KNOWLEDGE, ATTITUDES AND CULTURAL PRACTICES: THEIR INFLUENCE ON MALE INVOLVEMENT IN REPRODUCTIVE HEALTH

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Abstract

The need to include men in all matters that require joint spousal decisions is crucial in achieving key reproductive health goals. However, men have not been involved as they should and progress to involve them has been insufficient and uneven. This study aimed to explore the factors that influence male involvement in reproductive health. Data from 220 men, ages 18-70 years old, who were legally married, with at least one child, living together with their spouses and able to read and write in Tagalog, was collected through purposive sampling from randomly selected barangays of Silang Cavite and Santa Rosa City. Descriptive-correlational design was used to analyze the data. The respondents were highly knowledgeable on reproductive health, had a positive attitude towards reproductive health and each respondent engaged in at least two cultural practices. They had a high involvement in reproductive health. Knowledge and attitudes had a significant positive relationship to male involvement in reproductive health. However, there was no significant relationship between culture and male involvement in reproductive health. There was a significant difference in male involvement in reproductive health when the respondents' religion, occupation, educational attainment and the wife's occupation were considered. However, there was no significant difference in male involvement in reproductive health when age, family income and length of marriage were considered. Knowledge and attitudes significantly influenced male involvement in reproductive health.

Keywords: Knowledge, attitudes, cultural practices, male involvement, reproductive health

Introduction and Literature Review

Reproductive health programs around the world are increasingly recognizing that men are an important target for their services. Men not only have reproductive health concerns of their own, but their health status and behaviours also affect women's reproductive health. The need to include men in all matters that require joint spousal decisions is crucial in achieving key reproductive health goals. However, men have not been involved as they should and progress to involve them has been insufficient and uneven (United Nations Population Fund, 2010; Chowdhury, 2009).

Evidence advocates for the involvement of men in reproductive health issues in general (Rosliza and Majdah, 2010). In the Philippines, few studies on involvement of married men in family planning and responsible parenthood, sexual health and support for safe motherhood are available. The focus of the available studies is on young unmarried men's perception of male involvement in reproductive health (Achumbre, Deronia, Diaz , Llagas, & Torregoza, 2010).

The International Conference on Population and Development ICPD held in Cairo in 1994; emphasized the importance of male involvement in reproductive health, efforts to involve men in reproductive health are as a result of the ICPD conference in Cairo.

In the public health sector, reproductive health services have long been offered mostly through the existing outlets of maternal and child health (MCH) centres and obstetric and gynaecology clinics. Unfortunately, these centres are usually attended by women and mothers only. This partly explains why population, development and health agencies have largely ignored men's influence on women's reproductive health actions and decisions and have also ignored the reproductive health needs of men (Senate Economic Planning Office, 2013).

Presently, decision makers are looking for ways and programs to involve men in reproductive health

decisions, including family planning and support for safe motherhood. Previous programs have established that a supportive partner facilitates women's reproductive health and contraceptive use. Contraceptive use has also been boosted by the advent of acquired immunodeficiency syndrome (AIDS) pandemic and the increasing rates of sexually transmitted diseases (STDs) which have given safer sex practices and the condom renewed importance (UNAIDS, 2009).

Women have for a long time been the main target of family planning campaigns at the expense of their male counterparts. Despite this, a greater percentage of women using contraception use a male contraceptive method or a contraceptive method that requires male cooperation. In 1988, 66 percent of married women aged 15-49 years who used contraception utilized male methods or ones requiring male cooperation. However, by 1993, only 34 percent of married women in the same age range were using male methods or methods requiring male cooperation. In the Philippines, according to the Demographic Health Survey of 2008, 37 percent of all women who used contraception employed ones that require male participation, whereas 54.6 percent of married women, who used contraception, utilized ones that require male participation (DHS, 2008). According to the same survey 98.7 percent of married women reported that their husbands are aware of their use of contraception; however, it did not state whether the husbands participated in selection of the contraceptive method, which is the focus of this study (World Health Organization, 2012).

