

**PROMOTING THE INVOLVEMENT OF BOYS AND MEN IN
REPRODUCTIVE HEALTH AND HIV/AIDS: Findings from a
Review of IPPF projects in Lesotho and Uganda**

Study Conducted on behalf of IPPFARO by

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November 2008

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Acknowledgements

This study would not have been possible without the invaluable support of the following organizations and individuals to whom we are extremely grateful:

- Reproductive Health Uganda (RHU) whose support made it possible for the Uganda part of the survey to be carried out smoothly. We are particularly grateful to the Executive Director, Elly Mugumya and Ms. Betty Tukey.
- Lesotho Family Planning Association (LFPA) for supporting the survey and providing both administrative and logistical support for field work. In particular, we thank Dan Mofekeng Makhetha, Thato Tsukulu, Mamokete Sepheka-Ntsupa, Itumelenge Lebina, David Manele, Mohale Letsatsi, Lehlohonolo Sekoto, Manthakoana Lehloka, Mekhoa Tsiamé, Alicia Crawford and all the research assistants for their invaluable assistance during the field work.

We are grateful to IPPFARO for facilitating this work, particularly Leonard Zondesta and Cecilia Kihara for their valuable guidance and support. Finally we would like to thank the staff of the Centre for Study of Adolescence who participated in this study. In particular; Humphries Evelia, Martin Omondi and Rosemarie Muganda-Onyando for their support in overseeing the study including the report writing.

Executive Summary

A growing body of international research and interventions are demonstrating significant potential in encouraging men and boy's positive roles in building gender equality and improving men's, women's and children's health.¹ These developments reflect the recognition that, as key decision-makers, men and boys are essential partners in addressing today's public health challenges, and in building more equitable and prosperous societies. The necessity of this active engagement is reinforced by an increasing number of international declarations,² and is now recognised as key to meeting the Millennium Development Goals (MDGs).

IPPFARO commissioned a study on boys and men involvement in two countries, Uganda and Lesotho to provide information on the extent of male involvement in SRH interventions. The study aimed at providing information of the programs dealing with male involvement and generating information useful in developing a toolkit on how to involve men in SRH interventions.

In Lesotho the study was conducted in the capital city Maseru. In Uganda, it was conducted in rural districts of Arua, Bushenyi and Hoima. The studies gathered both qualitative and quantitative. Three instruments were used; male questionnaire to collect data from both married and unmarried men aged 15-64years; service provider questionnaire collected information from health service providers at both public and private health facilities on the extent of provider interaction with boys and men and the services offered.

The study explored knowledge and attitudes on key reproductive health issues, gender attitudes, parenting, communication on SRH issues, and STIs including HIV/AIDS. It also investigated health seeking behaviour and decision making on SRH in the family. Findings show that general knowledge about key reproductive health issues including general awareness of STI, HIV and AIDS is relatively high. Knowledge of complications of pregnancy including prenatal, delivery and postnatal care is generally very low. Significant proportions of the boys and men in the study were not aware of any complications. Similarly, support for health care for their spouse is low. This is critical given that men control the financing of healthcare and family expenditure.

There are poor attitudes among men and boys in regard to discussion making around gender roles. The study shows that knowledge of condom use is very high compared to other methods particularly those used by women. In both countries, gender based violence seemed to be more acceptable. Health seeking behaviour is relatively low and the range of services consumed by men and boys is low. There is need to deliberately target boys and men to increase knowledge levels on SRH, improve their attitude and increase access to health care for themselves and their families on contraceptive use support of yet the study

Other findings are summarized below:

- **Few programs promote male involvement:** Apart from the initiatives implemented by IPPF, there are few programmes that promote the role of men in SRH. In both Lesotho and Uganda men were hardly the main target in most SRH and HIV/AIDS programmes which mainly targeted women and youth. Few programmes which recognized the important role that men play, limited their focus to the promotion of condom use without making the link with broader issues of gender and sexuality and how the impact of this on women's sexual and reproductive health.
- **Male involvement initiatives are limited in scope:** Programmes that support male involvement are limited in scope in both countries. In Lesotho the initiative covers a small area mainly Maseru, with a more urban focus. While in Uganda the initiative has activities scattered in a few small sites. The Ugandan initiative has a more rural focus when compared to the Lesotho one. There is also limited scope in terms of issues addressed. In both countries the male involvement initiatives are in their early stages. It is therefore difficult to gauge the extent to which they have made a difference in addressing issues around the role of men in SRH.

¹ See inter alia World Health Organization (2007). Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. Geneva

² See ICPD Program of Action, CSW, etc

Approaches are limited to increasing male uptake of SRH services: Programme approaches remain narrow with most initiatives still focusing on serving men as clients. For male involvement programmes to succeed, they need to go beyond working directly with men to promote a positive shift in gender norms, away from attitudes and behaviors that undermine women's and men's own health and general well being. Programmes must therefore adopt approaches that combine service delivery, community education, outreach and advocacy.

There is limited capacity to design and implement Male involvement interventions in both countries. The documentation of process and experience in setting up programmes which could affect the scaling up and replication of existing interventions is weak. In both countries programs targeting men started with limited diagnostic studies or baselines to identify priority issues and design the interventions appropriately. Baselines would also have helped in establishing benchmarks to assist in measuring success.

1.0 Introduction and Background

There is growing recognition that addressing gender inequities in health, promoting sexual and reproductive health and rights (SRHR) and preventing HIV and AIDS and gender-based violence at all levels in society is not possible without efforts to directly engage men and boys as partners in these processes. This need was clearly reflected within *inter alia* the 1994 International Conference on Population and Development (ICPD) Program of Action. More recently, work seeking to engage men and boys has increasingly been seen as essential to not only empowering women and improving women and children's health, but to improving men's own health outcomes. There is an increasing acknowledgement and evidence that men's lack of health seeking behaviors (often due to social and cultural norms) have direct health implications for the wellbeing of their partners and children

A growing body of international research and interventions are demonstrating significant potential in encouraging men and boy's positive roles in building gender equality and improving men's, women's and children's health.³ These developments reflect the recognition that, as key decision-makers, men and boys are essential partners in addressing today's public health challenges, and in building more equitable and prosperous societies. The necessity of this active engagement is reinforced by an increasing number of international declarations,⁴ and is now recognised as key to meeting the Millennium Development Goals (MDGs).

While biological and socio-economic factors contribute significantly to early sexual activity and related consequences, socialization too plays an important role in shaping the attitudes of adolescents towards key aspects of Reproductive Health (RH) (Riedlberger, 1994). It leads to stereotyping, which in turn affects the planning, and implementation of reproductive health, family planning and HIV/AIDS prevention programs. For instance, most RH programmes target women, and focus almost exclusively on family planning, a warped social attitude has emerged where family planning is treated as solely a female responsibility.

Many reproductive health programmes are now incorporating a "gender perspective" in sexual health services yet they are still focused mainly on serving women (Shepherd, 1996). These programmes need to expand their focus to include men and couples, to deal effectively with bipolar gender system that underlies many of the problems they address. Involving men will require both significant changes in the structure of programmes, and a considerable re-education effort for the staff of programmes (Shepherd, 1996). Although men are less likely to be targeted in reproductive health services, men are more likely than women to be sexually active, have multiple partners and begin sexual activities early. Given current gender power imbalances "women empowerment" and "male involvement" need to be seen and implemented with critical eye, both from the point of view of men and women as sexual partners, and as part of service provision and policy setting (Helzner, 1996).

Available data indicate that whereas the process of reproduction entails mutual responsibility, men's participation in reproductive health is mostly negligible. Working with men to promote gender equality can be an effective way to improve health and fight disease among both women and men. As research and other activities that address the behavior of men are seen as essential (Wang, 1999), it is critical that increase male involvement should not detract resources from existing programmes (Hall, et al 1996).

There are limited interventions in scale and reach targeting men. Review of existing programs demonstrates that most programs which target men and boys for health care interventions use one of the three approaches or a combination of these:

- Serve men as clients
- Involve men in improving women's health
- Work directly with men to promote a positive shift in gender norms, away from attitudes and behaviors that undermine women's and their own health and wellbeing.(engaging men and boys to achieve gender equality: building on what has been learnt- ICRW & PROMUNDO

³ See *inter alia* World Health Organization (2007). Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. Geneva

⁴ See ICPD Program of Action, CSW, etc

1.1 Why focus on men and boys

Increasing better understanding of men's central roles in determining women's health and wellbeing and the realization that many health development efforts for women and girls do not address gender based values and norms. For instance men often dominate reproductive health decisions whereas women often have no say regardless of how these decisions affect them. On the other hand men generally have little access to information and resources for communication with and supporting their sexual partners.

Some barriers to men participation in reproductive health activities are traditional gender roles, fear of losing respect from their peers, lack of communication skills, lack of knowledge and strong perceptions about masculinity. To be break through these barriers and achieve a just social order that would challenge the destructive models of hegemonic masculinity, an understanding of men's attitudes towards reproductive health as a first step to engaging them in taking action is required.

Generally men do not accompany their partners to family planning, antenatal or postnatal care services and would not be expected to attend labor or birth of their child. In most cases, men are rarely exposed to clinic reproductive health services as they often seek care for STIs in the private sector and condoms are obtained from clinics without contact with the service providers. The exclusive use of RH services by women has to a great extent made RH services unfriendly for men

Like women, men have reproductive health concerns that change over time. The absence of reproductive health education combined with the proliferation of traditional but ineffective healing practices have led to men's lack of awareness of the signs and symptoms of RTIs and STIs as well as modes of transmission and means of preventions.⁵ All these issues lead men to disregard or not use available health services⁶ appropriate program efforts are needed to educate men about reproductive and sexual health, healthy practices, and services available at health facilities.

The reproductive health seeking behaviors of men need to be improved. Most men procure medical services from unqualified medical practitioners and pharmacist, or they rely on medicating themselves. Most men feel embarrassed to obtain services for RTIs and STIs from institutional facilities. However there is a growing realization that unless services reach men, efforts to improve women's reproductive health will also have limited impact.⁷

1.2 IPPF involvement in work targeting men as partners

IPPF has been involved in pioneering work on engaging men and boys in gender equality, addressing their own sexual and reproductive health needs, and working with them as partners in supporting and promoting the needs and rights of other men, women and children. Across the organization's six geographical regions, work on men and boys plays an essential role in the achievement of its five strategic priorities. This has been in line with the WHO's engagement in men and boys in changing gender-based inequality in health.

IPPF recently joined the Steering Committee of the global MenEngage Alliance. This alliance brings together international organizations to strengthen the engagement of men and boys in promoting gender equality, enhancing sexual and reproductive health and rights and preventing HIV/AIDS and gender-based violence. MenEngage aims to maintain momentum on the importance of working with men and boys, through advocacy, promoting leadership and enhancing the sharing of resources and information. IPPF is a founding member of this alliance, and has specific responsibility for SRHR issues. Two regional MenEngage consultation meetings have recently taken place (in South and East Africa and South East Asia), following which IPPF Member Associations and Regional Offices

5 Population Council & NIPORT, 2004: Integration of Reproductive Health Services for Men in Health and Family Welfare Centers In Bangladesh

6 Ashraf, A., T.T. Kane, A. shahriar and B. Khunda. 1999 "male involvement in reproductive health services in Bangladesh: A Review," Special Publication. OR Project, Health and Population Extension Division. Dhaka: ICDDEB

7 Directorate of Family Planning, NIPORT, AND Population Council 1998 " getting men involved in Family Planning: Experience from an innovative program"

have become actively involved in the country and regional MenEngage networks formed as a result of these discussions.

