recognise the input of the stakeholders.
- The registered nurse should be able to identify the values of others. This will help create open relationships with an expectation of success.
- The registered nurse should be quick to identify the traits of responsibility and trustworthiness in others, which will, in turn, produce warm, open responses.
- The registered nurse should behave assertively especially in situations which he/she regards as being of high priority.
- The registered nurse should provide constructive feedback about behaviour rather than about personal traits.
- *Conflict prevention*. The facilitators must be able to monitor and to intervene to stabilise a potentially violent conflict before it occurs by initiating activities that address the root causes of the conflict as well as the trigger of the dispute. A mechanism needs to be put in place that detects early warning signs and records specific indicators that may help to predict impending violence.
- *Peacekeeping*. The registered nurse should have the ability to act diplomatically in order to transform violent behaviour into non-violent dialogue. This should take the form of negotiation and consultation.
- *Peace building*. The registered nurse should have the ability to introduce a new third party to assist in the transition from violent conflict to stable peace.
- *Forcing*. The registered nurse needs to use formal authority or the power vested in him/her to satisfy male and female partner concern.
- *Compromise*. The registered nurse needs to have the ability to attempt to resolve a conflict by identifying a solution that may be partially satisfactory for both parties but not completely satisfactory for either.
- *Collaboration*. The registered nurse needs to promote teamwork and cooperation in order to

satisfy the needs of both partners.

❑ Activities for decision making and problem solving

Both decision making and problem solving comprise an integral part of management. In this regard all the stakeholders need to understand the process. Activities for decision making and problem solving are as follows:

- *Selling.* The registered nurse should sell the ideas or decision/solution to the stakeholders so that the decision is actually taken.
- *Testing*. The registered nurse should present the ideas and decisions to his/her subordinates for them to debate and then to provide feedback.
- *Consultation*. The registered nurse should ask for opinions and inputs from other stakeholders about the decisions or ideas to be implemented.
- *Consensus decision making*. It is essential that the stakeholders be given sufficient time to debate and to agree on the decisions or ideas which are to be implemented after planning.
- *Negotiation*. There should be a platform on which individual stakeholders come together intentionally in order to reach a mutually acceptable agreement.

❑ Activities for time management

Time management refers to the effective and efficient use of the time. It includes the effective planning and scheduling of the work to ensure that the most important work is completed and that sufficient time is left to deal with any unexpected emergencies and crises that may occur during the facilitation process. Booyens (1998) suggests the following important principles for the effective use of time:

- The registered nurse and other stakeholders should plan and organise the activities involved in facilitating male partner involvement in RH effectively – these include planning and scheduling activities in order to accomplish the goals set, and they should be carried out within a specific time frame.
- The registered nurse should concentrate on a few critical tasks or problems that will produce sound results.
- The registered nurse should eliminate trivial activities.
- The registered nurse should delegate responsibility and authority as far as possible.
- The registered nurse should think before taking action and endeavour to solve problems scientifically.
- The registered nurse should use time wisely. As a coordinator it is essential that the facilitator be aware of his/her goals. It also important to draw up a list of personal and career goals.
- The registered nurse should identify the way in which he/she spends his/her time and ascertain the amount of time spent on unproductive or minimally productive activities.
- The registered nurse should keep a time log in which he/she enters his/her activities and the time taken.
- The registered nurse should analyse this time log to determine the way in which his/her time is being utilised.
- The registered nurse should avoid time wasting and interruptions by controlling the amount of time spent on the telephone. In this regard a secretary should be trained to manage and handle telephone calls.

❑ Activities for the management of change

It is expected that the facilitators should have a vision in terms of which to plan, manage, implement and evaluate change. In the dynamic health facilities environment within which the nurse (agent) operates it is important that he/she develop skills that will enable him/her to deal with change effectively. In the process of involving the male partner in RH, resistance to change might be encountered. This resistance to change may arise from misconceptions, habits, fear that privacy will not be respected, economic considerations, fear of the unknown, lack of awareness, misunderstandings and inaccurate beliefs (Hayens, 1992; Booyens, 2004):

- Facilitators are expected to have a vision in place for planning, managing and implementing change.
- *Education and communication.* It is important to use and to provide accurate information that allows people to understand the reasons for the proposed change. Communication will help dispel fear of the unknown. The implementation of a training programme to increase the stakeholders' awareness of the problem(s) to be overcome by the change process will aid in overcoming resistance.
- *Participation and involvement*. Stakeholders who will be affected by the change should be called upon to help design the change process. This could help reduce any resistance on their part to the proposed change. Involvement and participation is important in situations in which commitment is essential for the successful implementation of change.
- *Facilitation and support*. Stakeholders often tend to fear the unknown and, thus, facilitation and emotional support is necessary in order to help them accept the change.
- *Negotiation and agreement*. During the change process some stakeholders may lose interest and decide not to participate in any activities pertaining to RH. Negotiation and agreement are useful tools for overcoming resistance.
- *Manipulation and co-opting.* These methods need to be utilised correctly, otherwise they could lead to problems later when the partners may feel that they have been manipulated into accepting the changes.
- *Explicit and implicit coercion*. The facilitator may use either explicit or implicit coercion when other methods of overcoming resistance have failed or where speed is essential, for example, by stating that female partners who are not accompanied by their male partner at antenatal clinics will not be treated.
- *Establish trust*. A trust relationship between agent and recipient makes it much easier to implement changes than in situations where one party does not trust the other.
- Plan the changes in stages: The following stages may be put in place during the change process:

▪ Step1. Define the goal of the programme.
▪ Step2. Decide who will lead the programme.
▪ Step3. Obtain the commitment of the stakeholders.
▪ Step4. Build the change process incrementally by stating the specific objectives to be attained.
▪ Step5. Emphasise the main goal to be achieved.
▪ Step6. Provide continuous support.
▪ Step7. Teach stakeholders new ways in which to define and solve problems.
▪ Step8. Communicate the change process (Bolton, Aydin, Popolow & Ramseyer, 1992).

6.5.3.2.4 **Activities for control**

The activities for control are discussed in section 6.2.4

6.5.4 Guidelines for phase 4: Maintaining a conducive environment

The aim and activities for each guideline for maintaining a conducive environment are discussed below:

6.5.4.1 The aim

The aim of these guidelines is to empower registered nurses in terms of ways in which to maintain a conducive environment. Such an environment is characterised by safety, interest, commitment, motivation, patience, support, respect, adequate resources and networking. These activities may be described as follows:

6.5.4.2 Activities for maintaining a conducive environment

The activities in terms of the attributes of a conducive environment may be described as follows:

- **Activities to promote safety**

The word "safe" means to be protected from any danger or harm (Hornby, 2000). Health facilities encompass several physical and psychological factors that may influence or affect a life partner's decision of whether or not to become involved in RH. In this study, safety is expressed in terms of privacy and the confidentiality of information and treatment. The following strategies for promoting safety may be implemented in order to establish a positive environment in terms of male partner involvement in RH:

- It is essential that the registered nurse identify any factors that threaten the safety of the partners in the RH facilities. In this study, such factors refer to the lack of privacy and confidentiality.
- The vision, mission and value statement of RH facilities should indicate clearly the way in which safety will be ensured.
- Teaching material, such as pamphlets and posters, should be used to remind male partners of the ways in which safety in terms of their health can be managed and maintained.
- The male partner should be informed about what happens in the RH facilities and allowed to explore these facilities.

- During the visit or consultation the male partner should be treated either as an individual or as a partner. The registered nurse must ensure that any private information is kept confidential.

❑ Activities for creating an interesting environment

The word "interesting" may refer to any attribute that attracts attention because it is special, exciting or unusual (Hornby, 2000). The RH environment should attract the attention of partners in terms of the availability of adequate resources, safety, privacy and recognition of their presence.

- The environment should promote and strengthen networking by fostering the active participation and involvement of stakeholders such as youth leaders, political leaders, traditional leaders and church leaders. This will play a vital role in the facilitation of male partner involvement in RH.
- The environment should promote cooperation between the stakeholders in realising their common aim. This is possible only if agents and recipients understand their respective roles in the RH context.
- *Collaboration* as an interactive mechanism should be promoted in the RH facilities by the fostering of collective thought and coordinated action. Through collaboration different perspective are examined, new ideas and possibilities are explored and common knowledge derived from the integration and synthesis of these ideas.
- The environment should promote interactive communication in terms of which the sharing of information, shared decision making, and positive attitudes are promoted by congruence, acceptance and empathy.
- The environment should promote the sharing of responsibility by encouraging the partners both to provide and to share information about their roles and responsibilities in the RH context. The environment should be such that it enhances the partners' knowledge and skills in terms of RH and also in terms of their roles in promoting the active participation of males in RH services.
- The environment should promote joint decision making in terms of which male partners and nurses make decisions together and, thus, avoid conflict.
- The environment should promote trust and respect as the foundation of male partner involvement in RH. This encompasses trust and respect for one's own dignity and for the dignity, values, ideas, thoughts and feeling of others which, in turn, enhances human interaction and social transformation. The agent needs to use leadership skills to establish a trusting and respectful relationship. Trust must be earned and carefully nurtured over time if the male partners are to build such a relationship (interpersonal relationship). In addition, such a relationship needs patience, consistence, dependability and endless attention over a relatively long period of time.
- The environment should promote confidentiality and, thus, foster and maintain high standards of professionalism. This confidentiality refers to information given to the clients in respect of their diseases or problems regarding their RH.

❑ Activities for creating a committed environment

The word "commitment" refers to a promise to support or to do something (Hornby, 2000). In this

study the RH facilities and institutions should be committed to providing quality services in order to facilitate male partner involvement in RH. Such a commitment includes the following:

- The availability of staff who are knowledgeable about RH issues and who are willing to serve in the facilitation of male partner involvement in RH.
- The information being furnished to the partner in the form of training and education.
- Treatment that should be available in case the male partner needs help.
- The proper management of time by keeping time logs, which helps to avoid time wasting. In addition, appointments should be respected and activities organised more effectively; this includes planning and scheduling.

❑ **Activities for creating a motivational environment**

Motivation is the concept used to describe both the extrinsic conditions that stimulate certain behaviours and the intrinsic responses that make human beings the way they are. The intrinsic is described in terms of needs, wants and drives (*Oxford Dictionary,* 2000). In this phase motivation is expressed in terms of recognition, praise and reward.

- Recognition, praise and reward are regarded as status motives in terms of which male partners, who are actively involved in RH, need to be granted, for example, recognition and acknowledgement by being given, say, a token of appreciation in the form of being given precedence and not having to wait to be treated or being introduced during the health education conducted by the nurses at the commencement of their duties.

❑ **Activities for support and respect**

The term "support" may be defined as the act of helping or encouraging by saying or showing that you are in agreement with another person; while respect may be defined as a feeling of admiration for something because of its good qualities (Hornby, 2000).

- It is essential that the registered nurse be able to spend time with the partners and that this involvement renders them visible. This visibility also arises from listening, and interpreting body language as well as being sympathetic and responding to problems.

- When communicating with the partners the registered nurse will establish relationships of trust by being honest, and open and respectful of the partners' problems and their presence. Information which is in the interests of the partners must not be withheld, while personal secrets and confidential information, in turn, must not be divulged (Barker, 1990).

- In order to build such relationships it is essential that the registered nurse treat the partners with respect, courtesy, care and concern (Barker, 1990).

- In building such relationships, the registered nurse must be consistent in all his/her actions and behaviour and keep any promises that may have been made. In order to be trusted a leader needs to be mature, wise, autonomous, competent, goal directed and empathetic and to have a solid sense of ethics (Booyens, 1998).

- **Activities for adequate resources**

A resource may be defined as something that may be used to help realise an aim. Resources may be human, physical and material (Hornby, 2000; Muller *et al*., 2006). In this study the strategies adopted for the maintaining of adequate resources (human, material and physical) include planning, organising, leading and control. The strategies for each step were discussed in detail in phase 3.

- **Activities for maintaining networking for a conducive environment**

Networking is a process that includes the developing and use of contacts for the purposes of information, advice and support. Networking is self-generating and self-

Organising; it is also the way in which human beings and material are linked together in order to achieve goals, joint ventures in programmes or services. The aim of networking is to gather information across workgroups, to encourage the exchange and sharing of ideas, to offer support, and to foster and share expertise and services (Barker & Gaut, 1996). The activities for networking have been discussed in phase 2**.**

6.5.5 Guidelines for phase 5: Control and outcome

The aim and activities for control may be described as follows:

6.2.5.1 The aim

The aim of this guideline is to control and evaluate those activities which are aimed at effectively facilitating male partner involvement in the RH context. During this phase the registered nurse will evaluate the actual performance against planned performance by using planning, organising, leading and control.