These efforts led to the Philippine Senate and House of Representatives adopting the Philippine Reproductive Health Act of 2012: RA 10354 which cites male involvement and participation in reproductive health as one of its elements. It defines male involvement and participation as commitment and joint responsibility of men with women in all areas of sexual and reproductive health, as well as reproductive health concerns specific to men (Senate and the House of Representatives of the Philippines, 2008). Globally the onus has been to make men more involved in matters of reproductive health, this is because men are considered the "gatekeepers" of the health of their families (Char, 2011; Tilahun et al., 2013). The United States government through its Healthy People 2010 initiative, had as one of its goals to increase male involvement in sexual and reproductive health. It recognized that male involvement is very important in the accomplishment of other goals such as improvement in sexual and reproductive health of not just men, but their partners as well and the overall well-being of families (Kalmuss & Tatum, 2007). In the Philippines, men have not been involved as intended in reproductive health. In the 1990s, there was a drive to improve male involvement in reproductive health. Programs were initiated, but they were not sustained and therefore the desired result of having men participate fully in reproductive health was not achieved (Commission on Population, 2011).

It is worth noting that women can control fertility without the husband's knowledge and cooperation However, the husband's understanding and help make family planning easier and more comfortable, additionally, reproductive health requires an equal commitment from both husband and wife (Petro-Nustas & Al-Qutob, 2002).

This study was aimed at exploring the factors that influence male involvement in reproductive health. It was anchored on the information-motivation and behavioral skills model developed by W. Fisher and J. Fisher. This model suggests that health related information, motivation and behavioral skills are important determinants of whether or not a behavior is performed (Fisher, Fisher, & Harman, 2008).

This model has been used as a basis for understanding HIV risk behavior and for developing interventions to change this behavior. It has also been used to study and intervene in a wide variety of high risk patients/populations including injection drug users, military personnel, severely mentally ill individuals, HIV infected persons among others. This model has also been used as a basis for understanding and promoting adolescent contraception, abstinence from sexual activity, sexually transmitted infection (STI) risk reduction and as a basis for reproductive health promotion education efforts (DiClemente, Crosby, & Kegler, 2009).

The model addresses three constructs, namely information, motivation and behavior. Information refers to basic knowledge about a medical condition. It also refers to understanding of the concepts that lead to behavior change and the ways and means of achieving the behavior change. Motivation deals with the individual's affect and favorable attitude towards positive health behaviors and utilizing existing social norms and support systems to reinforce motivation. Motivation is also enhanced by recognizing the possible barriers and finding ways to overcome those limitations. The behavioral aspect refers to the psychomotor or action component and skills required to bring about

behavior change (Mehta, 2010; World Health Organization, 2003).

Methods

Research Design

A descriptive-correlational design was used in this study. The study was conducted from December 2014 to February 2015.

Population and Sampling

The respondents of the study were residents of rural and urban villages in Silang Cavite, and Sta. Rosa City. A total of 220 respondents were included in the study. Random sampling was used to choose six villages, purposive sampling was then used to recruit participants who met the inclusion criteria as follows: Men who were in the age bracket 18 to 70 years, legally married and living together with their wives, had at least one child and were able to read and write in Tagalog or English, and willing to participate. Table 1 shows the distribution of the respondents based on the barangays.

Table 1

Distribution of the Sample Size

Region	Barangay	Number of respondents
Santa Rosa City	Don Jose	55
	Pulong Santa Cruz	50
	Malitlit	20
Total		125
Silang Cavite	Bucal	20
	Tubuan 1	45
	Ulat	30
Total		95
Grand Total		**220**

Ethical Considerations

The study was approved by the Adventist University Research Center. Each respondent was informed of the purpose of the study and they signed a consent before participating, they were informed that the information gathered was confidential and that they were free to withdraw at any moment.

Instrumentation

A self-constructed questionnaire based on literature and related studies was used to collect data. The questionnaire was submitted to experts for validation, then it was translated into Filipino with the help of a Filipino professor from the Filipino department of the Adventist University of the Philippines. The items were then crosschecked and reverse translated by the researcher's thesis advisor to ensure retention of meaning and translation into conversational Tagalog.

Results

Demographic Profile

There were 220 respondents most (64%) were below 39 years old, average age was 37 years. More than half (69%) were Catholics, about (38% were skilled workers and more than half (55%) of the respondents' spouses were housewives. Most of the respondents had attained High school education (41%), about a third (33%) of the respondents had been married for less than five years and 29% had a family income of PhP4, 999 and below. Demographic data of the participants are summarized in Table 2.

Knowledge on Reproductive Health

To assess the level of knowledge of reproductive health, the respondents answered a total of 26 true or false questions, the level of knowledge was based on correct responses given. The respondents had a high level of knowledge (mean = 18.65, SD = 4.46). Table 3 summarizes the respondents' knowledge of reproductive health.