It is with this background that IPPF conducted a research in Uganda and Lesotho. The study aimed at addressing the aforementioned challenges to benefit the wider SRHR and development community. The assessment reviewed existing programmes and interventions on male SRH and men as partners. Among the questions addressed were:

1. What evidence of impact can be ascertained from the existing programmes and interventions that seek to address the SRHR needs of men and boys, and engage them in transforming gender-based health inequalities and improving health outcomes?
2. What particular types of SRHR, HIV/AIDS and gender-based violence interventions with men and boys show more evidence of effectiveness (i.e. what does and doesn't work)? What are the key gaps and challenges? What can existing interventions teach us about working with poor and marginalized communities?
3. What monitoring and evaluation frameworks should organizations, including IPPF, use to evaluate future programmes and interventions, to further contribute to an increasingly comprehensive evidence base on this work? What indicators should be used within these frameworks in tracking/auditing this work?
4. What links can be shown between advocacy and service delivery interventions with men and poverty eradication, particularly in relation to Millennium Development Goals (MDG), particularly MDG 3, 4, 5& 6?
5. What are the key policy issues that need to be addressed by DFID, the Nordic Plus group and other donors and organizations when seeking to take this work to scale?

1.3 Objectives of the assessment

- Provide information on the extent of male involvement in SRH interventions
- Establish the successes of programs that deal with male involvement in SRH interventions
- Development of monitoring and evaluation framework to be used by IPPF member organizations and affiliates
- Develop a toolkit on how to involve men in reproductive health interventions

This report presents results of an assessment on engaging men in sexual and reproductive health. It explores perceptions, attitudes and health seeking behaviors on men. It also investigated SRH decision making process in the family and how it affects women's health. The study was conducted in two countries, Lesotho and Uganda targeting both married and unmarried men. In Lesotho the study covered the catchment area for a male involvement project implemented by Lesotho Family Planning Association in Maseru. LPPA has established a male only clinic to serve men. In Uganda, the study covered catchment areas in Arua, Bushenyi and Hoima Districts.

1.4 Overview of country situation

Lesotho

Lesotho is a country surrounded by South Africa with an estimated population of 2.2 million people. Since 2001, Lesotho has faced multiple crises caused by high HIV prevalence, deep-rooted poverty and chronic food insecurity. The HIV prevalence rate among adults aged 15-49 is estimated at 23 per cent, with 57 per cent of all infections occurring among females.⁸ HIV/AIDS prevalence in adults increased from 4% in 1993 to 23.4% in 2004 – the third highest rate in the world. According to UNAIDS 2008, there is an estimated 260,000 people living with HIV/AIDS in Lesotho with 58% of the cases occurring among women (ages 15-49) by the end of 2007. Over 18,000 deaths due to AIDS occurred during 2007.⁹ Lesotho faces a serious and worsening HIV/AIDS problem. One quarter of the people 15–49 years old in Lesotho is HIV positive, among the highest rates in the world.

8 UNITED NATIONS POPULATION FUND 2007 Country programme document for Lesotho www.unfpa.org/exbrd/2008/firstsession/dpfa_cpd_iso_5.doc -

9 UNAIDS 2008 Report on the Global AIDS Epidemic. July 2008

The per capita gross domestic product is approximately \$272, and 56 per cent of the population lives below the poverty line.¹⁰ About 58% of who are very poor, with some 25% of people chronically undernourished. Generalized poverty and social dislocation because of migratory labour are the two main factors driving the HIV epidemic. Most of the population that migrate are men and are always accused of having multiple sexual partners.

While biological and socio-economic factors contribute significantly to early sexual activity and related consequences, socialization too plays an important role in shaping the attitudes of adolescents towards key aspects of Reproductive Health (RH) (Riedlberger, 1994). It leads to stereotyping, which in turn affects the planning, and implementation of reproductive health, family planning and HIV/AIDS prevention programs. For instance, most RH programmes target women, and focus almost exclusively on family planning, a warped social attitude has emerged where family planning is treated as the solely a female responsibility.

Like in all countries men are more likely to use a condom with their partners than women. Regardless of partner status, men are more likely than women to report use of condoms during a sexual encounter (27 percent versus 19 percent). Both men and women are less likely to use a condom during a sexual encounter with a cohabiting partner (12 percent and 11 percent, respectively) than with a non-cohabiting partner (42 percent and 39 percent, respectively) (LDHS 200 4).

The reproductive health status in Lesotho is poor, despite the fact that the total fertility rate declined from 5.3 children per woman in 1986 to 3.5 children per woman in 2004. The decline has been higher in urban areas, where the rate fell to 1.9 children per woman, than in rural areas, where the rate fell to 4.1 children per woman. The contraceptive prevalence rate declined from 41 per cent in 2001 to 37 per cent in 2004.

The number of deliveries conducted by skilled attendants fell from 60 per cent in 2000 to 55 per cent in 2004. The maternal mortality rate increased from 419 deaths per 100,000 live births in 1996 to 762 deaths per 100,000 live births in 2004, while the infant mortality rate increased from 81 deaths per 1,000 live births in 2001 to 91 deaths per 1,000 live births in 2004. The inadequacy of, and inaccessibility to, reproductive health information and services, especially for emergency obstetric care, has contributed to this situation. The mountainous terrain common in most parts of Lesotho further hampers access to services.

About 36 per cent of the population is younger than 15 years old. Among the challenges facing youth are unintended pregnancies and sexually transmitted infections, including HIV. The HIV prevalence rate is 18.4 per cent among male youth and 25.8 per cent among female youth. The vulnerability of youth is compounded by inadequate access to life skills-based sexual and reproductive health information and services. Gender-based violence, intergenerational sex, multiple concurrent sexual partners, and low condom use during high-risk sex (47.6 per cent among male youth and 50.1 per cent among female youth) exacerbate the situation.

Uganda

Uganda is one of the three East African countries with an estimated population of about 29.6 million people¹¹. With its population growing at the rate of 3.2% per annum, Uganda has one of the highest growth rates in the world and higher than the sub-Saharan average of 2.4%.¹² According to the 2006 Uganda DHS, the country had a total fertility rate of 6.7 births per woman with child bearing starting early and nearly universal. Ninety –four percent of women who had a live birth in the five years preceding the survey received antenatal care from a skilled health professional for their last birth. Following a number of macro-economic policies, Uganda has experienced solid economic growth of 6-7% per annum over the last decade.¹³

¹⁰ ibid

¹¹ Uganda Bureau of Statistics 2007. Projections of Demographic trends in Uganda 2007-2017 (vol1)Kampala, Uganda: UBOS

¹² State of Uganda Population Report 2007

¹³ National Strategic Plan for HIV/AIDS Uganda, 2007/2008-2011/12

Although income poverty is estimated to have reduced from 56% in 1992 to 31% in 2005¹⁴, the country is still facing challenges equitable distribution of the economic gains.¹⁵ According to the Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005, 6.3% of adults aged 15-59 years are infected by HIV.¹⁶ The under 5 mortality is 137 per 1000 lives and life expectancy at birth is 51.5 years for females and 48.4 years for males. About 12 % of the population has no education.¹⁷ One in four women and 21% of men 15-49 reported that they had been tested for HIV at some point and received the results.

Contraceptive use in Uganda is low and the unmet need for family planning is high¹⁸. According to the Uganda Health Demographic Survey, only 24% of currently married women report use of contraception and 41% have unmet need for family planning. Of the countries with a DHS in the past five years, Uganda has the highest level of unmet need for family planning among currently married women.¹⁹ In 2000-01, the UDHS results showed that approximately two of every five births were unplanned in the five year preceding the survey²⁰ (Using Indirect estimation techniques, another study found that one in five pregnancies in 2003 ended in abortion in Uganda²¹

1.5 Methodology

The study was conducted in Lesotho and Uganda. In Lesotho the study was conducted in the capital city Maseru. In Uganda, the study was conducted in rural districts of Arua, Bushenyi and Hoima. The studies gathered both qualitative and quantitative data. Three instruments were used; male questionnaire to collect data from both married and unmarried men aged 15-64years; service provider questionnaire which collected information from health service providers at both public and private health facilities in the project catchment areas; and Focused Group Discussions with both men and women in the same age bracket. These tools were adapted from previous DFID funded project²² IPPF studies in India and Nepal.

A house hold survey was conducted where houses were mapped and each house was numbered according to the mapping strategy. Systematic sampling (a sample drawn from a list using a random start followed by a fixed sampling interval i.e. select every nth case) was used to ensure that each house had equal probability of being selected. To qualify for selection and to be mapped a house had to have at least one resident who was male age between 15-54 years. Selection of eligible interviewees used the Clitche box especially where there was more than one eligible person for the interview. The sample size was about 324 respondents for the male questionnaire and about 24 more for the focus group discussion and 29 service providers

14 Uganda Human Development report 2007

15 UNGASS Country Progress Report Uganda Jan-Dec 2007 http://data.unaids.org/pub/Report/2008/uganda_2008_country_progress_report_en.pdf

16 Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005

17 Uganda demographic and health survey, 2006 Uganda Demographic and Health Survey 2006. Calverton Maryland, USA:UBOS and ORC Macro

18 Khane, S., S.E.K. bradely, J. FischeI, &V. Mishra. 2008. Unmet Need and the Demand for Family Planning in Uganda: Further Analysis of the Uganda Demographic and Health Surveys, 1995-2006 Calverton Maryland, USA: Macro International Inc.

19 Macro International Inc., 2008a. Description of the Demographic and Health Surveys Individual recode. Available at <http://www.measuredhs.com>

20 UBO and ORC Macro, 2001. Uganda Demographic and Health Survey 2000-2001. Calverton Maryland, USA:UBOS and ORC Macro

21 Singh S., e. Prada, F, Mirembe, and C. Kiggundu 2005. The incidence of Induced abortion in Uganda. International Family Planning Perspectives 31(4): 183-191

²² These tools include FGD guides, structured questionnaires for males and females and semi-structured questionnaires for service providers

2.0 Study Results

2.1 Introduction

This section presents results from interviews with boys and men in Lesotho and Uganda. It provides discussions on background characteristics, . knowledge and attitudes on key reproductive health issues, gender attitudes, parenting, communication on SRH issues, STIs including HIV/AIDS, health seeking behavior and decision making on SRH in the family. Although two separate studies were conducted in Lesotho and Uganda, instruments were similar. The instruments were adapted to cultural sensitivities in the two countries. However, results from the two countries have been presented alongside each other for ease of presentation and does not imply that the studies were comparative.