6.2.5.2 Activities for control and outcome

After planning, organising and leading, the registered nurses have to implement control as a step in the management process in order to ascertain whether all the activities which were suggested in the three prior steps have been implemented in accordance with the strategic intent and the subsequent strategies and plans. Thus, the aim of the control aspect of phase 4 is to ensure that the goals and outcomes as suggested have been accomplished. Muller *et al.* (2006) suggest the following four steps of control to guide the registered nurse during the process: setting standards, measuring actual performance, evaluating deviations, rectifying deviations and feedback

- **Activities for setting standards**

A standard is a written description or statement detailing the expected level of performance with reference to structure, process and outcome. A standard also describes the desired and achievable level of performance against which actual performance is measured (Muller *et al*., 2006). The strategies for setting standards include the following:

- A standard should be in written format indicating the level of performance with reference to the structure (the support systems – human, financial and physical – required for the delivery of health services), the process (the way in which specific actions should be performed and applied to what the stakeholders themselves do), and the outcome which is related to those objectives which were realised and addressed.
- The standard should be set by the registered nurse in collaboration with the stakeholders.
- In this study standards may refer to the situational analysis standard, developing partnership standard, management standard and control and outcome standard.
- Standards should be relevant, realistic, attainable and measurable. Thus, standards are a function of the goals that are formulated during the planning phase.
- Standards should clearly define the activities identified in the programme.
- Criteria and indicators should be formulated in order to determine whether the set standard has been met. The criteria should deliver concrete proof that a standard has, indeed, been met. The indicators refer to measurable norms or the outcome statement, for example, the indicators for the RH facilities may be the number of partners attending these facilities, the number of male partners who bring their female partners to these facilities, the number of woman who come alone to these facilities and the number of cases treated in these facilities.

❑ Activities for measuring actual performance

During the facilitation of male partner involvement in RH from phase 1 to phase 3 it is incumbent on the registered nurse to measures the outcome of this process of facilitation of male partner involvement in RH. The aim of measuring performance is to identify any deviations and problem areas that might affect the process of involving male partners in RH. The strategies for measuring the standards include the following:

- The registered nurse should measure the actual performance of the stakeholders in RH.
- The criteria need to be set so as to indicate what should be evaluated by whom and when this evaluation should be carried out.
- The registered nurse needs to collect, correlate and present the performance standards in

order to identify any disparities between the performance standard and the actual performances based on the identification of activities in each phase.

- It is expected that the registered nurse will collect valid, quantifiable and absolutely reliable data.
- The measuring of the actual performances should be based on the outcome standard.
- Each standard indicated in "setting the standard" will determine the type of information to be collected as well as the way in which this information should be collected.
- In terms of RH the standard should not be compromised.

❑ **Activities for the evaluation of deviations**

The aim of this step is to determine the performance gap between the performance standard and the actual performance:

- The registered nurse, as agent, in the facilitation of male partner involvement in RH should ensure that the deviations/disparities are trustworthy (reflect the truth). Non-compliance should be determined and evaluated with reference to its impact.
- Contributory factors should be investigated in order to guide the nature and scope of any corrective/remedial action which may be required. It should be determined whether the extent of the deviations requires or justifies further investigation.

❑ **Activities for rectifying deviations**

The aim of this step is to determine the need for collective or remedial action and to ensure that deviations do not reoccur*:*

- The rectification of any deviations should be done in accordance with the problem that was identified.
- Consultation and counselling are imperative in this regard in order to arrive at the appropriate solution.
- One of the most important measures comprises sufficient feedback to the partners from either the

registered nurse or the enrolled nurse.

❑ Activities for feedback

The individual providing feedback should

- be specific, avoid generalisations and base the feedback on observable behaviour. It is imperative to provide sufficient information to indicate to the stakeholders those areas which need to be improved.
- be descriptive when stating views and not be evaluative or emotionally manipulative
- be consciously non-judgmental – offer personal views but not act as an authority. The individual should offer personal feelings rather than value-laden statements.
- not compare, but rather treat each person's problem separately because comparison undermines intrinsic motivation
- be diligent and check whether responses are an accurate reflection of what is intended
- be direct. In other words it is important not to wrap the message up in circumlocution, fancy words or abstract language.
- be positive. In other words state what is appreciated and genuinely felt and do not focus on anything which evokes negative reactions.
- be aware of their own emotional state before providing feedback

❑ General information in respect of feedback

- Feedback should be aimed at improving productivity and outcomes.
- Feedback should be planned in a such way that the registered nurses should be able identify the key areas in terms of what feedback is required, for example, the registered nurse must take into account the details of the issue that must be conveyed. This might include deficiencies, successes, problems or acknowledgements.
- It is essential that the recipients (partners) be able to understand the situation fully and also that they understand exactly what is expected of them after feedback. However, in order to accomplish the latter, there must be mutual respect between the stakeholders.

6.3 SUMMARY

This chapter focused on the guidelines to facilitate male partner involvement in RH. These guidelines were discussed in terms of the aims of the activities for each guideline and include guidelines for the implementation of the model for facilitating male partner involvement in RH through the management of a partnership environment. The guidelines were written in the format of a series of phases from 1 to 5. The guidelines for each phase consisted of the aim and activities. The five phases included phase 1: situational analysis; phase 2: the establishment of the partnership; phase 3: the management process; phase 4: the maintaining of a conducive environment; and phase 5: control and outcome.

CHAPTER 7

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

7.8 INTRODUCTION

In the previous chapter, the final structure and process of a partnership model to facilitate male partner involvement in the RH context in the Oshikoto Region, Namibia, was described.

The guidelines for the operationalisation of the model were also discussed. This chapter focuses on the conclusions, limitations and recommendations of the study/model.

7.9 RATIONALE OF THE STUDY

In view of the fact that RH is concerned with individual health from conception, during birth, and through to adulthood, it may be regarded as a crucial aspect of the general health of all individuals. Health care providers render RH services in all health facilities, in particular at antenatal clinics (ANCs) during the antenatal care period and at postnatal clinics (PNCs) during the postnatal care period.

Traditionally, RH care has been regarded as the specific domain of females and children because these services are concerned with pregnancy and birth. However, it has been realised that men could play an important role in RH care delivery. It should be pointed out that all partners and individuals have the right to decide freely on RH treatment and to be provided with all the relevant information and education on RH. This is possible only in an environment in which men participate fully in RH services. This implies that men should participate in and play an active role in the RH system (UNFPA. 2001, p. 3).

As result of the system, however, it was not possible for male partners in Namibia to participate as effectively in RH initiatives as elsewhere. This was as a result of the fact that male partners have never fully participated in the RH context, which has resulted in a system that neither makes adequate provision nor recognises or promotes, the active role and participation of male partners in RH initiatives. Health facilities are not user friendly for males and male partners feel excluded and alienated from these services. Namibia is ranked number five in the world in terms of the prevalence of the HIV/AIDS epidemic and, in addition, it is recognised is that it is the males who are the reservoirs of RH diseases and problems that affect women and children as well as the males themselves. These problems will be resolved only if male partners start participating in RH.

On the other hand, male partners do not seem to realise the importance of their involvement in RH, while, at the same time, the nurses who provide the RH services are not well equipped to facilitate this process. Thus, the aim of this study was to develop a partnership model for empowering health care providers to facilitate the process of male partner involvement in RH.

7.10 CONCLUSIONS

The conclusions are based on the objectives of the study and the evaluation of the model.

7.10.1 Aim and objectives

The overall aim of this study was to develop and describe a model to facilitate male partner involvement in the RH context. This model provides a theoretical frame of reference for the senior registered nurse and other stakeholders in facilitating the process of male partner involvement in the RH context through the management of a partnership environment. The following research objectives were formulated in order to achieve the overall aim.

7.10.1.1 **Objective 1: Analyse the concept of male partner involvement in RH**

It was concluded that there are different perceptions in respect of male involvement and the factors that influence this involvement. Furthermore, a lack of optimum functioning in the health care delivery service in terms of facilitating male partner involvement in RH was identified, as well as a lack of knowledge and skills on the part of the stakeholders as a result of inadequate education, training and the dissemination of information.

The relationship between the concept and the statement was constructed by means of definition and classification. The concepts in respect of the central abstraction of management, partnership and environment were defined by using both dictionary and subject definitions of the essential and related criteria for each concept. These essential and related criteria were merged together to form the overall related and essential criteria for the "*management of the partnership environment"*.

The essential and related concepts, as well as the dictionary and subject definitions of the central and other attributes, were used to construct a case that represents the experiences that were under investigation in the study. A model case is discussed in detail in chapter 4.

The classification of the concepts was completed in accordance with the survey list of Dickoff *et al.* (1968), that is, context, agent, recipient, dynamics, procedure and terminus.

7.10.1.2 **Objective2: Develop and describe a partnership model to facilitate male partner**

involvement in the RH context

The second objective was to develop and describe a partnership model to facilitate male partner involvement in RH. The description was covered in chapter 5. A diagrammatic concept of the model was developed to indicate its structure and process. It emerged unequivocally that the senior registered nurse, in partnership with other stakeholders, is capable of facilitating male partner involvement in the RH context.

7.10.1.3 **Objective3: Develop the guidelines in terms of which to operationalise the model**

The model was described in terms of step1.2 – the way in which to manage the partnership environment in order to facilitate male partner involvement in RH. Chinn and Kramer's (1991) method of theory generation was used. The definitions applied were in accordance with the work of Rossouw (2001/01) and (Copi & Cohen, 1996).

7.10.1.4 **Objective4: Evaluate a model that facilitates male partner involvement in the RH context**

The fourth objective was to evaluate a model that facilitates male partner involvement in the RH context and this was covered in chapter 6. The partnership model to facilitate male partner involvement in the RH context was subjected to evaluation by experts in theory development. The aim of this evaluation was to determine the adequacy of the model in describing, explaining, predicting and controlling the facilitation of such male partner involvement.

The corrections in terms of the clarification of the model were effected as recommended by both peers and experts in the field. In respect of the evaluation criteria, Chinn and Kramer's (1991) criteria were applied and the model was accepted in terms of simplicity, generality, clarity, empirical applicability, importance meaning, logical adequacy and contribution to understanding.

7.11 CONCLUSION, REMARKS AND CONTRIBUTION TO EXISTING BODY OF KNOWLEDGE

This research, which was conducted in the Oshikoto Region of Namibia, will contribute to the body of knowledge in, for example, general nursing, community nursing, nursing education and nursing research and administration.

The concept analysis of male partner involvement in RH was conducted in a systematic way and was based on scientific principles.

The result demonstrates that male involvement in RH is a systematic, dynamic, interpersonal and interactive process. In other words, in order to involve male partners in the RH context, the facilitator needs to apply this process systematically using scientific processes such as the nursing process and the management process. The facilitation of male partners in RH is a dynamic process because it is depends on the nature of the condition that the client presents, as well as the level at which the client receives the treatment. The process may also be regarded as dynamic since RH may be influenced by several factors including personal and socioeconomic factors.

The study will be presented at different levels, that is, national, regional as well as international, for further validation and refining of the concept analysis. Experts in the field of nursing and specifically in the field of RH have had and will have the opportunity to give their views and recommendations in respect of the changes that need to be made in the model.

The concepts used in developing the model were delivered and synthesised both empirically and literally by using scientific processes such as research processes, theory development processes and processes such as synthesis, derivation and analysis for concepts, statements and model development (Walker & Avant, 1998).

The unique and original practice model was developed together with guidelines to empower both those nurses who play a significant role in the facilitation process in respect of male partner involvement in RH as well as other stakeholders. The model indicates that it would be possible to attain this facilitation successfully through interactive and interpersonal processes such as facilitation, involvement, participation, communication, motivation, mobilisation of resources, empowerment, networking and partnerships.

The model may be regarded as a valuable and unique tool for Namibian society in respect of the eradication of and fight against unacceptable acts and forms of behaviour including the spreading of RH diseases such as HIV/AIDS and other STDs, woman and child abuse, family separation and a reluctance to assume social and economic responsibilities, all of which were rampant in the past. Since culture has been identified as an influential and determining factor in respect of men's behaviour and actions, this model may also be applicable to the facilitation of a change in contemporary culture.

7.12 IMITATIONS OF THE STUDY

Male involvement in the RH world is a challenging field which is open to new research. The facilitation of male involvement in RH has resulted from the escalation in maternal complications, death and reproductive diseases such as HIV/AIDS to which men have contributed. In addition, Namibia does not have sufficient human and material resources to facilitate this male involvement in RH. Although there is a policy on RH in place, it does not articulate the way in which to involve male partners in RH clearly.

There were also methodological limitations to this study – the population and the sample of participants were selected from RH facilities in the Oshikoto Region. The majority of the participants (male and female partners and nurses) were Oshiwambo speaking which limited the findings of this study.

The fact that the participants tended to assign different interpretations to the topic of "male involvement in RH" was a problem which forced the researcher to explain in detail the meaning of male involvement and its significance prior to posing the questions to the participants.

Cultural influences, especially in respect of the male participants participating in the issues pertaining RH and talking about female issues, for example, were one of the problems which confronted the researcher during the data collection. These cultural influences often resulted in participants giving biased and unilateral answers rather that facing reality and providing direct, truthful responses.

Basic to any professional discipline is the development of a body of knowledge that can be applied to its practice. Such knowledge is often expressed in terms of concepts, theories/models and guidelines. The following consitute the contribution that this study makes:

- Understanding the challenges that affect male partner involvement in the RH context.
- The identification of concepts and statements for developing a model to facilitate male partner involvement in RH.
- The development of a model to facilitate male partner involvement in the RH context.
- Guidelines for a model to facilitate male partner involvement in RH.

7.13 RECOMMENDATIONS FOR NURSING PRACTICE, NURSING EDUCATION AND NURSING RESEARCH

Recommendations will be made regarding the possible application of the generated model to nursing education, nursing practice and nursing per se.

7.13.1 Recommendations for nursing education

Male involvement in RH is regarded as a challenging issue, not only in the health facilities themselves,

but also within the training institutions. It is therefore the opinion of the researcher that it would be possible to incorporate this model into the existing nursing curriculum for trainee midwives, as well as into that for post basic students.