Less than half of the participants correctly recognized some of the modern contraceptive methods, such as Depo-Provera (43.2%) and Norplant (44.5%). Majority of the participants (98.2%) correctly answered that planning their families enables them to

have healthy children, (96.4%) correctly answered that prenatal car is very important for the mother and the fetus. Furthermore, majority (93.2%) were aware that sexually transmitted diseases can be contracted through unprotected sexual contact with an infected person, and (91.8%) were aware that prostate cancer can be treated if it is detected early.

Attitude towards Reproductive Health

The results of attitude are shown in Table 4. Items 2 to 4, 6, 7 and 9 were negatively stated in the questionnaire, these items were re-coded in SPSS and were therefore interpreted as positive statements. The respondents' responses to attitude scored a grand mean of 2.92 and a standard deviation of .43. This implies that the respondent's had a positive attitude towards reproductive health.

Table 2

Profile of Respondents

Category	Percentage
Age	
29 and Below	22
30 - 39	43
40 - 49	21
50 and Above	14
Religion	
Catholic	68
Non-Catholic	32
Family Income	
4,999 and Below	30
5,000 - 9,999	20
10,000 - 14,999	26
15,000 - 19,999	14
20,000 and Above	10
Occupation- Respondent	
Businessmen	32
Professional Occupations	17
Skilled Workers	39
Unskilled Workers	11
Occupation- Wife	
Housewife	56
Businesswomen	25
Skilled workers	20
Highest Educational Attainment	
Elementary	8
High school	41
Vocational	17
College	29
Masters/Doctorate	6
Length of Marriage	
Less than 5 years	33
6 - 10 years	30
11 - 15 years	11
15 - 20 years	9
More than 20 years	17

As Table 4 shows, majority of the respondents agreed that making joint decisions on family planning with their spouses improved their relationship (mean = 3.47). They further agreed that for family planning to be effective, they must be fully involved (mean = 3.33). The results also revealed that the respondents disagreed that contraceptive use is unacceptable to them (mean = 2.42). This means that it was acceptable for them to use contraceptives. They also disagreed that vasectomy lessens a man's sexual drive (mean = 2.42). This shows that they believed that undergoing vasectomy will not reduce their libido.

The results also show that respondents agreed that they are weak if they involve themselves in reproductive health (mean 2.7). The respondents also agreed that use of contraceptives encourages women to be unfaithful (mean 2.56).

Table 3

Knowledge of Reproductive Health

Items	Correct answer	Percent	Interpretation
1. The following are modern contraceptive methods:			
a. Pills.	183	83.2	High
b. Implants/Norplant	98	44.5	Average
c. Intrauterine device IUD	108	49.1	Average
d. Injectable/ Depo-Provera	95	43.2	Average
e. Condom	167	75.9	High
f. Sterilization	101	45.9	Average
2. Planning my family enables my wife and I to produce healthy children.	216	98.2	Very High
3. Condoms effectively prevent pregnancy.	171	77.7	High
4. For contraceptive pills to be effective, they should be taken every day at the same time.	169	76.8	High
5. Hormonal contraceptive implants such as Norplant are effective for 3 to 5 years.	128	58.2	Average
6. Contraceptives increases a woman's sexual enjoyment by taking away the worry of becoming pregnant.	151	68.6	Average
7. Prostate cancer can be treated if detected early.	202	91.8	Very High
8. The prostate gland produces fluid that nourishes and protects sperm.	164	74.5	High
9. Every man over 40 years old is at risk for prostate cancer.	165	75	High
10. Smoking increases the risk of prostate cancer.	194	88.2	High
11. Impotence is a medical condition that can be treated.	165	75	High
12. Sexually transmitted diseases are transmitted through unprotected sexual contact with infected person.	205	93.2	Very High
13. Signs and symptoms of Sexually Transmitted Infections in men include:			
a. Fever	153	69.5	Average
b. Painful urination	162	73.6	High
c. Discharge from the penis	155	70.5	High
14. Prenatal care is very important for the mother and the fetus.	212	96.4	Very High
15. Proper nutrition for a pregnant woman prevents fetal abnormalities.	207	94.1	Very High
16. The following are signs and symptoms of complications in pregnancy:			
a. Excessive vomiting	177	80.5	High
b. Vaginal bleeding	138	62.7	Average
c. Fatigue	77	35	Low
d. Increased blood pressure	140	63.6	Average
Grand mean of Knowledge = 18.65 or 71.726% *SD* 4.46194 = High knowledge		**71.73**	**High**

Note: Interpretation for level of knowledge in percentage: 90 and above = very high, 71–89 = high, 40-70 = average, 21-40 = low, 0-20 = very low.