2.2 Respondent Characteristics

Data was obtained from a sample of 604 male respondents - 282 in Uganda and 322 in Lesotho. Figure 2.1 below shows the age distribution of the respondents from both countries. Majority were aged 35 years and below (75 %). The mean age for Lesotho was 30.5years with a median of 28years while the mean age for Uganda was 28.6 years with a median of 27 years.

Figure 2.1 Age distributions of respondents in Lesotho and Uganda

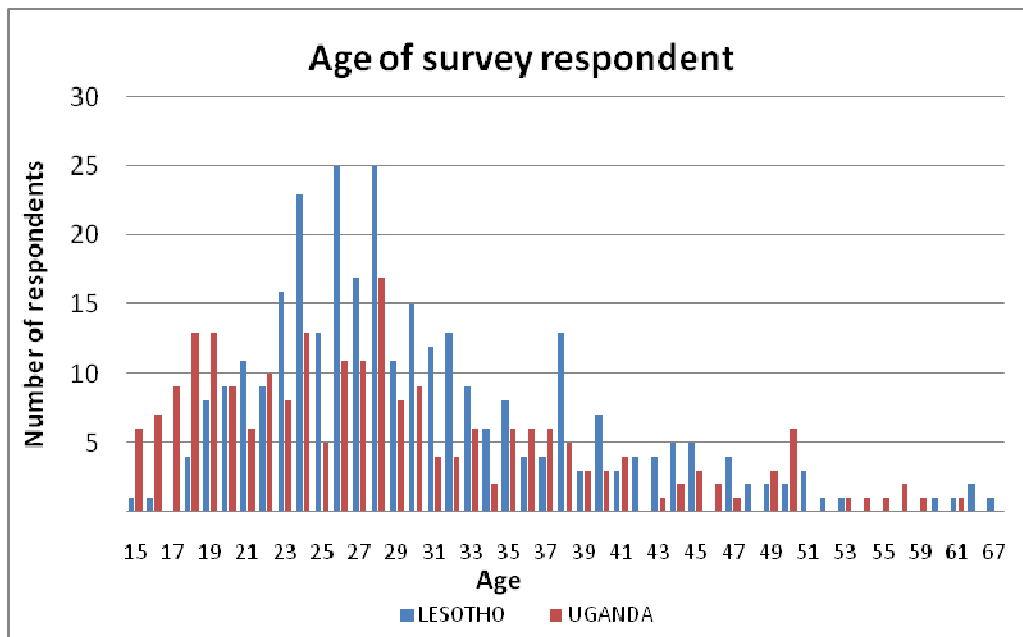


Table 2.1 shows the socio demographic characteristics of the respondents. In Lesotho, over 67% of the respondents were fairly well educated having completed at least secondary education compared to 36% in Uganda.²³ In both countries, the majority of respondents were Catholics followed by Protestants. Nearly half of the respondents in Uganda were married (47%) compared to 44% in Lesotho. The proportion of those single were 47% in Lesotho and 46% in Uganda. The mean age at first marriage in Lesotho was 25.5 years while in Uganda was 23.5 years. The median age was 25years and 23 years for Lesotho and Uganda respectively. 51% in Lesotho had at least one child compared to 59% of those in Uganda.

²³ Lesotho study conducted in the capital city district while Uganda- was it rural districts to explain the differences in education attainment

Table 2.1: Socio-demographic profile of respondents			
		Lesotho (n=322)	Uganda (n=282)
Length of stay in the place of interview			
	5 years or less	35%	25%
	6 - 10 years	8%	5%
	11 - 20 years	10%	6%
	21 - 30 years	4%	3%
	31 - 50 years	0%	1%
	Always	43%	60%
Religious denomination			
	Catholic	57%	49%
	Muslim	0%	6%
	Protestant	34%	43%
	Traditional	6%	1%
	No-religion	3%	0%
Highest level of education			
	No-formal-education	0%	3%
	Primary-incomplete	8%	19%
	Primary-complete	10%	17%
	Secondary-incomplete	7%	21%
	Secondary-complete	8%	10%
	High-school-incomplete	8%	3%
	High-school-complete	28%	10%
	Tertiary-level	23%	13%
	University	8%	4%
Marital status			
	Currently-married	44%	47%
	Widowed	2%	2%
	Divorced	1%	2%
	Separated	4%	2%
	Deserted	1%	1%
	Single	47%	46%
	Total	100%	100%

About 60% and 25% of the respondents in Uganda had stayed in their current residence all their life or at least for the preceding five years. This indicates some level of permanence in residence. In Lesotho on the other hand, less than half of the respondents (43%) had lived in their current place of residence always. About 35% had stayed in their residence for at least five years. There are greater migratory shifts among men in Lesotho. Many Basotho men migrate to South Africa to work in mines and farms. It is suggested that because women are excluded from work in South Africa, they tend to migrate to urban areas in Lesotho, thus creating a large imbalance between the sexes among the urban populations²⁴

Uganda showed larger unemployments status among men(59%) than lesotho(42%). Those employed were mainly civil servants, military personel, police, teachers and construction workers. In terms of household finances, in Lesotho, 14% reported to be in severe deficit situation, 25% in deficit situation, 33% were breakeven and 17% had a surplus. In Uganda, 17% were in severe deficit situation, 38% in deficit situation, 20% breakeven, 12% had a

24 Wilkinson R.C. 1982. "Migration in Lesotho: some comparative aspects, with particular reference to the role of women" *Geography*. 1982 Jun;68, Part 3(300):208-24. At <http://db.jhuccp.org/ics->

surplus. Employment status and household financial position has an impact on health. Households in a weaker financial situation are less likely to prioritize allocation for medical care which may imply poorer health status.

Nearly half (47%) and 44% of all men in the study in Uganda and Lesotho respectively were married. Among those married in Uganda, 75% had been married once and 25% had been married at least twice. In Lesotho, 94% had been married once, and 6% had been married at least twice. In Both countries, an almost similar proportion, 47% in Lesotho, and 46% in Uganda, reported to be single.

2.3 Knowledge and Attitudes on key Reproductive health Components

2.3.1. Pregnancy

In Both countries, the majority of men (85% in Lesotho and 91% in Uganda) were aware that pregnant women need regular checkups. . 81% of men in Lesotho and 73% in Uganda acknowledged that all women need medical checkup even after childbirth. Table 2.2 below shows the identified signs of complications during pregnancy that would require a woman to seek health care.

Table 2.2.1 Knowledge of Signs of complications during pregnancy

Signs	Lesotho		Uganda	
	N	Percentage	N	Percentage
Feeling very weak/tired	89	32%	115	46%
Swelling of legs hands and face	51	18%	74	29%
Severe headache and blurred vision	38	14%	63	25%
Fever	27	10%	108	43%
Pain in abdomen	39	14%	111	44%
Vaginal bleeding	40	15%	78	31%
Vomiting	61	22%	106	42%
Loss of appetite	50	18%	81	32%
Baby not moving	36	13%	70	28%
Back pains	30	11%	52	21%

In Lesotho, 37% of men were not aware of any danger signs in pregnancy. About 21% knew of one sign, 29% knew two to three signs while only 14% knew of four or more signs of complications during pregnancy. In Uganda, 20% did not know of any danger signs in pregnancy. About 20% knew one sign, 19% knew two to three and 41% knew four or more signs. Knowledge of danger signs during pregnancy was better among men in Uganda than Lesotho.

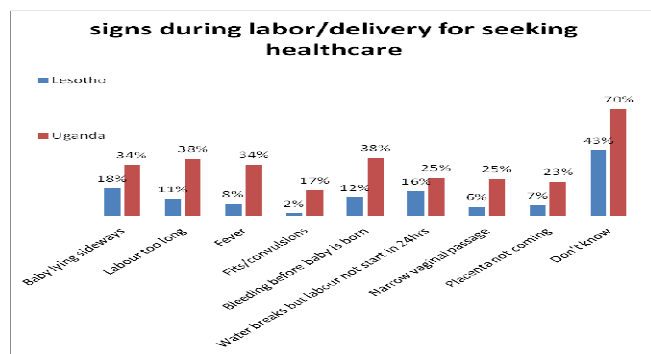
Slightly more than half of all men in the study in both countries were able to correctly identify at least one sign of complication during labor or delivery. In Lesotho, 25% of the men could be able to identify one complication, 15% two to three signs and 3% four or more complications. The majority of the men in Lesotho (57%) could not state any sign of danger during labor or delivery. In Uganda, 30% of all the men in the study could not state any sign of complication or danger signs during labor or delivery. About 21% of the men knew one sign, 16% knew 2-3 sign and 30% knew 4 or more signs.. Table 2.2 below shows the number of respondents by the number of complications stated.

Table 2.3.2 Knowledge of Signs of complications during labor or delivery:

Signs	Lesotho		Uganda	
	labor and at delivery complications		Post partum complications	
	N	N	N	N
Doesn't know any signs	163	73	149	52
Knows one sign	73	59	78	57
Knows two to three signs	42	39	48	46
Knows four of more signs	10	74	9	81

Pertaining to the postpartum period, over half (53%) of men in Lesotho did not know any sign of complications after delivery. Twenty-seven percent of men in Lesotho knew one sign, seventeen percent knew two to three signs and three percent knew four or more signs of complications after delivery. In Uganda, 22% of the men in the study reported that they did not know of any sign of complications after delivery. Twenty-four percent knew one sign, 20% knew 2-3 signs and 34% knew at least four signs. The study further asked the respondents to identify signs during delivery that meant a woman should get to hospital. The bar-graph below shows the results.

Figure 2.3.1 Signs during labor/delivery that a women need to seek healthcare



It is apparent that knowledge of signs of complications before, during and after delivery is low. A significant proportion of men in both countries do not know of any signs of the complications. Given that men are key decision makers in the family, this is critical especially as it touches on the health of women and children.

Over 81% (241) and 73% (182) of the men in Lesotho and Uganda respectively felt that a woman should go for check up following child birth even if she is fine. Despite the fact that most men in both countries support women seeking healthcare during and after pregnancy, very few of them actually accompany them to health facilities. About 42% of the men have never accompanied their wives to any prenatal visit during pregnancy. An additional 11% do not even know of their wives prenatal care.

Table 2.3.3: Distribution of the respondents according to whether they will accompany their spouses in prenatal visits.

	Lesotho		Uganda	
	N	percent	N	percent
accompany mother to prenatal visit in last or present pregnancy				
I-don't-know-of-her-prenatal-care	18	11%	12	9%
No-prenatal-care	9	6%	6	5%
Yes-went-with-her-always	11	7%	29	22%
Yes-to-some-visits	55	35%	46	36%
No-not-to-any-visit	66	42% - 1 out of 2	36	28%
Number (N)	159	100%	129	100%

2.3.2 Contraceptive Knowledge and use

Knowledge appears to be high for all contraception methods in both countries. Across board in both Lesotho and Uganda, the condom, pill and injectables were the most popular contraceptives. The table below shows the distribution of knowledge by method.