The model may also be used in in-service education for induction and orientation purposes during the rotation of staff from the health facilities that provide RH services or during the reception of new staff into the RH department.

The significance of this model is that the strategies developed are not only applicable to the nurses, but they would also be of benefit to other institutions involved in RH, such as line ministries and private sector organisations which are also aiming at the promotion of male partner involvement in RH.

7.13.2 Recommendations for nursing practice

The strategies developed in this model could be applied to all health facilities that provide RH services at different levels – community, district, regional and national. These health facilities may include clinics, health centres and hospitals. The strategies developed could be used by nurses for the strategic planning of the human and material resources needed to promote male partner involvement in RH. This model may also be used as a tool to mitigate the impact of HIV/AIDS in Namibia.

The model may also be implemented to assist senior registered nurses and other stakeholders to mobilise and facilitate male partner involvement in RH through the management of human and material resources:

- The exploration of those factors which are impeding male partner involvement in the RH context – either health facilities or within the community environment. The information so obtained could be used to form a database for planning, organising, implementing and evaluating.
- Policies, guidelines and regulations should be formulated in order to facilitate male partner involvement in RH.

7.13.3 Recommendations for nursing research

Male partner involvement in RH is a challenging, dynamic and ongoing process because it includes human beings from different backgrounds in different contexts who are influenced by several factors – physical, social and economic. On other hand, one of the weaknesses of the study is that it does not provide evidence of a relationship between the above-mentioned variables and, therefore, it is the opinion of the researcher that students who are involved in social study could look at the following topics which would merit exploration.

- Interpersonal relationships between the stakeholders in the RH context

- Attitudes of the stakeholders in the RH context
- Cultural aspects and practices in respect of RH
- Personal attributes of the stakeholders in the RH context
- Sociocultural influences on RH, such as polygamous practice, myths about reproductive issues, gender disparity, migration, alcohol abuse by male partners and household activities
- Impact of human and material resources on RH services
- Availability and utilisation of policies and regulations pertaining to RH
- Dissemination of information on RH
- Influence of education and training
- Knowledge and skills of stakeholders in respect of RH issues

7.14 SUMMARY

This chapter has described the overall aim of the study in terms of which three objectives were evaluated. The conclusion, limitations and recommendations in respect of the facilitation of male partner involvement in RH with regard to nursing practice, nursing education and nursing research were described together with empirical data.

REFERENCES

A2zpsychology. (2002–2006*). Perception.* Retrieved November 22, 2007 from http://www.a2zpsychology.com/psychology - guide/perception.htm

Allen, R. E. (1990). *The concise Oxford dictionary of current English.* Oxford: Clarendon Press.

American Heritage. (2007a). *Dictionary of English language [Online]* (4th ed.). Houghton Mifflin Company. Retrieved December 10, 2007, from http://www dictionary. Reference. Com/search=involvement=66

American Heritage. (2007b). *Dictionary of English language [Online]* (4th ed.). Houghton Mifflin Company. Retrieved December 10, 2007, from http://www dictionary. Reference. Com/search=involvement=66

American Heritage Dictionary. (2007). *Partnership*. Retrieved March 5, 2007, from http://www.answer.com/topic/partnership

American Heritage Dictionary. (2008). *Management.* Retrieved September 19, 2008, from. http://www.answer.com/topic/management

American Psychological Association (APA). (2002a). *Association rules of American Psychological Association.* Washington, DC: AMA.

American Psychological Association (APA). (2002b). Criteria for evaluating treatment guidelines. *American Psychologist*, *57*, 1052–1059.

American Psychological Association. (2002c). Criteria for evaluating treatment guidelines. *American Psychologist*, *57*, 1060–1073.

Amukugo, H. J. (2002). Effective leadership skills of nursing service manager in Namibia. Unpublished Master's thesis. Medical University of Southern Africa.

Anderson, P. A. (2003). Men's call. Men of quality are not afraid of quality: Men, HIV and AIDS. Regional conference*,* 2003. Report Back. Voluntary Service Overseas (VSO).

Andrews, P. H., & Herschel, R. T. (1996). *Organizational communication: empowerment in a technology society.* Boston, MA: Houghton Mifflin.

Armstrong, B. (1997). Cyclical level of interest in men's participation in reproductive health. (Colombia School of Public Health) Personal communication.

Babbie, E., & Mouton, J. (2001). *The practice of social research*. Cape Town: Oxford University Press.

Babbie, E., & Mouton, J. (2002). *The practice of social research.* Cape Town: Oxford University Press Southern Africa.

Bandman, E. L., & Bandman, B. (1988). *Critical thinking in nursing.* Norwalk, Conn.: Appleton & Lange.

Barker, A. M. (1990). *Transformational nursing leadership.* London: Williams and Wilkins.

Barker, G. (1998). Male involvement in reproductive health may take away from women's services, personal communication. University of Chicago.

Barker, L. L., & Gaut D. A. (1996). *Communication* (7th ed.). Allyn & Bacon: USA.

Basford & Slaving. (1995). *Communication.* UDA: Allyn & Bacon.

Becker, M. H., Radius, S. M., & Rosenstock, I. M. (1978). Compliance with a medical regimen for asthma: A test of the Health Believes Model. *Public Health Reports*, *93*(3), 268–277.

Becker, S., & Robinson, J. C. (1998). Reproductive health care: Services oriented to couples. *International Journal of Gynecology and Obstetrics, 12*(2), 108–115.

Bertrand, J. T., Makani, B., Edwards, M. P., Baughman, N. C., Niwembo. K. L., & Djunghu, B. (1996).*The male versus female perspective on family planning.* Kinshasa, Zaire.

Best, K. (1998). *Men's reproductive health risks.* Network Family Health International.

Beyer, B. K., (1988). *Developing a thinking skills programme*. London: Allyn and Bacon.

Biddlecom, A. E., Casterline, J. B., & Perez, A. E. (1997). Spouses' view of contraception in the Philippines. *International Family Planning Perspectives, 12*, 108–115.

Bless, C., & Higson-Smith, C. (1995). *Fundamental social research methods: An African perspective* (2nd ed.). Lusaka, Zambia: Juta.

BNET Business Dictionary. (2008). *Management.* Retrieved September 19, 2008, from. http://dictionary.benet.com/defenition/Management.htm

Bohm, D. (1996). *On the dialogue.* London: Routledge.

Bolton, L. B., Aydin, C., Popolow, G., & Ramseyer, J. (1992). Ten steps for managing organizational change. *JONA*, *22*(6), 14–20.

Booyens, S. W. (1998). *Dimensions of nursing management* (Second edition). Cape Town: Juta.

Botes, A. C. (2000). Integrated approach to ethical decision-making in the health team. *Journal of Advanced Nursing, 32*(5), 1–7.

Botes, A. C. (2000/01). Validity, reliability and trustworthiness. In D. Rossouw (Ed.), *Intellectual tools: Skills for the human sciences.* Pretoria: Amabhuku.

Bourdieu, P. (1977). *Outline of a theory of practice.* Oxford: Cambridge University Press. Retrieved October 20, 2007 from http://en.wikipedia.org/wiki/culture

Brink, H. I. (2002). *Fundamentals of research methodology for health care professionals.* Cape Town: Juta.

Britannica Concise Encyclopedia. (2007). Partnership. Retrieved March 5, 2007, from. http://www.answer.com/topic/partnership.

Brown, L. (1993). *The new shorter Oxford English dictionary of historical principles.* Oxford: Clarendon Press.

Bureau of Reproductive Health Care. (2002). Washington D.C.

Burns, N., & Grove, S. K. (1993). *The practice of the nursing research: Conduct, critique, and utilization* (2nd ed.). Philadelphia: Saunders.

Burns, N., & Grove, S. K. (1997). *The practice of nursing research: conduct, critique, andutilization* (3rd ed.). Philadelphia: Saunders.

Business Dictionary. (2008). Management. Retrieved September 19, 2008, from http://www.businessdictionary.com/definition/management.htm1

Business Encyclopedia. (2007). Partnership. Retrieved March 5, 2007, from http://www.answer.com/topic/partnership.

Business Encyclopedia. (2008). Management. Retrieved September 19, 2008, from http://www.answers.com/topic/management.

Bwalya, M. (2003). Using sport: Community sexual reproductive health and football camps. Men of quality are not afraid of quality. Men, HIV and AIDS. Regional Conference 2003. Report Back. Voluntary Service Overseas (VSO).

Catholic Encyclopedias. (2007). Partnership. Retrieved March 5, 2007, from http://www.answer.com/topic/partnership

Cavanagh, S. J. (1991). The conflict management style of staff nurse and nurse manager. *Journal of Advanced Nursing*, *16*, 1245–1260.

Chabeli, M. M. (2001). *A model to facilitate reflective thinking in clinical nursing education.* Johannesburg: Rand Afrikaans University.

Charlton, G. (2000). *Human habits of highly effective organizations: The human race*. Cape Town.

Chinn, P. L., & Kramer, M. K. (1991). *Theory and nursing: A system approach* (2nd ed.). St Louis, MO: Mosby.

Chinn, P. L., & Kramer, M. K. (1995). *Theory and nursing: A system approach* (3rd ed.). St Louis, MO: Mosby.

Chinn, P. L., & Kramer, M. K. (1999). *Theory and nursing: A system approach* (4th ed.). St Louis, MO: Mosby.

Clark, H. F. & Maas, H. (1998). Comox Valley Nursing Centre: From collaboration to empowerment. *Public Health Nursing, 15*(3), 216–224.

Collins Pocket Dictionary. (1994). Oxford: Clarendon Press.

Compact Oxford Thesaurus. (2007). Compact Oxford thesaurus for university and college students. New York: Oxford University Press.

Concise Oxford Dictionary. (1995). Oxford: Clarendon Press.

Copi, I. M. (1986). *Introduction to logic* (7th ed.). New York: Macmillan.

Copi, I. M., & Cohen, C. (1996). *Introduction to logic.* New York: Macmillan.

Creswell, J. (1994). *Research design: Qualitative and quantitative approaches*. London: Sage.

Creswell, J. W. (1998). *Quantitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Cullen, K., Davidson, G., Flackett, S., Grandison, A., Marshall, P., Munro, M., & McGovern, U.

(Eds). (2000). *The concise English dictionary*. Edinburgh: Chambers Harrap.

Danforth, N., & Jesowski, T. (1994). *Beyond Cairo: Men, family planning, and reproductive health.* Washington, DC.

Daniels, T. D., Spiker, B. K., & Papa, M. J. (1997). *Perspective on organizational communication* (4th ed.). Boston, MA: McGraw-Hill.

Davidson, G., Seaton, A., & Schwarz, C. (Eds). (1999). *Chambers large print dictionary.* Edinburgh: Chambers Harrap.

Del Bueno, D., & Vincent, P. M. (1986). *Organizational culture: How important is it? JONA, 16*(10), 15–20.

Dennill, K., King, L. M., & Swinepoxes, T. (1996). *Aspects of primary health care: Community health care in Southern.* Book Publisher: Durban.

Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research.* London: Sage.

De Vos, A. S. (1998). *Research at grassroots.* Pretoria: Van Schaik.

De Vos, A. S. (2002). Qualitative data analysis and interpretation In A. S. De Vos, H. Strydom, C. B. Fouché & C. S. L. Delport (Eds), *Research at grassroots for the social sciences and human service professions* (2nd ed.). Pretoria: Van Schaik.

Dickoff, J., James, P., & Wiedenbach, E. (1968). Theory in a practice discipline. Part 1: practice oriented theory. *Nursing Research, 17*(5), 415–435.

Douglas, C., Martin, J. S., & Krapels, R. H. (Eds). (2003). The experience and views of self management of people with schizophrenia, in *Proceedings of the Association for Business Communication Annual Convention on Change Communication*, Florida State University, 1–10.

Douglass, L. M. (1992). *The effective nurse leader manager* (4th ed.). St Louis: Mosby.

Ehlen, K.-J. & Sprenger, G. (1998). Ethics and decision making in healthcare. *Journal of Healthcare Management, 43*(3), 219–221.

Eisler, R., & Montuori, A. (2001). *The partnership organization: A system approach, 3*(2), 12–17.

Ellis, J. R., & Hartley, C. L. (2000). *Managing and coordinating nursing care* (3rd ed.). Philadelphia: Lippincott, Williams & Wilkins.

Ezeh, A. C., Seroussi, M., & Raggers, H. (1996). *Men's fertility, contraceptive use, and reproductive preferences,* Calverton, Maryland, Macro International, (DHS Comparative Studies No.18).

Farrante, J. (1997). *Sociology: A global perspective* (3rd ed.). USA: Wadsworth.

Fawcett, J., & Downs, F. S. (1986). *The relationship of theory and research*. Norwalk, CN: Appleton-Century-Crofts.

*Financial & Investment Dictio*nary. (2007). Partnership. Retrieved March 5, 2007, from http://www.answer.com/topic/partnership

Freese, B. T., Beckman, S. J., Boxley-Harges, S., Bruick-Sorge, C., Harris, S. M., Hermiz, M. E., Meininger, M., & Steinkeler, E. (1998). System model. In A. M. Tomey & M. R. Alligood (Eds), *Nursing theorists and their work* (4th ed.) (pp. 267–299). New York: Mosby.

George, J. B. (1995). *Nursing theories: The base for professional nursing practice* (4th ed.). Englewood Cliff, NY: Prentice-Hall.