Table 4

Attitude towards Reproductive Health

No.	Items	Mean	*SD*	Scaled Response	Interpretation
1.	I must be fully involved in order to make family planning effective.	3.33	.84	Agree	Positive
2.	Contraceptive use is unacceptable to me.	2.42	.93	Disagree	Positive
3.	Having many children enhances my social status.	2.84	.97	Agree	Negative
4.	I am a weak man if I involve myself in reproductive health.	2.7	.94	Agree	Negative
5.	I am a responsible man if I involve myself in reproductive health.	3.08	.91	Agree	Positive
6.	Vasectomy lessens a man's sexual drive.	2.42	.95	Disagree	Positive
7.	Use of contraceptives encourages women to be unfaithful.	2.56	.96	Agree	Negative
8.	If I am unfaithful to my wife, I am at risk of contracting sexually transmitted diseases.	3.17	.87	Agree	Positive
9.	Reproductive health services are for older men.	2.55	1.01	Agree	Negative
10.	It is important for me to be aware of the complications of pregnancy.	3.25	.86	Agree	Positive
11.	The presence of the husband during labor and delivery is reassuring to the wife.	3.25	.86	Agree	Positive
12.	Joint decision on family planning improves gender relations.	3.47	.77	Agree	Positive
Attitude Overall		**2.92**	**0.43**	**Agree**	**Positive**

Note: Mean scores are interpreted as follows 3.5-4.0 = Highly Positive, 2.5-3.49 = Positive, 1.5-2.49 = Negative, 1.0-1.49 = Highly negative

Cultural Practices

The respondents practiced two out of the six listed cultural practices (mean = 1.9). Table 5 shows the cultural practices respondents engaged in.

Table 5

Cultural Practices Related to Reproductive Health

Items	Yes	Percentage
1. To prevent pregnancy, my wife and I use exclusive breastfeeding.	126	57.3
2 I take my wife to an untrained midwife for monitoring of labor and delivery.	81	36.8
3. To prevent pregnancy, my wife and I sleep in separate beds until the child is old enough.	65	29.5
4. To prevent pregnancy, my wife and I use herbs and traditional medicines.	59	26.8
5. My wife has no right to say 'no' to my sexual demands.	44	20
6. In my family, I value male children more than female children.	42	19.1

Majority of the respondents practiced exclusive breastfeeding to prevent pregnancy (57.3%) and taking their wives to untrained midwives for monitoring of labour and delivery (36.8%). Minority of the respondents (19.1%) valued male children over female children, only 20% agreed that their wives have no right to say no to their sexual demands.

Involvement in Reproductive Health

Involvement was divided into three parts; involvement in family planning, safe motherhood and maintenance of sexual health. Table 6 summarizes the involvement of men in the different aspects of reproductive health. The respondents had an overall high involvement in reproductive health with a grand mean of 3.67, SD .73.

The respondents had a high involvement in family planning and responsible parenthood (mean = 3.69), with a high involvement in planning and budgeting for the birth of their children (mean = 4.14). There was an average involvement in sexual health (mean = 2.95) with men being least involved in performing monthly self-testicular evaluation (mean = 2.48). There was high involvement in support for safe motherhood (mean = 3.97) the participants recording the highest involvement in providing money for their wives to attend prenatal check-up (mean = 4.14).

Relationship of Knowledge, Attitudes and Cultural Practices and Male Involvement

There was a significant positive correlation between knowledge ($r = .200$, $p = .003$) and involvement, similarly there was a positive correlation between attitudes ($r = .179$, $p = .008$) and involvement in reproductive health as shown in Table 7. Increase in knowledge and positive attitudes were correlated with higher involvement in reproductive health. There was no significant correlation between cultural practices ($r = -.031$, $p = .649$) and involvement in reproductive health, an increase in cultural practices was negatively correlated with involvement in reproductive health.

These findings support the information-motivation-behavioral (IMB) skills model. Having more information about reproductive health and having more motivation by having positive attitudes towards reproductive health and by not practicing the barriers to reproductive health such as negative cultural practices was associated with more involvement in reproductive health.

Difference in Male Involvement in Reproductive Health When Moderator Variables were Considered

The study sought to compare the involvement of men in reproductive health when the moderator variables were considered. Kruskall-Wallis test was used to compare the mean ranks in each category.