Table2.3.4 Proportions of men who know specific method of contraception

Method	Lesotho		Uganda	
Female sterilization	156	50%	183	72%
male sterilization	120	39%	175	68%
Pill	249	80%	217	86%
IUD or Loop	185	60%	164	66%
Injectables	248	79%	212	84%
Male Condom	301	96%	237	93%
Female Condom	260	84%	159	64%
Rhythm Method	194	63%	152	62%
Withdrawal	234	75%	164	67%
other methods to avoid pregnancy	59	19%	54	23%

To ascertain what the respondents knew about the method, they were asked for more information on how the methods are used. Knowledge of use varied by methods with most men as expected knowing that male condom can be used for one sexual act. On the other hand, knowledge about methods often used by women was below average. The table below indicates the specific questions asked over methods and responses provided by the men in the study

Table 2.3.5 Specific Knowledge of how method can be used

		Lesotho		Uganda	
can female sterilization be reversed	Yes	46	16%	28	11%
	No	92	33%	117	47%
	Don't-know	143	51%	103	42%
Does Male sterilization have effect on sexual performance	Yes	57	20%	56	22%
	No	72	26%	93	37%
	Don't-know	151	54%	101	40%
how often a woman should take oral pills	Every-day/weekly	150	50%	127	52%
	Other-response	10	3%	16	7%
	Don't-know	138	46%	102	42%
where is the IUD placed	Uterus	112	39%	69	29%
	Other-response	6	2%	22	9%
	Don't-know	167	59%	143	61%
How often women need to get injection	Weekly	32	12%	41	17%
	Monthly/every- 3 months	150	54%	125	52%
	Once-in-year	21	8%	1	%
	Other	1	%	1	%
	Don't Know	73	26%	74	31%
one male condom can be used for how many sex acts	once	284	93%	206	84%
	other response	6	2%	9	4%
	Don't-know	16	5%	30	12%
one female condom can be used for how many sex acts	Once	218	74%	90	37%
	More-than-once	18	6%	23	10%
	Other-response	1	%	7	3%
	Don't-know	57	19%	121	50%
Days on which woman most likely become pregnant	immediately-before-MC	63	23%	25	11%
	Immediately-after-MC	24	9%	30	13%
	After-2-4-days-of-MC	22	8%	9	4%
	At-middle-of-two-cycles	21	8%	13	6%
	Don't-know	148	53%	156	67%
when should a man pull out of a woman during sex	Before-climax	226	79%	111	47%
	Other-response	10	3%	16	7%
	Don't-know	50	17%	110	46%

The study asked the respondents about ever use²⁵ of each of the method. As expected, ever use of condom was very high in both countries 82% in Lesotho and 62% in Uganda. The second most widely used method in both countries was withdrawal method (47% in Lesotho and 28% in Uganda). The least widely used method by men in both countries was male sterilization 1% in Lesotho and 4% in Uganda. The table below shows distribution of respondents by ever use of method in both countries.

²⁵ Ever use refers to individual respondent or partner use of method

Table 2.3.6 Contraception ever use

Method	Lesotho		Uganda	
Female sterilization	7	3%	14	6%
male sterilization	4	1%	10	4%
Pill	66	22%	51	21%
IUD or Loop	17	6%	14	6%
Injectables	73	25%	55	23%
Male Condom	250	82%	153	64%
Female Condom	72	25%	27	12%
Rhythm Method	62	23%	36	17%
Withdrawal	133	47%	62	28%

Over 67% (199) and 57%(126) of respondents in Lesotho and Uganda reported that they were currently using a method of contraception. The majority in both countries were using condoms followed by injectables.

Table 2.3.7 Current use of specific method

	Lesotho		Uganda	
Oral-pill	25	13%	18	15%
IUD/Loop/Cooper-T	8	4%	3	3%
Injectables	33	17%	30	25%
Implants		%	1	1%
Male-condom	119	61%	54	45%
Female-condom	4	2%	1	1%
Male-sterilization			2	2%
Female-sterilization			1	1%
Rhythm-method			5	4%
Withdrawal	4	2%		%
Others	1	1%	4	3%

Over half of all respondents in both countries reported to be either very satisfied or satisfied with the method they were currently using. In Lesotho, 29% (55) were very satisfied with the method they or their partners were currently using compared to 33% (43) in Uganda. Half of the respondents in Uganda were just satisfied with method of current use compared to 53% of them in Lesotho. The main source of contraceptives used by men and their partners was NGO clinics in Uganda and LPPA male clinic in Lesotho.

Table 2.3.8 shows the distribution of the respondent attitudes towards some issues on contraception. About 4 out of 10 respondents in both countries believe that contraception is a woman's business. In Lesotho, nearly half of the respondents believe that contraception leads to promiscuity. In both countries majority know that condoms can prevent pregnancy, while about half believe using condoms reduces sexual pleasure. It is evident that in both countries, knowledge on sterilization is low.

Table 2.3.8 Number of respondents showing attitudes towards contraception

Number of poor attitudes	Lesotho	Uganda	Total
Those agreeing that contraception is a women's business	38	40	81
Those agreeing that women using contraception promiscuous	98	65	163
Those disagreeing that male condom can prevent pregnancy	93	92	185
Those agreeing that condom reduces sexual pleasure	51	36	87
Those agreeing that male sterilization no impact on sex pleasure	27	9	36
Those who disagree or don't know that male sterilization no impact on sex pleasure	4	1	5

Emergency Contraception

Almost half 49% of men in Lesotho and 41% of their counterparts in Uganda had heard of EC. Among those who had heard of EC; 91% (125) from family planning workers in Lesotho and 74%(77) in Uganda; 57%(81) in Lesotho and 61%(63) in Uganda heard from government health facilities; 53% (77) in Lesotho and 91%(94) in Uganda heard from chemist; 70% (105) Lesotho heard from the LPPA clinic; and 20%(21) in Uganda heard from CBDs/peer educators.

When the respondents in Lesotho were asked if EC would work if a woman missed her periods, majority of men 60% (94) believed EC would not work; 31% (48) did not know; and 9%(14) believed that EC would still work. In Uganda, 46% (49) believed EC would not work; 42% (44) did not know and 12 % (13) believed that EC would work if a woman missed her periods. More than 55% (88) of all men in Lesotho who knew about EC indicated that EC should be taken within 72 hours after having unprotected sex. About 18% (29) of the men in Lesotho believed that EC should be taken immediately. In Uganda 39% (55) of the men who had heard about EC believed that EC would work if taken within 72 hrs after having unprotected sex while 17% (18) believed that EC should be taken within 24 hours.

2.4 Gender attitudes and gender based violence

The study investigated gender relations and stereotypes in both countries. While nearly half of the respondents believe that major household purchases decision should be made by both the man and his spouse, about 4 in 10 think that such decisions should be made by the husband. The respondents in Lesotho appear more egalitarian with regard to the households purchase decisions. The response towards daily purchase is nearly similar in both countries.

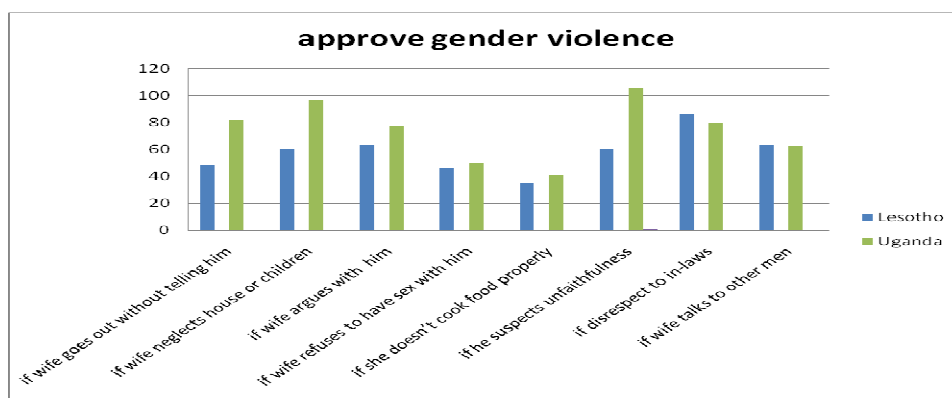
In both countries about 70% of the respondents believe that both husband and wife should take decisions on when to have a child. Nearly 4 out of ten respondents believe in giving preference to boy's education. Asked about decision making about marriage, nearly 60% of respondents in the study believe that girls should make their own decision on when to get married. On sexual relations, 39% of the respondents in Lesotho were in agreement with the statement that nits the man who should decide the type of sex to have. In Uganda, the proportion was almost similar at 40%. In both countries, slightly over 40% Of the respondents disagreed with the statement (43% in Lesotho and 41% in Uganda). Over Half of the respondents (52%) in Lesotho and 45% in Uganda believe that men are always ready to have sex. In Lesotho, 68% of the respondents in the study believe that a man and woman should decide the type of contraceptive to use. In Uganda the proportion who believes the same is slightly higher at 73%.

Men in both countries seem to approve some level of sexual negotiation between partners. The majority of men in both countries feel that a woman is justified in refusing to have sex if husband has an STI, knows husband is having sex with another woman and if woman is tired or not in the mood. Similarly, majority of the men in the survey felt that a woman is justified to ask husband to use condom when she suspects the husband or when she knows that he or herself may be having an STI.

The study asked respondent about decision making around health care. In both countries, a clear majority of respondents 84% in Lesotho and 85% in Uganda indicated that they made decisions on seeking health care. In both countries, only 10% of respondents indicated that it's the spouse that makes the decision on seeking health care. Over half of the respondents in Lesotho (57%) believe that that a man should have the final word about decisions in his home. In Uganda, the proportion was slightly less than half (48%).

The proportions approving for any form of justification of gender violence is very low in both countries. It's clear from the data that those approvals for gender violence are much lower in Lesotho than in Uganda. For instance those who felt that husband was justified in hitting wife if she goes out without telling him was 15% (48) in Lesotho compared to 32% (82) in Uganda. Those who felt that husband is justified in hitting wife if she neglects house or children were 20 % (60) in Lesotho and 38% (97) in Uganda.

Fig 2.4.1 Proportions approving of gender violence if:



About 40% of men in lesotho were of the opinion that they would defend their reputations even by force when insulted. In uganda, the proprtion was abit lower at 37%. About 14% of the men in Lestho and 18% of their counterparts in Uganda indicated that a man can hit his partner if she wont have sex with him. About 25% of men in lesotho and 29% in Uganda believe that a woman should tolerate violence to keep her family. Another 30% each of men in lesotho and Uganda believe that if a woman cheats on a man, its is okay for him to hit her.

According to Focused group discussion with men in Uganda, men are perpetrators of violence against women for various reasons such as perceived lack of respect to people, witchcraft, wife cheating and disagreements. The discussion with men in Uganda report that men believe that women talk too much and the only way to silence them is by beating. The men in the discussion reported that at times violence is meted on women by men to prove that they are men and to correct bad manners by women. Men in the discussion agreed that violence against women is disrespectful and demeaning to the women. But where violence is justified according to them, it should be private and should

“not be done where there are people, it should only be confined to the house.” Male FGD Uganda

2.5 Discussions and Communication on SRH

Communication on sexual and reproductive health issues is important be it among partners, parents and their children as it influences decisions and behaviors adopted. More important is the quality of communication on SRH issues. This study investigated whether respondents in the study discussed issues round SRH in their families and the community.