Gorgen, R., Yansane, M. L., Marx, M., & Millimounou, D. (1998). Sexual behavior and attitudes among unmarried urban youth in Guinea. *International Family Planning Perspectives, 24*(2), 65–71.

Government of Western Australia. (2008). Department of Education and Training: Guidelines for community participation in decision making within the Department of Education and Training.

Green, C. P., Cohen, S. L., & Belhadj-el Ghouayel, H. (1995). *Male involvement in reproductive health, including family planning and sexual health.* New York: United Nations Population Fund.

Guba, E. G., & Lincoln, Y. S. (1985). *Naturalistic inquiry.* London: Sage.

Gubrium, J. F., & Holstein, J. A. (1997). *The new language of qualitative method*. New York: Oxford University Press.

Handelsman, D. J. (1995). Hormonal male contraception: Progress and prospects for the 21st century. *Australian and New Zealand Journal of Medicine, 25*(6), 808–816.

Hayens, S. (1992). Let the change come from within. *Professionals Nurse*, *x*, 635–638.

Hein, E. C., & Nicholson, M. J. (1990). *Contemporary leadership behavior: Selected readings* (3rd ed.). Philadelphia: Lippincott.

Hellriegel, D., Jackson, S. E., & Slocum, J. R. (1999). *Management* (8th ed.). New York: South Western College.

Hellriegel, D., & Slocum, J. W. (1989). *Management* (5th ed.). Menlo Park, CA: Addison Wesley.

Helzner, J. F. (1996). Men's involvement in family planning. *Reproductive Health Matters*, *7*, 146–154.

Henderson, L. (2007). *Encyclopedia of mental health: Shyness.* Portola Valley, CA: The Shyness Clinic.

Hornby, M. (2000). *Oxford Concise dictionary of linguistics.* Oxford: Oxford University Press.

Howell, C. (2000). *Recommendations for the development of a conducive environment for mine action: First of the Standing Committee of Mine Clearance related technologies*. Geneva: Handicap International. Retrieved November 12, 2000, from:http//www:fhi.org/en/rh/pubs/network/v18-3nw183ch3

Huber, D. (1996). *Leadership and nursing care management.* Philadelphia: Saunders.

Hughes, J., & McCauley, A. P. (1998). Improving the fit: Adolescents' needs and future programs for sexual and reproductive health in developing countries. *Studies in Family Planning, 29*(2), 233–245.

Hulton, L., & Falkingham, J. (1996). Male contraceptive knowledge and practice: What do we know? *Reproductive Health Matters, 7*, 90–100.

Ignatavicius, D., & Griffith, J. (1982). Job analysis: The basis of effective appraisal. *JONA*, *12*(78), 37–41.

International Conference on Population and Development (ICPD). 2009. *Women.* Retrieved June, 2009, from http://www.un.org/ecosocdev/geninfo/women/womepro.htm

International Council of Nurses. (2003). *Nurses always there for you: Caring for families.* Geneva: ICN.

Investment Dictionary. (2007). *Partnership*. Retrieved March 5, 2007, from http://www.answer.com/topic/partnership

Ipinge, S. (2000). A model of capacity building to facilitate home care in rural. Unpublished doctoral thesis, Rand Afrikaans University, Johannesburg.

Jackson, H. (2002). *AIDS in Africa: Continent in crisis.* Zimbabwe: SAFAIDS.

Jary, D., & Jary, J. (1991). *The Harper Collins dictionary of sociology.* New York: HarperCollins. Retrieved November 20, 2007, from http://en.Wikipedia.org/wiki/culture

Jooste, K. (2003). *Leadership in health services management.* South Africa: Juta Academic.

Kahn, J. E. (Ed). (1989). *Reverse dictionary*. London: Reader's Digest.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, *45*(30), 214–222.

Kreigh, H. Z., & Perko, J. E. (1983). *Psychiatric and mental health nursing: A commitment to care and concern* (2nd ed.). Reston, VA: Prentice-Hall.

Krueger, D. A. (1988). *Focus groups: Practical guide for applied research.* London: Sage.

Krueger, D. A., & Casey, M. C. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). California: Sage.

Lamonica, E. l. (1990). *Management in nursing.* New York: Springer.

Lasee, A., & Becker, S. (1997). Husband–wife communication about family planning and contraceptive use in Kenya. *International Family Planning Perspectives*, *23*(1), 15–20.

Leadership 501. (2008). *Management.* Retrieved September 19, 2008, from http://www.leadership501.com/definition

Levenstein, A. (1984). Feedback improves performance. *Nursing Management*, *15*(2), 64–66.

Levinger, B., & Mulroy, J. (2004). *A partnership model for public health: Five variables for productive collaboration.* Child Survival Collaborations and Resources Group. Washington DC: Pact Publications.

Lewin, K., Lippit, R., & White, R. K. (1939). Patterns of aggressive behaviour in experimentally created social climates. *Journal of Social Psychology*, *10*, 271–301. Retrieved March 7, 2007 from http://en.Wikipedia.org/wiki/culture

Lincoln, Y. S., & Guba E. G. (1985). *Naturalistic inquiry.* London: Sage.

Lindberg, J. B., Hunter, M. L., & Kruszewski, A. Z. (1994). *Introduction to nursing concepts, issues, and opportunities* (2nd ed.). Philadelphia: Lippincott.

Luft, R. L. (2008). *Management.* Retrieved September 19, 2008, from http://www.answers.com/topic/management

Lumbu, J. (2003, January 10). [Interview – Mr J. Lumbu, Registered Nurse, Katonyala AIDS Organisation, Onandjokwe Hospital]. Oniipa: Oshikoto.

Mabote, P. A. (2003). Men's call. Men of quality are not afraid of quality. Men, HIV and AIDS. Regional conference. 2003. Report Back. Voluntary Service Overseas (VSO).

Marshall, C., & Rossman, T. (1999). *Designing qualitative research* (3rd ed.). London: Sage.

Matthews, P. H. (Ed). (1997). *Oxford Concise dictionary of linguistics.* Oxford: Oxford University Press.

Mavalankar, D. V., Banga, R., & Banga, A. (1998). *Quality reproductive health services in rural India: The research experience (ICOMP).* India: BIRPERHT.

Mbizvo, M. T., & Bassett, M. T. (1996). Reproductive health and AIDS prevention in sub-Saharan Africa: The case for increased male participation. *Health Policy and Planning, 11*(1), 84–92.

McCauley, A. P., & Salter, C. (1995). *Meeting the needs of young adults.* (Population Reports, Series J, No. 41.) Baltimore, MA: John Hopkins School of Public Health, Population Information Program.

McConnell, C. R. (1984). *Management the health care professionals.* Rockville: Aspen.

McGinn, T., Bamba, A., & Balma, M. (1989). Male knowledge, use and attitudes regarding family planning in Burkina Faso. *International Family Planning Perspectives*, *15*(3), 84–88.

McGinn, T., Maine, D., McCarthy, J., & Rosenfield, A. (1996). *Setting priorities in international reproductive health programs: A practical framework.* New York: Center for Population and Family Health, Colombia School of Public Health.

Mellish, J. M., Brink, H. I. L., & Paton, F. (1998). *Teaching and learning the practice of nursing.* Johannesburg: Heinemann.

Men, HIV and AIDS. Regional conference 2003. (2003). Report Back. Voluntary Service Overseas (VSO).

Merriam-Webster Online Dictionary. (2007). *Management.* Retrieved September 19, 2007, from **Error! Hyperlink reference not valid.**

Merriam-Webster Online Dictionary. (2008). *Management.* Retrieved September 19, 2008, from **Error! Hyperlink reference not valid.**

Merton, R. K., Fiske, M., & Kendall P. L. (1990). *The focused interview: Manual of problems and procedures* (2nd ed.). London: Collier Macmillan.

Ministry of Health and Social Services in Namibia (MoHSS). (1994). *Male knowledge attitudes and practices towards family planning and North West Health Region.* Windhoek: National Plan.

Ministry of Health and Social Services (MoHSS). (2001). *National Policy for Reproductive Health.* Windhoek: Solitaire Press.

Ministry of Health and Social Services in Namibia (MoHSS). (2002). *A training and resources guide (Strengthening male involvement in reproductive sexually related issues*). Windhoek: Government Printers.

Morse, J. (1994). *Critical issues in qualitative research methods.* London: Sage.

Morse, J. M., & Field, P. A. (1996). *Nursing research: The application of a qualitative approach* (2nd ed.). United Kingdom: Stanley Thornes.

Mouton, J. (1996). *Understanding social research.* Pretoria: Van Schaik.

Mouton, J., & Marais, H. C. (1990). *Basic concepts in the methodology of the social sciences*. Pretoria: Human Sciences Research Council.

Mouton, J., & Marais, H. C. (1996). *Basic concepts in the methodology of social sciences.* Pretoria: Aurora Printers.

Muller, M. (1996). *Nursing dynamics* (1st ed.). Johannesburg: Heinemann.

Muller, M., Bezuidenhout, M., & Jooste, K. (2006). *Health care service management*. Cape Town: Juta.

Mullick, S., Kunene, B., & Wanjiru. M. (2005). Involving males in maternity care. *Health Services Delivery Issues. Agenda Special focus*.

Murapa, P. (2003). Risk taking behavior of migrant workers. Men of Quality are not afraid of quality. Men, HIV and AIDS. Regional conference 2003. Report Back. Voluntary Service Overseas (VSO).

Naude, M. (1995). A model for transformational leadership by nursing unit manager. Unpublished doctoral thesis. Rand Afrikaans University, Johannesburg.

Nell, M., Landry, L., Wilkinson, D., & Tzanis, J. (1998.) Men as partners in reproductive health: From issues to action.

Neufeldt, V., & Guralnik, D. B. (Eds). (1994). *Collier's dictionary A to J.* New York: Simon & Schuster.

Nickels, W. G., McHugh, J. M., & McHugh, S. (1987). *Understanding business.* Chicago: Irwin.

Retrieved September, 19, 2008, from http://www.answer.com/topi/management

Odetola T. O. & Ademola, A. (1994). *Sociology: An introductory African text.* London and Basingstoke:

Macmillan Education.

O'Neil, D. (2006). Behavioral Sciences Department, Palomar College, San Marco, California. Retrieved June 20, 2007, from http://anthro.palomar.edu/changes/change - l.htm

PANOS/NRCS/ SAfAIDS. (2003). *Men and HIV in Namibia.* Ruwa: MG Printers.

Pape, E. (2007). Brigitte Weidlich. Enforcement HIV Test. Official. *The Namibian, 22*(202).

Pierce, J. l., & Dunham, R. B. (1990). *Management.* Glenview, IL: Scott, Foresman/Little, Brown Higher Education. Retrieved September 19, 2008, from http://www.answer.com/topi/management

Planned Parental Association of Sierra Leone. (1998). Male involvement in sexual in addition, reproductive health/family planning. *Innovative Approaches to Populations Programme Management, 6,* 83–96.

Platt, B. (2002). Commercial sexual exploitation of children: Global problem requiring global action. *Sexual Health Exchange*, *3*, 10–11.

Polit, D. F. M., & Beck, C. T. (2004). *Nursing research: Principles and methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Polit, D. F., & Hungler, B. P. (1995). *Nursing research: Principles and methods* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

Population Reference Bureau (PRB). (1996). *Male responsibility in today's Africa.* [Audio cassette tape]. Washington, DC. PRB.

Potter, P. A., & Perry, A. G. (1993). *Fundamental of nursing concepts: Process & practice* (3rd ed.). St Louis, MO: Mosby.

Pretorius, T. (2002). Breaking the silence on rape in South Africa. *Sexual Health Exchange*, *3*, 10–11.

Rand Afrikaans University, Department of Nursing. (1999). *Paradigm: Theory for Health Promotion in Nursing.* Auckland Park, Johannesburg: Rand Afrikaans University.

Rand Afrikaans University, Department of Nursing. (2000). *Paradigm: Theory for Health Promotion in Nursing.* Auckland Park, Johannesburg: Rand Afrikaans University.

Rand Afrikaans University, Department of Nursing. (2002). *Paradigm: Theory for Health Promotion in Nursing.* Auckland Park, Johannesburg: Rand Afrikaans University.

Rattay, B. (2007). Brigitte Weidlich. Enforcement HIV Test. Official. *The Namibian*, *22*(202), 30 October.

Real Estate Dictionary. (2007). *Partnership.* Retrieved March 5, 2007, from

http://www.answer.com/topic/partnership

Republic of Namibia. (2004). *Nursing Act 8 of 2004.* Government Gazette of the Republic of Namibia. Windhoek: Namibia.

Republic of Namibia. (2007a). *National Policy on HIV/AIDS.* Windhoek: Solitaire Press.

Republic of Namibia. (2007b). *The Constitution of the Republic of Namibia.* Windhoek: Namibia.

Riley, M. (1983). Employee performance review that works. *JONA, 13*(10), 32–33.

Riley, N. E. (1997). Gender, power, and population change. *Population Bulletin, 52*(1), 2–48.

Robey, B., Thomas, E., Baro, S., Kone., S., & Kpakpo, G. (1998). *Men: Key partners in reproductive health.* Ouagadougou, Burkina Faso. (John Hopkins School of Public Health, Center for Communication Programs. Special Publication Series, .10, 61).

Robinson, M. (Ed). (1999). *Chambers 21st century dictionary* (Revised edition). Cambridge: Chambers Harrap.