There was a statistically significant difference in involvement in reproductive health when religion) was considered ($U = 4022$, $p = .02$. Protestants were more involved in reproductive health than Catholics. There was a statistically significant difference when husband's occupation was considered $X2$ (3, $N = 217$) $= 8.064$, $p = .045$. Men who had professional occupations (mean rank = 133.18) were more involved than businessmen (mean rank = 109.83), unskilled workers (104.92) and skilled workers (98.66). There was a statistical significant when wife's occupation was considered $X2$ (2, $N = 220$) $= 35.01$, $p < .001$. Men whose wives were skilled workers (mean rank 154.13) were more involved in reproductive health than men whose wives were businesswomen (121.41) and those whose wives were housewives. There was a statistically significant difference when educational attainment was considered $X2$ (4, $N = 220$) $= 17.38$, $p = .002$. Men who had masters and doctorate degrees were more involved in reproductive health (mean rank = 180.25), involvement decreased with a decrease in educational attainment as follows; college degree holders 115.17, vocational education 104.83, high school 103.53, and elementary 92.88.

Table 6

Overall Involvement in Reproductive Health

	Items	Mean	*SD*	Interpretation
1	I accompany my wife to the hospital for family planning counselling.	3.55	1.18	High
2	I help my wife in caring for the children.	4.03	1.12	High
3	I am aware of the contraceptive method my wife is using.	3.57	1.35	High
4	I plan and budget for birth of our children.	4.14	1.11	High
5	I assist my wife in :			
	a. bathing the new born baby	3.52	1.27	High
	b. feeding and burping the baby	3.50	1.17	High
	c. changing the diaper	3.50	1.14	High
	Family Planning grand mean	**3.69**	**.834**	**High**
6	I go for full medical screening including prostate health screening once a year.	2.63	1.30	Average
7	I perform self-testicular exam monthly.	2.48	1.26	Low
8	I have gone for HIV/AIDS screening and I know my status.	2.55	1.57	Average
9	I stay faithful to my wife to prevent sexually transmitted disease.	4.14	1.19	High
	Sexual health grand mean	**2.95**	**.87**	**Average**
10	I accompany my wife to the hospital for			
	a. prenatal care	3.96	1.10	High
	b. labor and delivery	3.75	1.16	High
	c. family planning counselling	3.88	1.17	High
11	I always have a plan of action in case my wife experiences an emergency during pregnancy.	3.94	1.07	High
12	I make arrangements for quick transportation in case there is an emergency during pregnancy.	4.02	1.06	High
13	I support my wife during pregnancy by:			
	a. readily providing money for prenatal check up	4.14	1.06	High
	b. providing her with nutritious food	4.13	1.07	High
	c. providing her with material needs such as maternity clothes	3.95	1.24	High
	d. helping in household chores so that she can have adequate rest	3.94	1.21	High
	Support for safe motherhood	**3.97**	**.88**	**High**
	Overall Involvement in RH	**3.67**	**0.73**	**High**

Table 7

Relationship between Knowledge, Attitudes and Cultural Practices and Involvement in Reproductive Health

Variables	Correlation coefficient	*P*	Interpretation
1. Knowledge	.200	.003	Significant
2. Attitude	.179	.008	Significant
3. Cultural Practices	-.031	.649	Not Significant

There was no statistically significant difference in involvement when age X2 (3, N = 220) = 6.124, p = .106, family income X2 (4, N = 220) = 5.331, p = .255 and length of marriage X2 (4, N = 220) = 5.534, p = .237 were considered.

Predictors of Male Involvement

Regression analysis was used to reveal the predictors of involvement in reproductive health, knowledge (p = .004) and attitude (p = .014) were the only predictors of involvement as shown in Table 8. As shown in Table 8, knowledge contributed 4% of the variance while attitude contributed 2.6% of the variance of the respondents' involvement in reproductive health. Overall knowledge and attitudes contributed 6.6% to involvement in reproductive health.

Table 8

Predictors of Involvement in Reproductive Health

Constant	Unstd. Coefficients		Std. Coefficients	R	R^2	R^2 Change	T	Sig
	B	Std. Error	Beta					
Knowledge	.031	.011	0.192	0.2	0.04	0.04	2.909	0.004
Attitude	.272	.110	0.163	0.258	0.066	0.026	2.467	0.014

Discussion

Reproductive health is not only the responsibility of women, men have a role to play as a shared responsibility, when men engage in reproductive health they not only safeguard their own health but the health of their families as well. However men have not been constructively involved (Kabagenyi, et al., 2014).