In both countries, respondents acknowledged that there is some level of discussions on SRH. The study shows that parents, other relatives and friends talk to young people on how to behave with their wives and in-laws before marriage. In Lesotho, 43% of the respondents reported that someone talks to the youth about sexual relations with their wives. In Uganda, the proportion of those who reported discussion was higher at 70%. In Lesotho, 43 % (88) of the respondents reported that someone had talked to them on how to behave with their wives and in-laws before actually getting married. In Uganda, this proportion is much higher at 58% (105) and in both countries, over half of respondents disclosed that they discussed this with their parents. In both countries the proportion of those who reported that someone had talked to them about the need to delay first child was very low 7% (13) in Lesotho and 26%(46) in Uganda

The study asked the respondents whom they would likely talk to if they had nocturnal emissions. In Lesotho, 17% indicated that they would talk to their fathers, 18% to healthcare providers and 19% to their spouse. About 9% reported that they would not talk to anyone. In Uganda, 13% indicated they would talk to father, 14% to mother, 25% to healthcare providers and 27% to their spouses. About 8% of the respondents in Uganda indicated that they would not talk to anyone. Asked about whom they would talk to if they had a urethral discharge, 12% of the respondents in Lesotho indicated that they would talk to father, 17% would talk to friends, 21% would talk to spouse and 28% would talk to healthcare providers. In Uganda, 12% of the respondents reported that they would talk to their mothers, 17% to their fathers, 13% to friends, 23% to health care providers and 19% to their spouses. About 4% and 5% of respondents in Lesotho and Uganda respectively indicated that they would not talk to anyone if they had a urethral discharge.

2.5 STIs/HIV & AIDS knowledge

Over the past two decades many countries in Africa have been hard by HIV and AIDS. In most of the countries, governments have joined efforts with private and civil societies to create awareness of the pandemic while promoting strategies to curb infections among the population. This study examined the knowledge levels for HIV and AIDS as well as STIs in Lesotho and Uganda. In Lesotho, 95% (296) of respondents had heard about HIV and AIDS while 5% (17) reported never to have heard about the pandemic. In Uganda, 92% (237) of the respondents indicated that they knew the disease while 8% (21) said they had not heard about the disease.

In both countries, almost similar proportions of respondents (87% in Lesotho & 85% in Uganda) knew that they could reduce chances of infection with HIV by having only one relationship with one uninfected partner. In Lesotho, 15% (43) of the respondents believe that HIV can be transmitted by mosquitoes compared to 18% (42) of their counterparts in Uganda. Although the majority of respondents in both countries believe that one could reduce the chances of getting infected with HIV by using condoms every time they had sex; 11% (27) in Lesotho and 7% (21) in Uganda did not believe so. An almost similar proportion (3%-10 in Lesotho and 4%-9 in Uganda) did not know whether using a condom every time they had sex would reduce the chances of infection. Only 7% (21) and 10% (24) of men in Lesotho and Uganda respectively believed they would contract AIDS by sharing food with an infected person. About 16 men in Lesotho (5%) and 6 men in Uganda (3%) did not know whether they would contract AIDS from sharing food with an infected person.

Fig. 2.5.1 Opinion on HIV transmission Lesotho

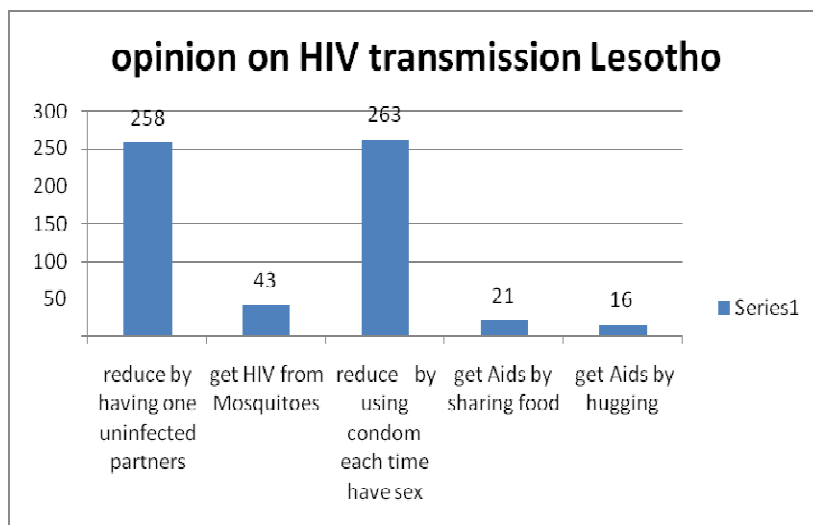
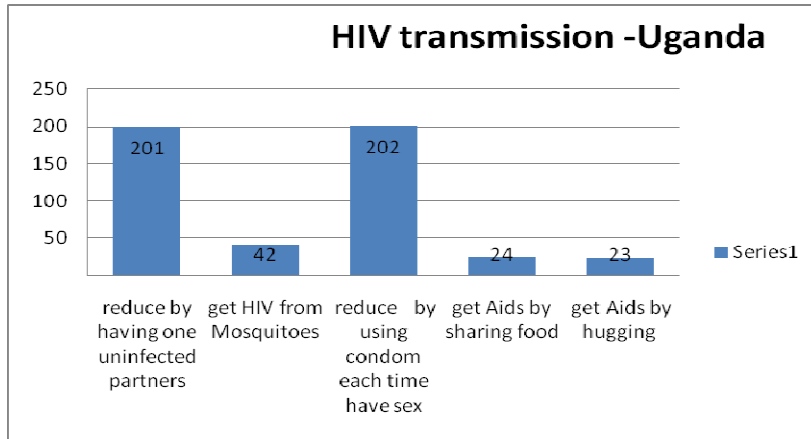


Fig. 2.5.2 Opinion on HIV transmission Uganda



Smaller proportions of men in both countries still held on some misconceptions on HIV transmission. About 5% (16) in Lesotho and 10% (16) in Uganda believe that one can get AIDS by hugging an infected person while 17(6%) in Lesotho and 1% (3) did not know whether they would contract AIDS by hugging an infected person.

The majority of respondents in both countries (90% in Lesotho and 78% in Uganda) believe that there is something one can do to avoid getting HIV infection. Such as using condoms (87% Lesotho, 71% Uganda) limiting self to one partner and staying faithful to the partner (60 % (143) Lesotho 60% (111) in Uganda); Avoiding sex with sex workers 13%(29) in Lesotho and 26% (47) in Uganda); Avoiding sex with homosexual 3% (7) in Lesotho and 16% (30) in Uganda); Avoiding sex with persons who use inject drugs 5% (11) in Lesotho and 10% (19) in Uganda); Avoiding blood transfusion 5% (11) in Lesotho and 31% (17) in Uganda); Use blood only from relatives 2% (5) in Lesotho and 8% (15) in Uganda); Avoid injections 4% (10) in Lesotho and 17% (32) in Uganda); use only sterilized or new needles 16%(36) Lesotho and 14%(25) in Uganda); Avoid sharing razors and blades 35%(82) Lesotho and 23% (43) in Uganda. About 12% (32) of respondents in Lesotho believe that having sex with a virgin would cure HIV/AIDS.

Fig. 2.5.3 anything one can do to avoid getting AIDS Lesotho

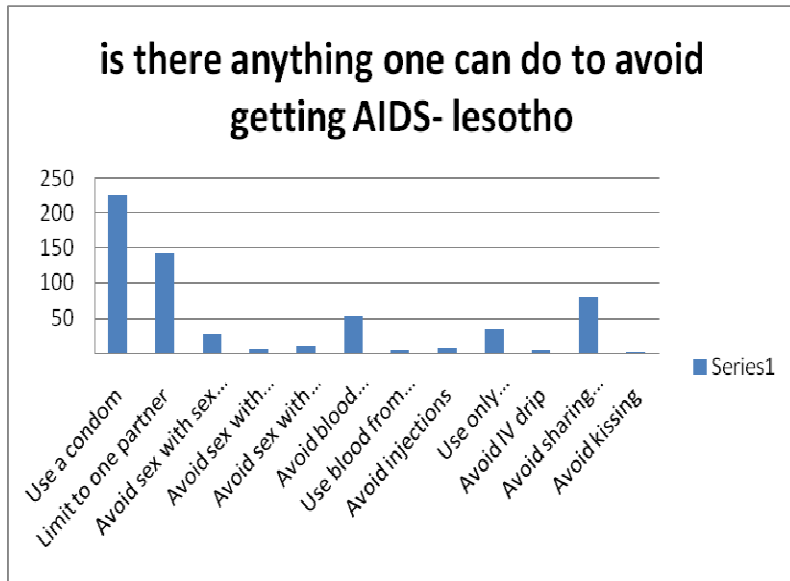
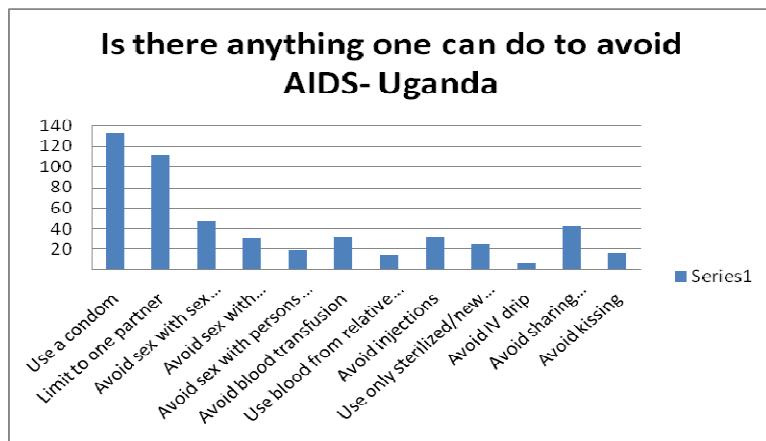


Fig. 2.5.3 is there anything one can do to avoid getting AIDS - Uganda



Majority of the respondents, 81% (235) in Lesotho and 83% (195) in Uganda were aware that healthy looking individuals could be infected with HIV. The majority of men in both countries (80% in Lesotho and 94% in Uganda) know that HIV can be transmitted from mother to baby

Table 2.5.1 Knowledge of HIV

Knowledge of :	Lesotho		Uganda	
Transmission from mother to baby	233	80%	224	94%
medications to reduce risk of HIV to baby	215	92%	181	82%
Heard of antiretroviral	256	89%	200	85%
know of a place people can get tested for HIV/AIDS	275	95%	169	89%

Similarly, most of the respondents are aware of antiretroviral (89% in Lesotho and 85% in Uganda). Most of the men (71% (209) in Lesotho and 95% (222) in Uganda) were of the opinion that boys should be tested before they got married. The majority of respondents knew of a place where one could get tested for HIV (95% in Lesotho and 89% in Uganda). About 80% of respondents in Lesotho and 73% in Uganda indicated that they personally knew someone who was HIV positive.