Rossouw, D. (2000/01). Concepts, meaning and definition. In D. Rossouw (Ed.), *Intellectual tools: Skills for the human sciences* (pp. 7–13). Pretoria: Amabhuku.

Roudi, F., & Ashford, L. (2004). *Men and family planning in Africa.* (Chart book of DHS data). Washington, DC: Population Reference Bureau.

Runyon, K. E. (1977). *Consumer behavior and practice of marketing.* Ohio: Charles E. Merrill.

Retrieved November 22, 2007, from http://www.ciaadverising.org/studies/student/97-fall/theory/selctive/biboli.htm

Salway, S. (1994). How attitudes toward family planning and discussion between wives and husbands

affect contraceptive use in Ghana. *International Family Planning Perspectives*, *X*(20), 44–47.

Samba, E. M. (1999). Health information package of the WHO African Region. *Reproductive Health Afr/ Inf/, 99*, 1.

Schaefer, K. M., Artique, G. S., Foli, K. J., Johnson, T., Tommey, A. M., Poat, M. C., Poppa, L., Woeste, R., & Zoretich, S. T. (1998). The conservation model. In A. M. Tommey & M. R. Alligood (Eds), *Nursing theorists and their work* (4th ed.) (pp. 195–206). New York: Mosby.

Schmidt, B. T. Y., & Nice, A. (2002). Challenging-based violence. *Sexual Health Exchange*, *3*, 10, 11.

Schwarz, C. (Ed.). (1994). *The Chambers dictionary.* Edinburgh: Larousse.

Seaman, C. H. C. (1987). *Research methods: Principles, practice and theories for nursing* (3rd ed.). Norwalk: Appleton& Lange.

Senge, P. (1993). *The art and practice of a learning organisation.* New York, London.

Simpson, J. A., & Weiner, E. S. C. (Eds). (1989). *The Oxford English dictionary* (2nd ed.). Oxford: Clarendon Press.

Soukhanov, A. H. (Ed.). (1992). *The American heritage dictionary of the English language* (3rd ed.). Boston: Houghton Mifflin.

Stewart, D. W., & Shamdasani, P. N. (1990). *Focus groups: Theory and practice.* London: Sage.

Stibbard, T., Robertson, L., & Noormahomed, N. (2003). Men of quality are not afraid of quality. Men, HIV and AIDS. Regional conference 2003. Report Back. Voluntary Service Overseas (VSO).

Streubert, H. J., & Carpenter, D. R. (1995). *Qualitative research in nursing: Advancing the humanistic imperative.* Philadelphia: Lippincott.

Sullivan, E. E., & Decker, P. J. (1992). *Effective management in nursing.* California: Addison Wesley.

Tavrow, P. 2005. International Conference on Population and Development, Cairo 1994 (ICPD). Retrieved June 6, 2009, from http://enbixbyprogram.ph.ucla.ed/edu/mattach/what _ isch_6 -05pt

Tomey, A. M. (1998). The elements of nursing: A model for nursing based on a model of living. In A. M. Tomey & M. R. Alligood (Eds), *Nursing theorists and their work* (4th ed.) (pp. 321–332). New York: Mosby.

Ulin, P. R., Robinson, E. T., Tolley, E. E., & McNeill, T. (2002). *Qualitative methods: A field guide for applied research in sexual and reproductive health.* USA: FHI.

United Nations (UN). (1995a). *Beijing declaration platform for action.* Fourth World Conference on Women (FWCW) http://gopher.undp.org/00/undocs/gad/A//CONF.177/95_11/20>

United Nations Population Fund (UNFPA). (1997). *Meeting the goals of the ICPD: Consequences of resources shortfalls up to the year 2000.* New York: UN.

United Nations Population Fund (UNFPA). (2001). *ICPD program for action.* New York: UNPF.

United Nations Population Fund (UNFPA). (2003a). Retrieved October 29, 2003, from http://www.nnfpa.org/profile/overview- euroasia

Uys, N. (2007a). Enforcement HIV Test. Official. *The Namibian, 22*(202) October 30.

Uys, N. (2007b). Winding down, teetotalling: The last weekend in BBA house. *The Namibian*, *22*(208), November 5.

Van der Waal (2000). Fieldwork. In D. Rossouw (Ed.), *Intellectual tools: Skills for the human sciences* (pp. 162–167). Pretoria: Amabhuku.

Voght, J. F. & Murrell, K. L. (1990). *Empowerment in organization: How to spark exceptional performance*. Amsterdam: Pfeiffer.

Waite, M. (Ed). (2002). *Concise Oxford thesaurus* (2nd ed.). Oxford: Oxford University Press.

Walker, L. O., & Avant, K. C. (1983). *Strategies for theory construction in nursing* (2nd ed.). California: Appleton & Lange.

Walker, L. D., & Avant, K. C. (1995). *Strategies for theory construction in nursing* (3rd ed.). Connecticut: Appleton-Century-Crofts.

Walker, L. D., & Avant, K. C. (1998). *Strategies for theory construction in nursing*. Norwalk: Appleton and Lange.

Walker, L. O., & Avant, K. C., (2004). *Strategies for theory construction in nursing* (4th ed.). California: Pearson Prentice Hall.

Walston, N. (2005). *Challenges and opportunities for male involvement in reproductive health in Cambodia.* USAID: America.

Weidlich, B. (2007). Enforcement HIV test. *The Namibian*, 202, October 3.

Wells, W., Burnett, J., & Moriarty, S. (1995). Advertising: Principles and practice (3rd ed.). New Jersey: Prentice Hall. Retrieved November 11, 2007, from http://www.ciaadverising.org/studies/student/97-fall/theory/selctive/biboli.htm

Wikipedia. (2007a). *Polygamy.* Wikipedia Foundation: USA. Retrieved October 2, 2007, from http://en.wikipedia.org/wiki/polygamy

Wikipedia. (2007b). *Partnership.* Retrieved March 5, 2007, from http://www.answer.com/topic/partnership

Williams, C. (2002). *Effective management: A multimedia approach.* United States: South Western Thomson Learning.

Wilson, D. C. (1993). *A strategy of change: Concepts and controversies in the management of change.*

Bristol: Leaper & Gard.

Wilson, H. S. (1989). *Research in nursing.* Redwood City, CA: Addison Wesley.

World Health Organization (WHO). (1999). *Regional office for Africa: Reproductive Health*. Afr/Inf/ 99:1.

World Health Organization (WHO). (2006). *Regional office for the western Pacific.* Retrieved June 6, 2009, from http://www.wpro.who.int/healthtopics/reproductive- health/

World Health Organization (WHO). (2008a). *Reproductive health.* Retrieved August 19, 2008 from http://www.who.int/topics/reproductive - health/en/

World Health Organization (WHO). (2008b). *Reproductive health strategy.* Retrieved July 24, 2008, from http://www.who.int/ reproductive _b health /strategy.htm

Young, A., Van Niekerk, C. F., & Mogotlane, S. (2003). *Juta's manual of nurs*ing. South Africa: Juta.

Zaltman, G., & Wallemdorf, M. (1979). *Consumer behavior: Basic findings and management implications.* NY: John Wiley. Retrieved November 22, 2007 from http://www.ciaadverising.org/studies/student/97all/theory/selctive/biboli.htm

Zimbardo, P. (2007). *Encyclopedia of mental health: Shyness.* California: The Shyness Clinic,

Stanford University.

ANNEXURES

ANNEXURE A: PERMISION LETTER TO CONDUCT TO A RESEARCH

ANNEXURE A1: MINISTRY OF HEALTH AND SOCIAL SERVICES**.**

P.O. Box 1079
Ondangwa
9000
12 July 2004

The Ministry of Health and Social Services
Private Bag 13198
Windhoek
9 000

Dear Sir/Madam

RE: **PERMISSION TO CARRY OUT A RESEARCH STUDY AT THE INSTITUTION AND PERMISSION FOR PERSONNEL AND PATIENT/CLIENT INVOLVEMENT**

I am currently doing a Doctoral Philosophy in Nursing Science at the University of Namibiunder the Supervision of Professor A. van Dyk (UNAM) and K. Jooste (RAU), and hereby wish to request permission to do a research study to meet the requirements for the above-mentioned degree.

The title of the study: *A model to involve male partners towards the participants in the reproductive Health system. a case STUDY IN OSHIKOTO Region, Namibia*

The purpose of the study is to: *develop, describe and implement the model that will initiate males to participate in the reproductive health system.*

The objectives are in four phases.

PHASE I: *To explore and describe the "need" perception of males partners, to involve*

towards the participation in the reproductive health system.

PHASE II: *To explore and describe the action to be taken to involve males partners towards the participation in the reproductive health system.*

PHASE III: *To validate the outcomes of PHASE I AND PHASE II.*

PHASE IV: *To develop, describe and implement the model.*

The participants: *male partner, female partner and the nurses*

Health facilities: *Hospitals, Health centres and Clinics*

Method of Data collection: *Individual and Focus group discussion questionnaire*

*C*onfidentiality will be maintained, no name or addresses will be required from the subjects. Questionnaire number will be used for control measures. I will provide my telephone and Address to all subjects for any problem clarification. Participation is voluntary and if one wishes to withdraw one is at likely to do so.

The research will be used as basis for involved males in the reproductive Health system and will be made available to you on completion of the study.

This research is officially approved by the Ministry of Health and Social Services and University of Namibia see the attached approval letters.

Your assistance in this matter would be greatly appreciated

Thanking you

_____

Hans J. Amukugo (Mr.)

RESEARCHER

ANNEXURE A2: CONSENT TO PARTICIPATE IN A RESEARCH. IN OSHIWAMBO AND ENGLISH

P.O. Box 1079
Ondangwa
9000
12 July 2004

OSHINIMA: ***Eindilo ziminino kaakutha mbinga momapekapeko (Research) Mehala, Kaanashilonga noshowoo aavu mboka yagumwa notaadhana onkandangala miinima yuundyolowele wunasha noluvala.***

Ongame ***Hans J. Amukugo*** omulongwa moshiputudhilo shopombanda mo University ya Namibia, tandi iilongo onkatu yuuNdohotola muupangi mewiliko lya ***Professor A.Van Dyk (UNAM***) na ***Professor K. Jooste (RAU koSA)***. Naampaka otandi indile eziminino okuninga omapekapeko opo ndaadhe iinakugwanitha yonkatu ndeyi popi metetekelo.Oshipalanyolo shomapekapeko oshoshika:

OKUTUNGA OMUKANKA NENGE OFUNDAMENTE NDYOKA TAYI KA YAMBIDHIDHA AALUMENTU NAYO WOO YAKUTHE OMBINGA NOYIITULEMO MUUNDYOLOWELE WUNASHA NIINIMA YOLUVALO.

Elalakano lyomapekapeko okutota, okufatulula nokutula omulandu miilonga nkene ootate taya yambidhidhwa opo woo yakuthe ombinga nokwiitulamo miinima yinasha nomaukolele moluvalo.

Efalomo:Osha dhidhilikwa kutya ootate/ aalumentu yelimepipi lyomvula dhokuvala ihaa dhana naana onkandangala yagwana miinima yinasha nuundyolowele moluvala.

Sigo oompaka kaku shiwike naana kutya omolwa shike aalumentu/ ootate itaaholoka kiipangelo hoka taa vulu okumona omauyelele onga "*tate na meme nuunona*" omeme owala nuunona haaholoka kiipangelo. Manga inandi ya komeho ondapumbwa okufatulula "***EKUTHOMBINGA MUUNDYOLOWELE WUNASHA NOMALUVALO"*** okokutya naana ngiini?

OMAFATULULO:

(1) Tate nameme taa holoka koshipangelo ayehe yuuve uuyelele kuusimba waholoka megumbo.

(2) Tate nameme taa holoka yaali koshipangelo yamone omauyelele nehungomwenyo uuna uuvu nenge omaunkundi gaholoka megumbo genasha nuundyolowele woluvalo.Tate nameme taa holoka ayehe yaali uuna pwa dhimbululwa kutya itaya mono uunona manga opo yakwathelwe.Tate nameme taa holoka ayehe koshipangelo uuna gumwe gwomoluvalo ta ehama shaakale owala oshimpwiyu shameme awike. Tate nameme taa ningi omatokolo ayegehe kutya uunona ungapi yena okumona, shaakale owala etokolo lya tate shaashi oye ena oonkondo dhomatokolo megumbo.

Shiikolela kwaashoka shapopiwa metetekelo Omukonakoni momapekapeko ngaka oti ipula omapulo ngaka?

Ootate yoyene noomeme nosho woo aapangi oyuuvite naana ngiini ekuthombinga lyootate/naalumentu miinima yuundyolowele yinasha noluvalo?

Omwolwashike mbela otate ihaakutha naana ombinga lela miinima yuundyolowele yinasha nomaluvalo?

Oshike shina okuningwa opo ootate yakuthe woo ombinga muundyolowele miinima yomaluvalo?

Akuthimbimga momapekapeko oyombaka:

- ALUMENTU YE LI MEPIPI LYOKUVALA NENGE YAKA NALE.
- ANKIINTU YELI MEPIPI LYOOMVULA DHOKUVALA NENGE YAKA NALE
- OOTATE NENGE OOMEME YAGUMWA UNENE KUUPYAKADHI UNASHA NUUNDYOLOWELE WOLUVALO.
- AAPANGI MBOKA YE LI MESILOSHIPWIYU LYIINIMA YINASHA NUUNDYOLOWELE WOLUVALO.