It cannot be overstated how family planning is an important concept of maternal and child health and reproductive health in general. Research shows that there is a strong linkage between closely spaced and frequent births and maternal and child mortality. A large proportion of maternal and child mortality can be prevented through more responsible health and sexuality behaviour (Commission on Population, 2011).

This study was consistent with other studies were conducted in Kenya and Malawi where men agreed that planning their families and spacing not only benefits them financially but also benefits the health of their wives and children (Onyango, Owoko, & Oguttu, 2014; Shattuck et al., 2011). The results are also consistent with a study done in Bangladesh, where men had high knowledge that antenatal care was important for the mother and foetus because of the advice they were given at the clinics (Nasreen et al., 2012).

Men have been shown to have higher knowledge on common aspects of reproductive health such as bleeding and high blood pressure as danger signs of pregnancy (Kunene et al., 2004), and on the more common contraceptive methods such as male condoms and contraceptive pills as modern methods of contraception (Nasir, Tahir, & Zaidi, 2010).

A report by Sonfield (2002) urged community-based organizations such as churches and youth groups to meet the needs of men by providing information and counselling on reproductive health issues so as to improve men's knowledge. The report noted that these aspects have been missing when men's roles in sexual and reproductive health needs are discussed, and this has been a major contributor to the low levels of knowledge on reproductive health.

This study showed that men with a positive attitude towards reproductive health are more inclined to be involved in reproductive health, the findings are consistent with other studies. Men who recognize the benefits of contraceptive use are more inclined to use contraceptives to achieve their desired family size (Guttmacher Institute, 2014). However, men who have poor attitudes or who are influenced by culture do not always involve themselves in reproductive health matters, this is consistent with Engender Health (2008) which suggests that some men, being strong and dominant, do not seek health information and services because of the traditional notions of masculinity. The article suggests that the men may view asking for help or seeking reproductive health services as a sign of weakness. Constructs of masculinity may prevent men from health-seeking behaviour because they see it as a sign of weakness (Esplen, 2006).

The results revealed that men still engage in cultural practices that are not beneficial to the health of their wives and children, 36.8% of the men still take their wives to traditional birth attendants for monitoring of labour and delivery. This result is similar to a survey conducted in the Philippines in 2008 which found that 36% of deliveries were assisted by traditional birth attendants (Department of Health, 2012). Traditional birth attendants may not have the skills or expertise to safely identify and manage or refer a complicated labour, this puts the mother and child at risk in the event that there is a complication.

According to Mistik, Nacar, Mazicioglu, and Cetinkaya (2003), men play an important role in reproduction and it is important for them to be involved in all aspects of reproductive health, the results of this study revealed a high involvement in reproductive health, particularly in the promotion of safe motherhood, there was high involvement in ensuring that they provide money for their wives to attend prenatal check-up, this is a big step towards safe motherhood by ensuring the women actually attend prenatal clinics for assessment of the

health of the mother and the foetus (Secka, 2010).

According to Centre for Health Training (2011), when men are involved in reproductive health, their spouses also benefit from the increased support for contraceptive use, financial and material support during pregnancy and help in raising the children as a benefit of responsible fatherhood. Involvement in reproductive health is important because men need to take responsibility for their sexual and reproductive health and their social and family roles. The results reveal that men are more interested in reproductive health than most often assumed (Greene et al., 2006). These results are consistent with a study in India whereby knowledge was significantly related to practice in reproductive health, particularly in contraceptive use (Nasir et al., 2010). The results are also consistent with the findings of Kisa, Zeyneloglu, and Delibas (2013) who argue that men with higher knowledge of reproductive health are more likely to involve themselves in reproductive health.

Conclusion

Based on the findings of this study, it can be concluded that the respondents were highly knowledgeable, had a positive attitude and are still practicing a few of the conventional ways in relation to reproductive health and therefore they had a high involvement in family planning and responsible parenthood, an average involvement in sexual health and a high involvement in support for safe motherhood. They had a high overall involvement in reproductive health. Men with higher education, non-Roman Catholics, with professional occupations and whose wives were skilled workers were highly involved in reproductive health. Knowledge and attitudes influence male involvement in reproductive health. This study therefore supports the Information- Motivation and Behavioural Skills model.

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