Fig. 2.5.4 Knows a place for HIV test Lesotho

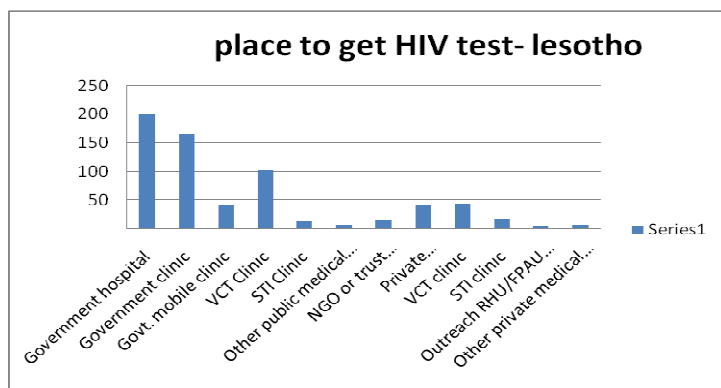
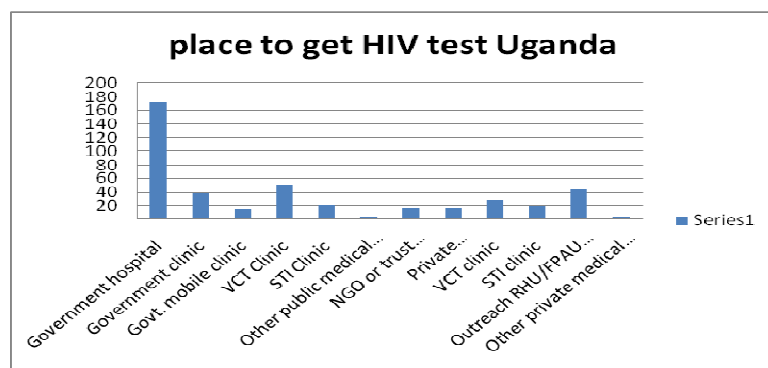


Fig. 2.5.5 Knows a place for HIV test Uganda



Sexually Transmitted Infections

Apart from HIV and AIDS, men in this study were asked about STIs. In Both countries, 89% of men (273 in Lesotho and 221 in Uganda) reported that they knew of other diseases that can be transmitted sexually. They also were able to identify some of the symptoms of STIs such as Ulcers/sore on private parts, genital discharge, Itching in private parts, lower abdominal tenderness/pain, warts or growth on private parts, burning pain on urination and others. The table below shows knowledge of symptoms of STIs

Table 2.5.2 Number of STI symptoms identified by client

Number of symptoms	Lesotho	Uganda	Total
Knows no STI symptoms	8	17	25
Knows at least one STI symptoms	105	175	180
Knows at least two to four STIs symptoms	98	55	153
Knows at least more than four STI symptoms	63	74	137
Total	274	221	495

About 16 % (45) of men in Lesotho and 37 men in Uganda (17%) who participated in the study reported to have had an infection they contracted through sexual contact. Reported having contracted an infection in the 12 months and 2(1%) could not tell whether they did. Two questions were asked to check the self reporting of STIs. The first asked if the respondents had had any abnormal discharge from the penis in the 12 month prior to the survey while the second asked if the respondents had had any sore or ulcer on or near the penis during the same period as shown below. Among those who reported to have had an infection, only 78 of them (35%) sort advice or treatment in Lesotho and 41 (21%) in Uganda.

Fig. 2.5.6 Self-reported STI experience and treatment- Lesotho

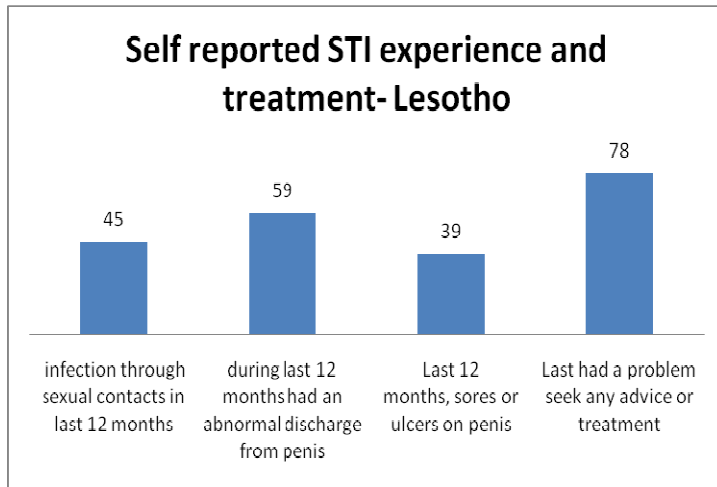
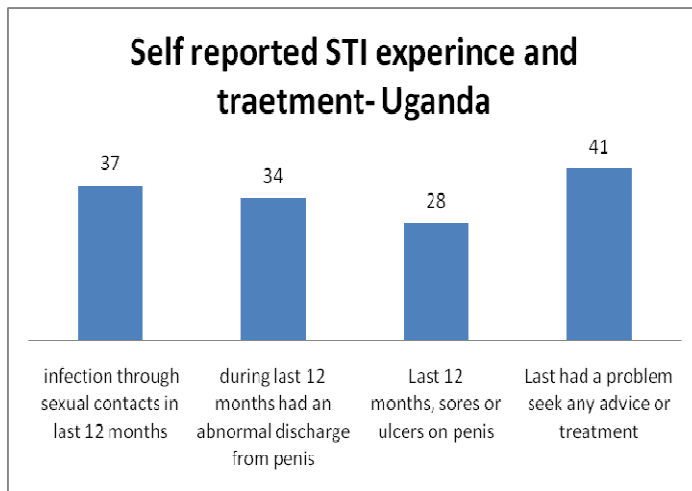


Fig. 2.5.7 self-reported STI experience and treatment- Lesotho



When they last had a problem majority of men 150(79%) did not seek any advice or treatment while 41(21%) sort advice or treatment. Those who sort treatment mainly reported seeing a government doctor with 64% in Lesotho and 58% in Uganda seeing a government doctor. Over half of the respondents (54%) in Lesotho went to a government facility, 12% went to a traditional healer, and 11% to a private doctor or nurse and 10 % went to an NGO clinic. In Uganda, 34% went to a government facility, 12% to an NGO clinic, 8% reported that they went to an STI clinic, and 7% went to a private doctor of nurse.

When asked if it was important for a man to go for medical checkup, most men 91% (259) of the respondents in Lesotho and 92% (213) in Uganda acknowledged that it was important that men go for check up. Some of the most commonly identified problems that men worry about in both countries were; shortened duration of sexual intercourse, impotence, ejaculation before coitus STIs and masturbation.

2.6 Abortion

The study investigated men's perceptions about abortion. Almost half of the respondents in both countries (48%each) were of the opinion that if a woman had a pregnancy that she did not want, there was nothing she could

do but carry the pregnancy to term. About 42% of men in Lesotho suggested that she could get an abortion compared to 36% of the men in Uganda.

As part of choices that women have on whether to have a child, carry pregnancy to term or not, it was clear in both countries that abortion is illegal- this has implications on reproductive health alternatives and choices for women and as has been shown in some studies that when abortion is illegal women tend to procure them in secrecy leading to complications from abortions procured with unqualified people and even death. ----- Implications for maternal mortality related to abortion cases.

- Men did not generally support the idea of having an abortion in the different scenarios of pregnancies they were presented with. (If foetus was male /female, if not able to afford another child, if child is likely to have serious defects etc).
- A slight variation though from Uganda where most of men felt that if the child had a high chance of being born with serious defect then a woman should be allowed to procure an abortion.
- There was a unanimous kind of response towards procurement of abortion in scenarios where pregnancy was as a result of rape. Most of the men both in Uganda and Lesotho suggested that women who got pregnant as a result of being raped should procure an abortion.---- has an indication that this are babies deemed to have been conceived in a bad way.
- Most of the men supported abortion being procured only in scenarios where the pregnancy endangered the life of the mother.

2.7 Parenting

For those who indicated that they had children, the study asked respondents about their parenting behavior. In Lesotho, half of the men (79) who had children indicated that they often take time to play with their children. In Uganda, less half 75(44%) said they often take time to play. In Lesotho most of respondents showed that they often exercised and played games outside with their children. 57(37%) of respondents said they often played and exercised outside the house with children; 47(30%) said they played outside now-and – again.

In Uganda 46% (78) of the respondents played and exercised outside the house now-and-again with their children. About 24% (41) indicated that they often played and exercised outside.

In Lesotho, the majority of respondents do talk with their children when having meals. 77(49%) of respondents said they often talked with children during meals; 44(28%) of respondents talking now-and- again with children during meals. About 35 (22%) never talk to their children during meals. The proportions were almost similar in Uganda. About 71(42%) of respondents talk with their children now- and –again during meals while 55(33%) often talk with their children during meals and 43(25%) never talk to their children during meals .

In Lesotho, over 60% (90) of respondents reported that they never visit their children in school 36(24%) visit them now-and-again while 23(15%) often visit their children in school. In Uganda, 42% (69) of men in Uganda visit their children in school now-and-again while 23% (39) often visit. Almost all men in Lesotho (97%) and Uganda (99%) felt that boys should be taught about changes in their bodies at puberty. An equally high number of men in both countries approved 84% (256) Lesotho, 92% (230) in Uganda of boys to be taught about changes in young girls' bodies at puberty including menstruation in school. Approvals for boys being taught about sex and sexual behavior were equally high (83% in Lesotho and 95% in Uganda).

Table 2.7.1 Approval for boys to be taught ASRH topics

Topic	Lesotho		Uganda	
	N	Percent	N	Percent
Changes in boys bodies at puberty	298	97%	249	99%
Changes in girls bodies, including menstruation	256	84%	230	92%
Sex and sexual behavior	255	83%	238	95%
Contraception	227	74%	211	85%
HIV/AIDS/STI	296	96%	239	96%
Condom use to avoid sexually transmitted diseases	271	89%	241	96%
Changes in boys bodies at puberty	284	92%	233	93%
Changes in girls bodies at puberty including menstruation	291	95%	247	99%
Sex and sexual behavior	253	82%	233	93%
Contraception	234	76%	213	86%
HIV/AIDS/STI	294	95%	238	96%
Condom use to avoid sexually transmitted diseases	271	88%	243	96%

It's clear that in both countries, men strongly support provision of reproductive health information and services as well as life skills for young people.