Shikolelela kwaashoka shapopiwa pombanda, onda tegelela oshipangelo, oklinika no health

centre yilongekidhe aantu taya landula ngele otashivulika:

ONGUNDU YOOTATE YATHIKAMA PO KAANTU YAAVULE (12)

ONGUNDU YOOMEME YATHIKAMAPO KAANTU YAAVULE (12)

AAPANGI MOSHIPANGELO, HEALTH CENTRE NOOCLINIKA (KEESHI GUMWE

Aakuthimbinga otaya tseyithilwa kutya iinima tayika kundathanwa oyopauyuuki noyopaushili nakehehe omukuthimbinga okwa gamenwa molwashooka omapekapeko ngaka ogeshiwike papangelo (tala kehulilo ombapila yeziminino okuza kUumimistry yuu Uukalinawa nOnkalonawa).

Kehe omukuthimbinga okuna uuthemba (hathiminiko) okutinda nenge okuzimina opo akuthe ombinga momapekapeko.

Ekuthombinga lyoye moshinima shomapekapeko ngaka otashika simanekwa uneene tuu pethimbo lyuuvu wavuka moshilongo shetu.

Ondemu pandula.

Hans J Amukugo

OMUKONAKONI (RESEARCHER)

IN ENGLISH

P.O. Box 1079
Ondangwa
9000
12 July 2004

Dear Sir/Madam

RE: CONSENT TO PARTICIAPATE IN A RESEACH PROJECT.

I am currently doing a Doctoral Philosophy in Nursing Science at the University of Namibia under the Supervision of Professor A. van Dyk (UNAM) and K. Jooste (RAU), and hereby wish to request permission to do a research study to meet the requirements for the above-mentioned degree.

The title of the study: A model to involve male partners towards the participants in the reproductive Health system. A case study IN OSHIKOTO Region, Namibia

The purpose of the study is to: develop, describe and implement the model that will initiate males to participate in the reproductive health system.

The objectives are in four phases.

PHASE I: To explore and describe the "need" perception of males partners, to involve towards the participation in the reproductive health system.

PHASE II: To explore and describe the action to be taken to involve males partners towards the participation in the reproductive health system.

PHASE III: To validate the outcomes of PHASE I AND PHASE II.

PHASE IV: To develop, describe and implement the model.

he participants: (I) (male partners and (ii) female partners, (iii) nurse

Health facilities: Hospitals, Health centres and Clinics

Departments: Ante natal and post Clinic/department).

Method of data collection: Individual or group interview.

Confidentiality will be maintained, no name or addresses will be required from the subjects. Questionnaire number will be used for control measures. I will provide my telephone and address to all subjects for any problem clarification. Participation is voluntary and if one wishes to withdraw one is at likely to do so.

The research will be used as basis for involved males in the reproductive Health system and will be made available to you on completion of the study.

This research is officially approved by the Ministry of Health and Social Services and University of Namibia see the attached approval letters.

Your assistance in this matter would be greatly appreciated

Thank you

_____

Hans J. Amukugo (Mr.)

RESEARCHER

ANNEXURE B:

PERMISION GRANT BY THE MINISTRY OF HEALTH AND SOCIAL SERVICES OF NAMIBIA AND UNIVERSITY OF NAMIBIA

MINISTRY

UNAM

ANNEXURE C: TRANSCRIPTS OF FOCUS GROUP (MALE PRTNER IN ENGLISH

Transcription of type: Date: 20/12/2004

Language for interview: English

Place: a

Region: Oshikoto

Time: 14H10 – 15H01

Participants: Male

Age: R_1 =, 25 years, 27

Parity: $R_7 = 2$

S: Mm....I am doing a research on men's Mm....involvement Mmm....reproduction health at this two departments from our ANC and Post natal, the aim is just to find out how the men perceive and how they or what are their experiences and what they expect from this tow departments.

S: So I would like to ask you, what are your perception, or how do you perceive aah!! Means involvement in these two departments?

R 2: Ok!! M...aah!! how do I perceive it (crossing his legs) is since I am not a culturalpersonand since I grew up without a culture Aaam.....at first when I like really grew –up (moving his hand up) I really do this one and PN aah...PNC (silent) as something just for women.

S: Why do you say it's just for women?

R 2: Well in the past, we (paused) were not really (paused) taught abou sexual things, about pregnant women, aah!! In past people believed that it was just for women itself. Mmm!! But now as I am sitting here (pointing to his chair) Aaah....I have been educated (pause) so I don't see it the same way anymore.

S: Meaning?

R: Meaning that I have got the information on certain aspects of this ANC and PNC departments. Aam!! I have the overview of what they are doing here (Pointing at the building) and mm...(Pausing) I just somehow, someway know that I have to be involved well really don't know up to what extend I should be involved (silent) but (pausing) I feel that for me to become involved will gives me then a greater overview of what is expected of me.

S: OK, as you said you were educated on what people are doing and what is happening around ANC, how did you really get to know or how did you get this info of men to be involved in this tow departments?

R: Well, Aam...since I have been (pausing) Aa!! On school and I have beein Grade 11 and

12, I had biology on school (nodding his head) and through that I learned about, the female aspects of life and mm!! I also have some coupons that I acquired from my wife, which she brought home from the....from, from this departments and which I have read and then I got the, the, the information from there. Aa!!, well as I am sitting here in oshiwamboland, Aa...at Onandjokwe, I haven't, it's not my first time, to be at an ante-natal care Aaa and PNC departments. I have been there once or twice with my women but that was in WHK (pausing and raising his eyebrows) and there I have noticed it's not really what it was in the past, its like (looking in the roof) you know at first people thought that you will go down on morals when, you accompany your women to your. but now I see it as it I go to this places I'll get more involved.

S: So you are saying that in the past more consent Aaa.. concentration was given to the women then to men.

R. Yaa... in the past it was more a women thing.

S: So do you really thing these departments are of great importance for men?

R: Well, in a way it is.....of great importance and in a way. I would say (silent) I really don't know whether there is a negative effect but as I grew – up I know that it can only be positive effect.

S: Meaning?

R: Meaning that MHMM as, as as if I came here, I learn a fear things, more I educate myself more on what is really happening on, in, in this this departments.

S: So you are telling me that it is important because you get education or you get more experience as you come more to the departments?

R: Well I do receive experience, I do receive education and I do receive the understanding (silent) of what women and children, women and the child in her womb go through.

S: So what are your experiences as you have come across as you visited these two departments?

R: Ok, MHMM...since this is my first time at this two departments what I experience is that, this departments is (pausing) a little bit down graded what I mean by that is that the infrastructure_____is not really up to standard.

S: Why are you saying is not up to standard?

R: Aaa...because the, the, the ANC department itself it's EEH....if I can go back and talk about WHK's department, WHK's department is a little bit bigger it have more privacy (crossing his legs) and this department here is very small there are a lot of people coming here and as you can see a lot of people are sitting out here, a lot of women and I don't know or whether it is due t (pausing) a lack of information, but I just know that somehow someway something has to be done.

S: So let me just ask you? What, as I hear that you, you, you are comparing withthis Onandjokwe ANC and WHK's aah...ANC departments, what do you think are the contributing factors to this lack of infrastructure?

R.: Ok, this contributing factors, is that (pausing) Aah....my experience on this things are that if I go to the Ante-natal clinic in WHK were I have been at least two to three times as I have said before Mm!! there if you go in you will feel this is a department for health and here the hygiene is a little bit mot very good because its a little bit dirty in here it's a very, very, very big negative aspect of the department itself.

S: So its also like discouraging men to come into this two departments?

R: Yaa...to tell you the truth I wouldn't really know whether it will discourage men but if me as a men come in this place as I am sitting here I don't feel good because my, my wife is been treated here and mm....she is under going some treatment here and whereby the hygiene is not good (shaking his head) and through my understanding and through what I have learned on school and what I have read out of books women are very, very, very Mmm how do you say the word Mmm...they are very vulnerable to infection.

S: So you are meaning that this lack of hygiene is contributing to the health of the women through what?

R.: Yaa, it does in a sense it, it, it brings the moral of a woman and for me as a man to bring my wife here (pointing to his chest) or come sit with my wife here and experience things like this its not a good thing cause for the fact that it is not clean and then Mmm....there is one experience that I have also (raising his eyebrows) one experience that I have also where I come down to the privacy Aa...since as I have already stated this department is too small.

S: So you are expecting it to he wide open or should it be spaces or should it be divided, what are you views really when it comes to privacy?

R: Is that the place should be expanded and they should get more equipments?

S: Like, specifically?

R: Like specifically first we come down to the social workers Aa....the health workers itself

this people (pausing) are very much that are sitting out here. There are only four nurses up in. Aah...up in this place Mm who are taking care of this people, which I think is the first thing that is already lacking and than we go to the equipment you know there is only one bed were this people are been whatever done to them and this people have to wait now for this one to finish and this one to finish (counting his fingers) and at the end of the day you are sitting there since morning till afternoon times wasting your time

S: So you said privacy so, you mentioned bed right now, so how do you really match this, the bed and the privacy part?

R: Ok, the bed and the privacy part mgh...mgh....is that Aah...this, this, this, part were the bed is as you can see is only covered with the screen mm...you know it's only some thing that is put up there which to my understanding they called it a screen and mm....this people if you go in there its, its, its, its not really private cause I feel that you should be almost like if you are in a room alone and now other people are sitting outside there just next to this screen as you can see here they are just sitting here and this people showing to the woman outside) they, they don't feel that they are really private you can even see on their expression they don't really feel and I feel that due to my experience on privacy also, this people to have the needed information on that.

S: Whom are you talking about?

R: I am talking about your clients, the client themselves, cause Mmm...for me, I would feel really, really uncomfortable to go in there stand there while I know here are people here outside who can anytime came around this screen or another nurse can just come walking in here without even having knocked or something like that, properly my wife would like to be with one nurse only or maybe she don't want other nurses to come interfere at that certain time.

S: So, What are you really experiences on the management of time at the department?

R: Oops, very much poor (expressing disappointment on his face)

S: Why do you say it's poor?

R: Mmm...at first (pausing) you bring your women here since, like me I brought my women this morning since I have today off. I brought my women. She encourages me to come along with her at this department and I came. I brought her eight o'clock (pointing at his watch) and that's the opening time of this department, which is even written on the board outside (showing outside) and Eeh...I have been sitting here with my wife outside and as you can see this is the time of July it is cold and I have been sitting there outside with my, my wife and nine o'clock (silent) the first people where started being calling in and the urine test they are doing here is...also a little bit off but let me go back to the time factor. They manage the time very wrongly. They have like I don't know where they are since eight o'clock in the morning till nine o'clock. Then they, they, they, take time with one women which I think is good thing to take time with one woman but then there is not enough beddings in here where people can at least have three or four people at one time being taken care off so that the process can speed – up.So, what do think is the contributing factors to the time limit

R: First of all (pausing) if not the laziness of this nurses, Mmm.....the equipments itself. ya Aaaa ..... you do one person at a time how many people are out there? Like right now I can not even count them, they even more than maybe 70 people here. So you take one person in there now you're trying to hurry up, you don't do a good job, Hum...but if you want to do a good job you take, take time Hum... and than you don't finish all this people in a time limit. So if you have more beddings or the department is more under than I think it will take a little bit less time.

S: Ok, so what do you really expect from the two departments?

R: Well, Hm...to talk what I expect is first of all for the infrastructure to be upgraded, for this building (showing on the roof of the building) to be at least expanded or

S: How will you expand it, do you expect division or just big whole building?

R: Yaa, they should have some division, but as you can see this room they call the ANC department is very small, Hmm....you can't even put two beddings in this department to at least limit your time Hm....to get time a time as a factor in here and I think that if they expand it a little bit more like make it a little bit bigger (extending his arms) or just mm...Maybe transfer this department to a bigger building were they can have at least two to three or four beddings in the room.

S: Besides now the expanding of the building or moving into another big building, what other expectation do you expect?

R: Well, I expect them to have like (pausing) not really rooms but u know when you go into a certain place, these should be a door, which will cover that area were the, the, the, the, the, the Mmm...the examination or whatever they are doing on this women of ....women that are been in there that should be, you know it should be more private. The women should feel they are private; they are alone with the nurses.

S: So what do you think are the involvement or who should be involved and what type treatment should be given?

R: Mmm....(silent) what type of treatment should be given (repeating the question).

S: What do you expect from the health workers themselves?

R: Ok, well what I just expect, is to have the, their, their time well managed Mmmmhu....Mm....when it comes to treatment I really don't know what type of treatment theywill give, but what I expect is for meetings to be called for, with the women and their partners, give education on the subjects on what they are doing exactly there, here and what they really want for the man (pointing to himself) cause for the involvement of the men you have to teach somebody to understand something. Now if you don't teach somebody something that person wouldn't understand and they wouldn't know why they should be involved.

S: So I understand your point but there are some circumstances that men tend to be negativealthough they are giving this health. What will you, what are you expectation form thesemen?

R: Well, as that is a very time point that you have just stated: some men have been more culturally brought-up in the world Mmm...Whereby me myself have said. I haven't been culturally mm...brought-up. Mmm...I think that you know this people who are negative is not the fact that they really want to be negative, is just the fact that they don't really see what is really necessary for them, Why is it really necessary for them to come there. But if this people could go out, go out to the community talk, have some health talks with the community itself, than it's a broader amount of mrn that will be reached and not just Mm... men who will, who will who have pregnant women and then I think that if you start it at root level. I you go down to the root level (punching his palm) and go and teach the kids mmhu... from the time they are in school all about this health facilities then I think that in the future or in the coming days people will be more excepting andmore understanding towards this programme itself.