3.0 Health service provider interactions with boys and men

Table 3.1 Characteristics of service providers

		Lesotho	Uganda
Sex of providers	Male	11.8	28.2
	Female	24.7	31.8
Age of providers	20-24	7.2	16.8
	25-30	7.2	16.8
	31-35	9.6	3.6
	36-40	6.0	6.0
	40 and above	14.4	8.4
Marital status	Married	33.7	28.9
	Unmarried	10.8	21.7
Job category	Medical doctor	3.2	0
	Counselor	3.2	4.8
	Nurse	32.3	43.5
	Mid wife	3.2	4.8
Type of facility	Primary health centre	4.2	6.3
	District hospital	25	12.5
	NGO clinic	0	16.7
	Private clinic	2.1	10.4
	RHU/FPAU clinic	2.1	12.5

Nearly all apart from 4% of health service providers interact with males every day in their work. All providers interviewed from Uganda interact with males in their work as compared to 92% in Lesotho. Of those providers who interact with males, 83% do so every day of their work, 11% once a week, 2% once a month and 4% more than once a month. Nine in every ten serve males aged 10-24 either exclusively or with girls of similar age while 11% interact with girls exclusively. The extent of interaction between providers and male clients 10-14 is at 39%, this nearly doubles with ages 15-19 at 72% and peaks with ages 20-24 at 79% and steadily declines in subsequent age groups. 73% of the providers reported interacting with male clients of ages 25-29, 68% of the providers interact with male clients aged 30-39 years, 56% with those aged 40-49 years and 44% interact with male clients aged 50 years and above.

A similar trend was observed in provider interactions with female clients even though the peak level among females is with a younger age bracket (15-19). Half of the providers interviewed interact with female clients aged 10-14, 88% with females aged 15-19, 76% interact with female clients aged 20-24, 67% with female clients aged 25-29, 52% with those aged 30-39, 46% interact with female clients aged 40-49 years and 30% of the providers interact with female clients aged 50 years and above. Providers are also more likely to interact with teenage girls than boys. In comparison to females; males are more likely to seek health services in latter age sets. For instance, between ages 20 to 50 years and above, provider interaction with female clients steadily reduces from 76% to 30%; while it reduces from 79% to 44% among the male clients.

Majority of the providers reached 10-50 young clients; 69% reached young females and 63% reached young male clients. 20% of the providers interviewed from both Uganda and Lesotho reported to have reached less than ten male clients and 18% reached 51-100 male clients. Some providers (4%) reached as many as 100 or more female clients, while no provider reported to have reached such a number of male clients. 10% and 17% of the providers reached less than 10 and 51-100 female clients respectively.

Table 3.2 Provider interaction with males and females

		Lesotho		Uganda	
In your work do you interact with males	Yes	33	92%	45	100%
In your work how often do you interact with males	Every-day	27	82%	37	82%
	Once-a-week	5	15%	4	9%
	Once-a-month	1	3%	1	2%
	More-than-once-a-month		%	3	7%
Do you interact with young female or male 10-24	Only-with-girls	6	17%	3	7%
	Only-with-boys	8	22%	2	4%
	Both	22	61%	40	89%
	Total	36	100%	45	100%

Table 3.3 Types of information provided to males and females

	Lesotho		Uganda	
Safe sex	32	89%	41	95%
Family planning	28	78%	41	93%
Maternal health/care during pregnancy	21	58%	37	84%
HIV prevention and treatment	33	92%	38	86%
Sexually transmitted infections	29	81%	41	93%
Menstrual regulation/abortion/Post abortion care	12	33%	32	73%
Gender based violence prevention	10	28%	29	71%
Nutrition	26	72%	39	89%

Providers were also asked the type of information they offer to clients. 92% of the providers give information on safe sex, 86% on family planning, 72% on maternal health/care, 88% on HIV prevention and treatment and 81% on nutrition services to both male and female clients. Slightly over half of the providers offer information on menstrual regulation/abortion/post abortion care and gender based violence prevention services at 56% and 52% respectively. 88% of the providers offer information on safe sex to young boys aged 10-24 years, 69% offer information on family planning to the same age group, and 51% offer information on maternal health/care during pregnancy and 88% of the providers interviewed offer information on HIV prevention and treatment to the boys of ages 10-24. Further, 93%, 60%, 85% and 78% of the providers educate boys on sexually transmitted infections, menstrual regulation/abortion/Post abortion care; gender based violence prevention and nutrition respectively.

The providers also offer information on the above topics to girls of ages 10-24 years. However the proportion of providers who reported to offer the services to girls is much higher than that of those who reported to offer the services to boys of similar age. 92%, 93%, 87% and 90% of the providers offer information on Safe sex, family planning, maternal health/care during pregnancy and HIV prevention and treatment. Similarly, 92% of the providers offer information on STIs, 98% on menstrual regulation/abortion/post abortion care, and 93% on gender based violence prevention and 85% on nutrition to girls of ages 10-24 years.

Noteworthy is that 49% and 40% of the providers do not offer information on maternal health/care during pregnancy and menstrual regulation/abortion/post abortion care services respectively to male clients. Similarly 31% of the providers do not offer information on family planning services to male clients.

Information on all services are offered to both married and unmarried male and female clients, apart from information on prevention of gender based violence which is not offered to unmarried male clients. Most providers are however more likely to offer these services to married female clients than any other category of clients. Unmarried female clients are also more likely to receive information on the SRH services than the males. For instance 52% of the providers offer information on safe sex services to married female clients compared to 11% who offer the services to married male clients. For unmarried clients, a female client is three times more likely to receive information on safe sex services than her male counterpart. This trend is observed in all services scrutinized.

Table 3.4 information provided to adolescents 10-24 years

	Lesotho		Uganda	
Safe sex	23	74%	41	98%
Family planning	11	41%	35	85%
Maternal health/care during pregnancy	2	10%	26	72%
HIV prevention and treatment	24	73%	38	100%
Sexually transmitted infections	23	85%	40	98%
Menstrual regulation/abortion/Post abortion care	1	9%	23	79%
Gender based violence prevention	7	70%	24	89%
Nutrition	19	70%	32	82%

Table 3.5 Information provided to young girls 10-24yrs

	Lesotho		Uganda	
A Safe sex	25	83%	41	98%
Family planning	21	81%	41	100%
Maternal health/care during pregnancy	14	70%	35	95%
HIV prevention and treatment	25	78%	38	100%
Sexually transmitted infections	22	81%	40	98%
Menstrual regulation/abortion/Post abortion care	10	91%	31	100%
Gender based violence prevention	9	100%	27	90%
Nutrition	19	76%	35	90%

Most of the providers give information to clients individually 84% in Lesotho and 86% in Uganda. Another 30% in Lesotho and 70% in Uganda reported that they provide information to couples. In Lesotho, 35% of the providers reported to give information in groups compared to 59% in Uganda. Twenty two percent and thirty one percent of providers in Lesotho and Uganda respectively reported to give information on SRH to clients in workshops. Other avenues cited are radio, parades and public meetings which together account for about 5%.

According to the data from the service providers, outreach activities are often conducted. 33%, of the providers reported that they conduct outreaches every day, 38% at least once in a week, 14% once in a month, and 15% more than once in a month. Most of outreaches/group meetings/workshops are conducted at least once in a week in Lesotho and almost daily in Uganda.

Most of the providers said they are comfortable discussing sexuality related topics with both married and unmarried young men and women in both countries. 93% and 89% of the providers interviewed alluded to be comfortable discussing SRH issues with married and unmarried females respectively and 87% and 84% said they were comfortable discussing with married and unmarried males respectively.

Most of the providers reported to have received training on SRH topics as illustrated in the table below. 71% have received training for educating males on safer sex/sex education, 81% on HIV and 72% on family planning. On safe motherhood, 61% have been trained in imparting information on care during pregnancy, 59% on delivery care, 47% on abortion/post abortion care and 62% on adolescent reproductive health. It is clear that fewer providers have received training in abortion and PAC as well as adolescent reproductive health.

Table3.6 Providers trained in SRH topic

Topic	Lesotho		Uganda	
Safe sex/sex education	23	62%	34	79%
HIV	29	78%	34	81%
Family planning	26	70%	31	70%
Care during pregnancy	23	62%	24	56%
Delivery care	22	59%	24	55%
Abortion/post abortion care	17	46%	18	45%
Adolescent reproductive health	18	49%	30	73%

Nearly all the providers, 94% in Lesotho and 98% in Uganda indicated that they would like to get further training on various topics. The major areas of concern for further training included first HIV (86%), family planning (70%), safe sex and sex education (66%), and adolescent reproductive health (52%). Less than half of the providers interviewed expressed interest for training in care during pregnancy (47%) abortion and post abortion care (44%) as well as delivery care (41%).

Table3.7 topics for further training

	Lesotho		Uganda	
Safe sex/sex education	22	63%	30	68%
HIV	30	83%	37	86%
Family planning	24	67%	30	71%
Care during pregnancy	13	36%	22	56%
Delivery care	10	29%	19	48%
Abortion/post abortion care	12	33%	21	53%
Adolescent reproductive health	13	37%	26	63%

Only 34% of service providers in Lesotho reported that they were aware of any services or programs in the community providing HIV and SRH related information and services, in Uganda, this proportion was 71%. Some of the services or programs identified in Uganda were AFFORD, AIDS Info programme, Any Time, Arua hospital AIDS programme, Bushenyi Reproductive CNT, Family Planning Association of Uganda, free VCTs for HIV/AIDS, HBC, Home Based VCT, Marie Stoppes Arua, Male FP AU clinics, RHU, Straight Talk, TASO ICOBI and YMEP. In Lesotho there was HIV Education for Head boys, LPPA PSI, Male Reproductive clinic and LPPA male clinic.

IEC materials on all topics were reportedly available in both countries. Fewer health providers reported availability of IEC materials on Delivery care, care during pregnancy, abortion and PAC, and ARH in Lesotho than Uganda. The health service providers were able to identify some of the common problems that men present with at the health facilities. These problems, similar to those identified in male questionnaire were related to STI and fears of sexual dysfunction.

3.1 Health services provided to clients

Contraception

Half of the service providers in Lesotho indicated that they provided contraceptive counseling to both married and unmarried men while in Uganda, 84% of providers offered contraceptive counseling to married males and 71% to unmarried males. In total, 70% of all providers interviewed offered contraceptive counseling to married and 62% to unmarried males. Less than half of providers in Lesotho provided contraceptive methods to married (44%) and unmarried (42%) males. In Uganda over 79% of the providers gave contraceptive methods to both married males while 74% provided contraceptive methods to unmarried males.

About half of the providers (52%) said they advise a newly married couple who come to them to use contraceptives before the first birth the rest do not. Majority at 67% give such advice just sometimes while 67% always do. Fewer providers 33% in Lesotho reported that they advise newly married couple about using contraceptives before birth compared to 59% in Uganda. Among these in Lesotho, 29% always provide advice and 71% provide advice sometimes. In Uganda, 38% reported to provide advice always compared to 62% who sometimes provide advice on contraceptive use before first birth among couples. In both countries, 80% of the providers advise both married males and females about dual protection. Nearly all (95%) providers in Lesotho reported that they advise young married men and women on dual protection, compared to 71% in Uganda. 70% of the providers in both countries reported to offer contraceptive services to unmarried girls while 63% offer to unmarried boys. In either country, girls are more likely to receive contraceptive services than boys; with 63% to 58% in Lesotho and 75% to 64% in Uganda.