S: I see, just recup, so just finalise what would be your general overview about the whole

R: Mmm... Ok wait before I go on, on your Question, I just like to state something. Man I have seen that there is one improvement that a men really gets involved even though

there are not really from the community with their women, but see at least they are training men how to become midwives. Mmm... I have heard that from the radio and I thing that is a very, very positive effect that they have now, cause then I thing that if men do come there they don't, wouldn't feel that this is just a women thing , they will feel more openly to come because the seen men working there. Mmm.. ah your question again?

S: I just said, just to recup what would be your general overview about the men's involvement in reproductive health?

R: I would say it would be a very, very, very good thing Mmm... I would say that if men do take part and do come to this facilities and they do get teached about what's going on, what's happening, I think they would play a positive role in the, in the, in the, in the children's life, they would play a more effective role in their women's life while being pregnant. And they will have a better understanding so I think the involvement of men to involve men in this programme would be a positive effect and Mm... men will then also towards a social causes the outside world they will be more effective role in their women's life, they would play a more effective role in their women's life being pregnant. And they will have a better understanding so I think the involvement of men to involve men in this programme would be a positive effect and mm... men will then also towards a social causes the outside world they will be more freely to talk about this things. Cause now men don't really doesn't talk freely, openly about Mm... pregnant women, about their women going to Ee... place and ....

S: So, which means Mm...? they, this men involved would it really contribute the development of this programme.

R: Yow!! I think it would, ya... if them men are involved and they really know what is going on. They will contribute even though not the development of the country but to the development of health system for the health system if the men are involved then

there won't be so much complication.

S: Like?

R: Like, like, you know some women, you know it you get down and read books you get an overview of what's really happening in the labour departments and things, now there on't be so much complications cause then the men would understand why certain things have to be done and he will really take care of his women. He would not let the women work hard while pregnant, he wouldn't do he wouldn't burden the women with certain things that the women are not suppose to be doing when they are pregnant. So, I thing it would be a good thing for them.

S: Thank you very much.

R: My pleasure talking to you, thank you very much.

Likewise!

D: TRANSCRIPTS OF FOCUS GROUP DISCUSSION (FEMALE PARTNER IN ENGLISH)

Transcription of type: Focus Group

Date: 20/12/2004

Language for interview: Oshiwambo

Place: Oshigambo clinic

Region: Oshikoto

Time: 10H10 – 10H56

Participants: 9 female

Age: R_1 = 52 years, R_2 = 29 years, 23 years, 38 years, 25 years, 27 years, 21 years and 56 years.

Parity: $R_1 = 6$, $R_2 = 3$, $R_3 = 2$, $R_4 = 1$, $R_5 = 8$, $R_6 = 1$, $R_7 = 1$, $R_8 = 1$ and $R_9 = 4$

Educational background: R_1 = read, R_2 = grade 2, $R_3 = 10$, $R_4 = 9$, $R_5 = 6$, $R_6 = 10$, $R_7 = 12$, $R_8 = 8$, R_9 = STD 6.

Employment status: all those unemployed

Marital status: all unmarried except $R_1 = 1$

Introduction:

Oshinima omapekapeko, okutunga omunkanka nenge ofundamente ndjoka tay ka longithwa okuyambidhidha aalumentu nayo wo ya kuthe ombinga noyi itule mo muundjolowele wu na sha niinima goluvalo. Osha ndhindhilikwa kuty ootate / aalumentu yeli mepipi lyoomvula dhokuuva ihaa dhana naana onkandangala ya gwana miinima yi na sha nuundjolowele woluvalo. Sigo oompaka kakushiwike naana kutya omolwashike aalumentu / ootate itaa holoka kiipangelo hoka taa vulu okumona omauyelele onga “Tate na meme nomunona” oomeme owala taa holoka kiipangelo.

Manga inaandi ya komeho, ondahala okumupandula sho mwa holoka, opo nane mukuthe ombinga momapekapeko ngaka. Ngaashi ndeshipopi metetekelo otandi ke mupula owala omapulo gatatu.

Epulo lyo tango olyo ndika; omuuvite naana ngiini ekuthombinga lyootate miinima yinasha nuundjolowele moluvalo? Pwamwe opuna gumwe gomune ta vulu okupandje uuyelele

***R*$_1$**: Oshinima shoshene....ootate yoyene nenge owutje tate natuye koshipangelo omusamane tiuuvuko, nenge waziko noopela okwatiwa natunwe omiti ndhika omusamane ita uuvuko. Otwee hama shike opo weetelendje omiti ndhoka, omusamane iteshi zimine. Nande owulombwele, gumwe otazimine ndele gumwe itazimine. Ngaashi nee epipi lyongaashingeyi, ookana kokamati otokekaadha peni? Kaye koshipangelo, uuna mukwawo eya mo, ototi ngaa mukweni omo ali muka, okwati indeni koshipangele, oteku lombwele owala kutya nafale omikithi dhe kokule, adhimbwa nale shisha lipo ohela.

S: Meme omutiyali owushuuvite ko ngiini, ekuthombinga lyootate / naalumentu minima yina sha nuundjolowele woluvalo? Oshinima shika oshiwanawa nenge oshiwinayi.

***R*$_2$**: (amwena po manka?) Iikwata ye tiikwata momeho. Oshinimaoshiwanawa lela.

S: Oshiwanawa ngiini?

***R*$_2$**: Oshiwanawa lela opo atuhe tukale nawa lela, tse tukale tuna uundjolowele.

S: Gumwe otati ngiini mbela

***R*$_5$**: Oshinima oshiwanawa lela, shaashi moompito dhimwe lela okanona otaka eehama, omushiinda teya okukutha opo u fale oka nona koshipangelo omanga omusamane eli megumbo eli kohi yiikolitha, peha lyokufal okanona koshipangelo.

S: Sha hala kutya “oshinima shika owinanawa lela?

R_6: Oshiwanawa lela, ootake ya kale haafala oomeme koshipangelo lela.

S: Omolwashike mbela?

R_6: Omolwashoka, opo a zeko uuvako epango tali pangwa omukulukadhi, ye aze ko uuvite kutya omukulukadhi gwandje okuviite shike. Pwamwe nayeokwakwatelwamo, nenge epuko olili owala momukulukadhi gwandje.

S: Tashiti oshili nawa lela ootate nayo yakale hayeya koshipangelo _____o famili.

R_6: Eeno lela.

S: Epulo etiyali, okutya omwandhindhilika iiyimbi yini mbyoka tayi imbi aasamane yaaheye koshipangelo? Kutya aasamane sho ihaayeya koshipangelo oshike mbela.

R_9: Ngame mwene ondiwete kutya omusamane gumwe okwasohoni okuya koshipangelo.

S: Asohoni?

R_9: Eeno, asohoni okupangwa, okupangwa pwamwe nomukulukadhi gwe.

S: Shahala kutya ohoni itayi mu falako?

R_9: Eeno, ohoni (ageya notapopi nomukumo) oyo itayi mu fala ko; shila oteya ngaa

nolukeno tati natuye ngaa nee. (tayelula oonyala).

S: Gumwe otati ngiini

R_8: Ongame ondiwete kutya omusamane okwatilako owala....(tamwena po manga etiisizimike)

S: Atila ko shike mbela?

R_8: Atila ko amonike nenge omukithi,

S: Tashiti atilako amonike omukithi osho shemutilitha ko?

R_1: Eeno (tapopi nomukumo)

S: Gumwe atandi mbela ngiini?

R_9: Aalumentu yamwe okwatilako, unene ngele okwatiwa naku thwe ombinzi,etamonika nee o HIV nenge okandongo, etakutiwa natukawende, osho owala hashi eeta uumbanda okuya koshipangelo.

S: Oshili nawa lela, gumwe otati ngiini mbela?

R_3: Omusamane shili ohati kutya omukulukadhi oye akongo omikithi ndeleomukithi ogwazi momusamane, ndele etagandja owala ombedhi komukulukadhi nafale omukithigwe oye eshi mpoka egukutha. Oshili nawa tuye atuhe tukakuthwe oombinzi dhetu, ndele oshinima shika ineshipanda.

S: Meme ngoye ototi ngiini?

R_1: Aasamane oyendji kayuuviteko oshinima, kutya owumulombweleoshinima, koshipangelo itayi ko, kuuviteko nande lela lela.

S: Kuuviteko nande nande?

R_1: Tuye koshipangelo kuuviteko nande nande, unene shinasha natse oomeme. Tomulombwele kutya natuye koshipangelo?....(tahakele oonyala) "otandi ka tala koshike? Ngame itandikathulwa? Inda ngoye awike.

R_4: Aasamane oyedji ihaa zimine shoka toya lombwele, gumwe otakala eli kokule, tomulombwele, kutya ondali koshipangelo, kutya eyamukulo lyandje ka li li nawa, otwa pewako oowenda dhontumba. Ote ku yamukula kutya ye itawendwa.

S: Tatindi owala lela? Mbela oshike ta tindi?

R_4: Gumwe kena eitaalo lyasha.

R_5: Gumwe nenge owumulombwele kuuviteko nande, nenge owutye natuy koshipangelo, otwa monika omukithi, otati owala ngono ogoye ye kenaomukithi.

S: Gumwe otati ngiini? Kapuna nande shimwe nande hashiya tinditha oku kiipangelo?

R_4: Gumwe ohakala noomeme oyendji ngawo, ye okushishi kutya omukulukadhigwe iha

ende okwatala owala muye. Shongaa omuntu tati okuli metegelelo, natuye koshipangelo tuka kuthwe ombinzi tutalike kutya otatu mono ekwathelo lili ngiini? Okwiiyageka kutya otathigwa po kumeme ngu eli megumbo itayi ko, nande lela.

S: Omwapopi kutya aasamane oyatila ko lela okuya koshipangelo, kayena euvoko lilinawa, oyena uumbanda wokuyakoshipangelo epulo lyathiginina olyo ndika? Oshike nee shina okuningwa po? Opo aasamane yaha tinde kiipangelo oshike mbela shina okuningwa po?

R_1: Otamuya ningile ngaa iigongi muyiithane kutya.....aasamane tamuya iithana lutatu nenge lune, tamu tala mbotayeya nambo itaa yeya. Ngele ngeya tamu popi ngaanayo kutya omukulukadhi gwaayeni ngele tayi koshipangelo indeni pwamwe naye. Ngele otati naye koshipangelo, oye mwene eshi kutya omikithi dhe oye eshi mpoka edhikutha, tapopi nane muuviteko.

S: Gumwe otati ngiini ishewe?

R_5: Oshiwanawa osho nee kutya ngaashi puna nee ompito ndji yokutya omukulukadhi ngele teya koshipangelo, naye netelele omusamane gwe mpono ngele otashi shiwa puna oveta kutya omukulukadhi ngele okuna etegelelo teya koshipangelo inathigako omusamane, pwamwe shoka otashi keya eeta popepi, shaashi kapuna naana oyendji taa.....yeetha omukulukadhi nkee ngaa aningile epunda inaaya komathulo ngiika naye otaka luluma ngaa, sigo tamuya amuhe, ye eteya nee uuvithwe ko nee nawa.

S: Wahala kutya napu kale puna ompango?

R_5: Kutya nee okanona taka eehama naka eetwe kaantu ayehe.

S: Oshili nawa lela; gumwe otati ngiini mbela?

R_4: Gumwe otavulu ngaa okutya shotatuyi atuhe oshimaliwa otashizi peni sholef? Shahala kutya oshimaliwa itashi gwanene atuhe.

S: Shahala kutya oproblema oyili po shimaliwa?

R_4: Eeno, oproblema oyili moshimaliwa

S: Gumwe otati ngiini? Noshike shina okuningwa po?

R_1: Ngame ondiwete owala kutya ompango tayi dhengele

S: Ompano tayi dhengele? Pwamwe itamuvulu okutya sha koshipangelo popwene?

R_7: Otatu shi gandja miikaha yaapangi, etaya ningi ehiyo lili ngawo.

S: Shahala kutya aapangi nayo nayakuthe ombinga?

R_7: Eeno lela (Takomona komutse)

S: Shike mbela vali? Mbela poshipangelo mpoka inamu ndhindhilikasha tashi iimbi aasamane yaye koshipangelo.

R_1: Ongele ndeya nokaana kandje nenge tandi eehama.

S: Okokutya, ongele pwamwe weya nomusamane goye pwamwe otwiindikwa nenge ongiini?

R_1: Ayee....aaye inatu mona sha.

S: Onde mupandula aaholike mwaashihe mwa pendje mpano otashika ninga ofundamente yokutunga omukanka gokuyambidhidha aalumentu nayo woo yakuthe ombinga noyiitulemo muundjolowele wunasha noluvalo. Shino kashishi osima okumwiithana.

ANNEXURE F: TRANSCRIPTS OF FOCUS GROUP (MALE PRTNER IN OSHIWAMBO)

Transcription of type no: 5 **Date**: 21/12/2004

Language for interview: Oshiwambo

Place: Onandjokwe ANC – Onandjokwe District

Time: 10H00 – 10H56

Participants: 18

Age: R_1 = 30 years, R_2 = 24 years, R_3 = 29 years, R_4 = 28 Years, R_5 = 32 years, R_6 = 30 years, R_7 = 22 years, R_8 = 37 years.

Marital status: 7 unmarried, one married

Employment status: 7 unemployment and one employed.

Introduction:

Ondemu pandula eholoko po lyeni opo mu kuthe ombinga momapekapeko genasha nokutungomukanka nenge ofundamente ndjoka tayi kayambindhindha aalumentu nootate nayo wo yakuthe ombinga noyiitule mo muundjolowele wu na sha niinima yoluvalo. Elalakano lyomapekapeko okutota, okufatulula nokutula omulandu miilonga nkene ootate taya yambidhidhwa opo wo ya kuthe ombinga miinima yinasha nuundjolowele woluvalo. Oshandhindhilikwa kutya ootate / aalumentu ye li mepipi lyoomvula dhokuvala ihaya dhana onkandangala ya gwana. Miinima yinasha nuundjolowele woluvalo sigo opompaka kaku shiwike naana kutya omolwashike aalumentu/ootate itaa holoka kiipangelo hoka taya vulu oku mona omauyelele onga "tate na meme nonuunona" omeme owala nuunona haya holoka kuupangelo. Oyo iikundathanwa tatu ka kundathana nena. Otandi ke mupula omapulo geli gatatu nolyotango olyo nee ndika:

S: Omuuvite naana ekuthombinga lyootate miinima yinasha nuundjolowele woluvalo? Omushuuvite ko naana ngiini oomeme?

R_1: Otuuvite nayi (tayolomo) shaashi ootate ihaya thikiko kiipangelo.

S: Muuvite nayi sho ootate ihaya thiki ko kiipangelo?

R_2: Ngame ondi uvite nayi kaa lumentu mboka haya gandja omadimo ndele etaye ga aanye taa ti kayeshi avo.....

S: Gumwe otati naana ngiini?

R_4: Ngame ondi uvite nayi shoka ihaya landele aantu shaashi ngele otandi yi koshipangelo nakale alongekidha iisaali niinima ayihe. Inaya hepeka aakulukadhi ya wo.

S: Inaya hepeka aakulukadhi yawo?

Mmhmm...shahal kutya ngele otoya koshipangelo tokamona okanona nekupe iinakugwanithwa (iipumbiwa) ayihe, mmm....

R_1: Mmmm....(takomona komutse)

S: Shahala kutya iha ye mu pe iinima yiigwanapo?

S: Tashiti nane omuuvite nawa lela uuna ootate taya kutha ombinga minima yinasha noluvalo? Sho ngaa mweya nena huka omusamane goye owemuthigi peni?

R_1: Okwa ya kiilonga.

S: Oshike iinaa muya naye?

*R1***:** Kandali ndishikutya otatu ya naasamane, kandishi naye okwa pumbiwa ko huka.

S: Iyoo, natuyeni ngaa kepulo, omuuvite naana ngiini ekutho mbinga lyootate miinima yuundjolowele woluvalo

R5: Ngame onduuvite naana kutya aasamane nayo nayakuthe ombinga, shaashi oto adha omuntu ohalongo maar, ihe kena shoteku pe nenge ta pe okanona. Omuntu ota mono okaana itekapesha ye omuntu ohalongo ngaa, kushiwo nee kutya omuntu ohiipula naana ngiini? Ngame ondi uvite ngaa haya landa iinima yagwana nawa lela okanona, meme alya naana lela nokanona taka zimo kapaluka nawa lela.

S: Osho nee shoka gumwe otati naana ngiini?

R: mmhmm...(tii memeha), ngame onda pandula owala ngele opuna omadhiladhilo opo ootate yakale haye tu landula kiipangelo. Otatu kala tuuvite nayi shaashi otandi vulu okumuthiga kegumbo,nenge ota vulu okweetandje huka koshipangelo etakala shihauto. Ita mono kutya mwiya otandi ka ninga shike, nda pu, tandi shuna mohauto etatu shuna umbo. Ndele ita kongo neekutya omukulukadhi gwandje otaka ningwa shike?

S: Tashiti omuwete nenge omuna ohokwe yootate yeye huka.

R_1: Eeno, oshapumbiwa, kutya nee ondaningi etegelelo, etandi ka mona okanona nakale akalelandje ngaa amone kutya okanona oha keya po ngiini. Shaashi otashi vulika ndize huno ndamono okanona shototi nee okanona ohaka eehama. Kuuvite uululume kaa. Uuna ngele opo eli atala kutya okanona haka okeya po nuudhigu, otamono ngaa kutya aaye, okaana oha keya po nuudhigu ngaa.

S: mmmh...., gumwe otati nee ngiini?

R: Ngame onduuvite lela nayi, omuntu gumwe nkene ngaa waningile etegelelo oteku hedha kokule. Nkene ngaa watamekele omathulo nyoko oye owala teku kwathele. Okukupa okamaliwa kokuya nako, kuna shoka to li, oto eta ohenda shili

uunene. (asizimana yetahala oku lila newi eta li lunduluka)

S: Tashi ti otamu mono iihuna?mmhmm....gumwe otati ngiini.

R: Otwe shipandula lela shaalumentu taya kala taa kutha ombinga, nenge taya kala hayeya naakulukadhi yawo kiipangelo, ashike nee ngaashi kombinga yetu inaatu hokanwa nenge yakwetu oyeli komagumbo gawo tse otu li komagumbo getu giili. Ondiwete ngaa kutya otashi ka kala oshidhigu okumu kutha ko kutya itu ye koshipangelo, omuntu gumwe nkene ekupele epunda inomu monawe. Ondiwete kutya shoka oshi nima shetu dhenga nayi koomwenyo, katu shi uvitile nawa, otwahala nayo yakuthe ombinga, katushiwo nee kutya onkatu yini okukuthwa opo wo nayo ya ku the ombinga.

S: Gumwe otati ngiini?

R: Tse otuwete kutya oshili nawa aasamane yakale haye eta aakulukadhi yawo kiipangelo, shaashi omusamane gumwe oteku thigi owala mpoka noshimaliwa ye ite ku pesha, gumwe ohalongo nee, naangu gwaayeni oteku thigi megumbo, ye ena gumwe eli mpeyaka oye ta pewa, ko okaana hoka takazi kwaangiya otaka eetwa kungoye, shotoyi koshipangelo owuna okusila uunona auhe oshimpwiyu, vamwe kaveshi woye, (tahala okulila ye tiidhana moonyala) omusamane okweenda owala.

S: Paife nee opo tuyandeni oshinima shika, omwandhindhilika naana shike mbela kutya omolwashike mbela aasamane ihaa holoka kiipangelo, kutya uuna mwakwatwa komukithi, okuya koshipangelo, omwandhindhilike shike? Shoka hashi yiimbi okuya koshipangelo.

R: Mbela ngame oteti ohaya kala ya soohoni, ngele taya ende pwamwe naakulukadhi yawo, maar ngele owagombokelwa oheya nga. Ngele owagombokelwa wuna etegelelo ite ku

eetako. Oteku tumu meme goye oye ekweeteko.

S: Tashiti ohaya kala yasako ohoni.

R: Ohaya kala yasako oohoni.....(tayolomo)

Maar ngele okanona okadalwa oheya tati okweya kokaana ke.

S: Gumwe otati naana ngiini?

R: Ngame ondiwete kutya ngiika pwamwe moNamibia ina shi simanekwa aasamane tayeya naakulukadhi kiipangelo, shaashi ando okwali shasimanekwa ando opuna omulandu kutya aantu naaye naasamane ngiika aasamane ando ohayeya ngaa? Ngiika yamwe itayeya shaashi inahalako.

S: Oshike mbela wandhindhilika hashiimbi ngawo?

R: Ondiwete kutya gumwe ina hala, gumwe ihahala pwamwe gumwe ehalo oku li na kapunaalasha lela (tapatulula oonyala ndhe)

S: Meme inda mo

$\boldsymbol{R_1}$: Gumwe okuna ehalo lyokuya kena eivoko ndjoka ndjokutya otandi ladula omukulukadhi sigo oompoka tayi

S: mmmh...kapuna euvoko? Kapuna omulandu.

R: Eeno, kapuna omulandu, ngele opuna omulandu nena otalamba mo ngaa mpokauuka. Ngele kapuna omulandu otahulile owala hwiyaka. Otashi vulika ngaa ekweeteko ndele okuna ngaa mpoka ha hulile, ngwe etoyi mpoka wa pumbiwa. Ngele nena opwali puna omulandu ando ohalamba mo ngaa.

S: Gumwe otati nee ngiini? Nenge natuye komeho?

R: Aaye, ngame ondiwete kutya oshinima shika oshili moofamily dhaasamane, ngele omusamane okwalandulandje nena, mongula shotandi ka yako, vokombinga yomusamane yo otaati O? Omusamane ihaa shaalapo komukulukadhi gwe "okwatulwamo".

S: Shahala kutya omuthigululwakalo nago otagu iimbi aasamane yaaholoke? Ooo.....

R_1: mmmh.....

S: Shimwe oshikwashike mbela, ngaashi pwamwe oweya nomusamane goye, aapangi ohaya kala yuuvite ngiini?

R_1: Aapangi ohaya kala yapanda, shashi otakoneke oshikondo shimwe ondeya ko nomusamane gwandje etandi mu eta kaapangi, ndele ondapandulwa, naye eta pandulwa otandi ku pandula shaashi aantu ayehe haya eetelele aasamane yawo kiipangelo?

S: Iyaalo, payife nee omwapopi iinima yasimana lela, kutya aasamane nawo oyena ohokwe yokuholoka, kakele owala, oyatilako, ngaashi gumwe ati otradition nayo otayi imbi yaayeko. Paife oshike nee shina okuningwa opo tuhile aasamane yetu?

R: Oshinima kaayuviteko owala, kandishiwo nee kutya mooRadio haantu ayehe hayakala yeli poo Radio, nomiigongi ngaa.

S: Gumwe otati ngiini?

R: Ngame otandi ti owala, nayii thanwe owala kutya okuna oshigongi shaasamane.

S: Tayiithanenwa oshigongi shaasamane?

R: Eeno oshigongi shaasamane, shaashi ngele omwapopi kutya okuna oshigongi tashipopi kombinga ya shike, oyendji itayeya ko, otayii thanwa owala ndele etayii adha yeli miipundi yo taalombwelwa iinima ngaashi topopi mpoka.

S: Iyaloo, gumwe otati ngiini oshike shina okuningwa po?

R: Aasamane naaningilwe iigongi tayiningilwa ngaa momikunda, oombapila dhehiyo tadhitumwa ngaa kooyene yomikunda yotaya hiya oshigongi nenge omusamane nge ke po ngame opondili yo nofamily opo yili nayo otayi vulu okufala etumwalaka.

S: Tashiti ngele ne omwapewa uuthemba woku eetelela aasamane yeni otamu shiningi?

R_1: Eeno otashivulika, kakele owala ngele ke lipo.

S: Yo otaa vulu ngaa okuya shomwatala?

R: (ayehe) Eeno otaa vulu lela

S: Otayeyaa?

R: (ayehe) Otaye ya

S: Shasimana lela aasamane ya ningilwe iigongi? Otavulu okuuva ko, notamutsu kumwe naashoo?

R: (ayehe) Eeno, (taayolomo ayehe yapanda yamwe otaakomona komitse)

S: Oshoopala lela, otwafa nee tuuka pehulilo lyoonkundathana dhetu, kashishi naana oshinima oshidhigu, kwaashihe mwapendje mpano, omwapandje oshinima tashi ka longithwa moNamibia nenge kiilongo yimwe yopondje. Ondemupandula lela.

ANNEXURE G

GUIDELINES FOR CO-CODER (CONCEPT ANALYSIS) PHASE2

Could you please kindly analyse the enclosed data (transcribed audio taped material individual in depth interviews and focus group interviews) with references to either steps of Tesch (1990) qualitative data analysis .

- Step 1: Please read through all the transcripts carefully to get a sense of the whole, jot down thoughts as they come your mind.
- Step 2: Pick any data document from the pile and read through for the meaning, more than the content. Jot down the thoughts in the margin of the document.
- Step 3: After completing all interview documents, make a list of all concepts and cluster similar ones together. Rearrange these concepts in three different columns such as major, unique and leftovers. (Keep research topic/purpose in mind).
- Step 4: Revisit the data. Abbreviate the concepts as codes and write the codes next to the appropriate segments of the text. Try out this preliminary system of data organizing to see whether new categories could be observe red.
- Step 5: Try to find most descriptive wording for your concepts and turn them into categories. Reduce the list of categories by grouping related concepts together. Capture interrelationships by drawing lines between the categories.
- Step 6: Make final decision on the abbreviations for each category and alphabetise these codes.
- Step 7: When finishing with coding, assemble the data material belonging to each category in one place and perform preliminary analysis. Lease take note of research questions and purpose of research study to maintain the focus during analysis. Look for commonalities, uniqueness, confusions and contradictions in content, as well as missing information with regard to research questions and purpose of the research questions/purpose.(see attached copy of research questions and purpose of research.)
- Step 8: If necessary, recode the existing data.

Yours

Hans J. Amukugo (PhD Student)

GUIDLINE FOR CO- CODER CONCEPTS ANALYASIS PHASE 2

Dear colleague

Kindly analyse the concepts “management of partnership environment” with the reference to concept analysis by Walker and Avant (1988: 35 – 50) Walker and Avant (2004: 35 – 50).