Abortion and post abortion care services

In the study, 23% of the providers reported to have offered abortion and post abortion in the preceding three months, 64% had not while 13% said the services were not offered at their facilities. Very few providers (19%- Lesotho and 26%- Uganda) gave abortion/post abortion care services to married females in the three months preceding the survey. 27% of the providers in both countries reported that they provide these services to unmarried young females.

An unmarried young female in Uganda is more likely to receive abortion and post abortion services than her mate in Lesotho at 30% and 19% respectively.

HIV/AIDS and STI Services

Providers interviewed offered both HIV/AIDS and STI services. 82% and 77% said they offered STI counseling and referral services to married young females and males respectively. The majority in both countries reported to give STI diagnosis and treatments to both married and married young girls (79%) and males (72%). Eight in every ten offered HIV/AIDS counseling services to married young females while 78% said they offered to boys. Two thirds of the providers reported to offer HIV/AIDS testing to young married females while 63% to boys in the period of three months preceding the study. Here the trend is clear, that a bigger proportion of providers reported to offer HIV/AIDS and STI services to young females compared to males.

In cases of RTI/STI/HIV infection, providers are more likely to advise female clients on partner notification than the males. Of the providers interviewed, 73% always, 24% sometimes while 3% never advise female clients on partner notification. 69% always advised a male client infected with an RTI/STI/HIV of partner notification, 28% sometimes advised while 3% never did. The providers identified unmarried boys (28%) and married girls (27%) as most vulnerable to HIV infection in the community. 22% said married boys were most vulnerable while 23% said unmarried girls were most vulnerable.

Training needs

Most providers indicated that they had some specific training on provision of most SRH services. But just 27% and 51% had some training in abortion/post abortion care and adolescent reproductive health services respectively. In fact most providers wanted to receive training in these two fields. 79% wanted training in abortion/post abortion care and 74% wanted training in adolescent reproductive health services. However the other SRH fields drew varied levels of interest for training needs as shown in table below.

Table 3.8 Proportion of providers interested in further training on topic

Topic	Lesotho	Uganda
FP counseling	63 %	67%
Pregnancy related counseling and services	69%	71%
Abortion/post abortion care services	77%	84%
STI/RTI counseling, diagnosis & treatment	58%	69%
HIV/AIDS counseling	61%	77%
HIV/AIDS testing	61%	69%
HIV/AIDS treatment	68%	78%
Adolescent RH services	79%	74%

Potential barriers to reaching boys and men

Some of the barriers hindering access to boys relate to lack of information on adolescent SRH issues, sexuality, inadequate socialization skills, SRH service affordability and rigidity in terms of accepting advice from providers. With older men (above 25 years), accessing them is made difficulty because of their lack of knowledge of available SRH services, rigidity in terms of health seeking behavioral changes and adaptation of new health behaviors, unwillingness to take advice from female providers, sometimes there are language barriers, inability to freely disclose health problems and denial of health status.

Fundamentally these barriers may be/have been overcome through health education to both the youth and adult men, both at the community and facility levels. Gender sensitivity in service provision has also assisted in overcoming these barriers. Use of IEC materials to educate the public is also a good mode of accessing men with health information. Facilitation in cases of affordability of SRH services encourages more males to seek health services.

Provider attitudes towards SRH

Nearly half (46%) of the providers interviewed either believe that provision of counseling to unmarried adolescents on contraception may encourage them to indulge in sexual behavior or were not sure. 14% believe it will promote unwanted pregnancy, while 89% and 67% think it will reduce unwanted pregnancies and element of risk of adolescents sexual behavior respectively.

There are providers who for various reasons believe adolescents do not need counseling. For instance, 17% believe adolescents should be disciplined rather than be counseled. 24% believe adolescent emotional turmoil is all related to hormonal imbalance and 35% believe adolescents should be controlled by their parents other be counseled.

It is also noted in the data that some health providers do not have enough information on HIV and AIDS. Some providers believe homosexuality is the cause of AIDS and that AIDS is a punishment from God meted on homosexuals. Some seem to feel that PLWHAs have no right to confidentiality. The majority recognize the importance of sex education in schools on HIV. Table 3.9 below highlights provider attitudes towards provision of services to young clients.

Table 3.9 Provider attitudes towards provision of services to the youth

	Yes (%)	No (%)	Not sure (%)
What is your opinion on the provision of counseling to unmarried adolescents on contraceptives			
May encourage adolescents to indulge in sexual behavior	39.3	53.6	7.1
Will promote unwanted pregnancies among adolescents	14.5	81.9	3.6
Will reduce unwanted pregnancies	89.3	9.5	1.2
Will reduce risk element of adolescents sexual behavior	66.7	19.0	14.3
What is your opinion about access to safe abortion by service providers to unmarried adolescents			
Reduce the contraceptives usage of adolescents	39.0	52.4	8.5
Encourage adolescents to enjoy sex and to receive services later	39.0	55.6	4.9
Enable adolescents to recognize that they have a greater control over their body	46.3	39.0	14.6
Will respect the choice of adolescents to terminate unwanted pregnancies	56.8	32.1	11.1
Counseling is not needed by adolescents because of the following reasons			
They are to be disciplined rather than counseled	16.9	81.9	1.2
It will be more expensive since they are the biggest segment in the population	6.1	91.5	2.4
Their emotional turmoil is all related to a hormonal imbalance	24.1	63.9	12.0
They should be controlled by their parents/guardians/teachers	34.9	61.4	3.6

4.0 Conclusion and Recommendations

The promotion of men's involvement in reproductive health and HIV/AIDS needs to start with change of attitudes towards their own health seeking behavior and that of their female counterparts. The nurturing of young people towards better health practices is therefore an important aspect towards achieving this. People both young and old, have a variety of channels to knowledge acquisition. This influences their attitudes which influence their practices. Parentage is a very important and influential factor to the health seeking behaviors and practices of their children. The study reveals that just less than half of the parents talk to their children; children need to learn early enough in life about their roles including roles in health matters. Therefore parents need to educate their children more on SRH issues. Forums for discussions of SRH issues need to be put in place to encourage discussions between parents and children, teachers and students and even health providers and young clients. This may assist young people understand changes in their physiology, anatomy and cognition as they grow up. Peer to peer forums may also facilitate experience sharing to allay fears among youths as they grow.

Most men in Lesotho (97%) and Uganda (99%) felt that boys should be taught about changes in their bodies at puberty. An equally high number of men in both countries approved 84% (256) Lesotho, 92% (230) in Uganda of boys to be taught about changes in young girls' bodies at puberty including menstruation in school. Approvals for boys' education on sex and sexual behavior were equally high (83% in Lesotho and 95% in Uganda). It's clear that in both countries, men strongly support provision of reproductive health information and services as well as life skills for young people. This acknowledgement by parents for the need to educate children on health matters is a step in the right direction in enhancing boys' understanding of their need to play a bigger role in health matters.

Study results show that knowledge of signs of complications before, during and after delivery is low among men. In fact a significant proportion of men in both countries do not know of any signs of the complications. Given that men are key decision makers in the family, this is critical especially as it touches on the health of women and children. Most men in both countries support women seeking healthcare during and after pregnancy but very few accompany them to health facilities. About 42% of the men have never accompanied their wives to any prenatal visit during pregnancy while 11% did not even know of their wives prenatal care. Given this, it is unlikely that such men may make the right decisions if any to seek health care in case a woman under their custody develops complications during the course of motherhood. Delayed decisions to seek medical care or lack of which during pregnancy related complications have led to maternal deaths which could otherwise have been avoided if the woman's custodian had knowledge of how to determine such complication. It is therefore pertinent that males seek better knowledge on safe motherhood or such knowledge is imparted. This will positively improve their role in reproductive health issues.

Males are highly knowledgeable about contraception methods in both Lesotho and Uganda. However, knowledge about methods often used by women was below average. Most of the males reported to have great knowledge and used the condom for contraception. However, most contraceptive methods are usable by females; like the second most widely used method-injectables. Males need to have more knowledge about mode of operation and use of female based contraception for more acceptance of the methods to promote female reproductive health. Male attitudes towards contraception also need to be changed. About 4 out of 10 respondents in both countries believe that contraception is a woman's business. In Lesotho, nearly half of the respondents believe that contraception leads to promiscuity. In both countries about half believe using condoms reduces sexual pleasure. Contraception and hence birth control leads to a healthier society. Improved attitudes by males will encourage more take up of contraception methods leading to a more healthy society.

Male involvement in decision making on matters reproductive health is a welcome idea. Acknowledgement by males that female involvement in decision making regarding reproductive health is a better idea. In both countries most men recognize the need for equal involvement of women in decision making on reproductive health issues such as when to have children, when to get married, sexual relations, whether to use contraception and what type and when to seek medical care. Most men also approve of the women's right to either have sex with the man or not under prevailing circumstances such as if the man has an STI, is cheating on her or the woman is not in the mood. The study also shows that most men approve of the woman asking the man to use a condom if unsafe sex may jeopardize the woman's health (infection or unwanted pregnancy). Women need to be empowered by their male

counterparts to be able to make decision regarding their health. This way, there will be an environment of freedom and ease in the home. Eventually, such an environment will lead to better health for both the man and woman since none lives in isolation. Nonetheless, there were indications that some men still hold onto the traditional gender roles. Over half of the respondents in Lesotho (57%) believe that that a man should have the final word about decisions in his home. In Uganda, the proportion was slightly less than half (48%). Such beliefs may negate efforts towards realization of better health care in the society especially if the decision maker (the man) is ignorant, aloof or unwilling to positively engage in his own or dependants health promotion. Hence it is pertinent to reverse such attitudes through education to such males.

The proportions approving for any form of justification of gender violence is very low in both countries. It's clear from the data that those approvals for gender violence are much lower in Lesotho than in Uganda. Men in the discussion agreed that violence against women is disrespectful and demeaning to the women. But where violence is justified according to them, it should be private. No form of gender violence is acceptable in the society if freedom of expression is respected. An environment that condones violence may undermine other social roles; and therefore inhibit behavior including health seeking. Therefore gender violence needs to be discouraged and respect for others' opinions and rights promoted among men who believe they have to use their strengths to suppress women and vice versa. Civic education on the importance of cohesive co-existence and use of dialogue to resolve gender conflicts needs to be given to the people.

Knowledge on HIV/AIDS and most STIs is almost universal in both countries. However study results show traces of lack of knowledge and misconceptions on modes of transmission, vulnerability and exposure, prevention and treatment in both Lesotho and Uganda. Lack of knowledge and misconceptions lead to increase in infection rates and spread of both HIV and STIs due to lack of protection and increased exposure. Those infected may not seek treatment for similar reasons. Misconceptions also lead to discrimination of those infected resulting to stigmatization, lack of positive living leading poor health seeking behaviors. If one is infected with HIV or an STI and they do not seek treatment due to ignorance or stigma, it results to suffering or death that could have otherwise been avoided. Provision of information on HIV and STIs through various forums may alleviate such consequences.

Accessibility to health provision is a major determinant of male involvement in reproductive health and HIV/AIDS. Health provider accessibility may be determined by various factors. The study shows that nearly all apart from 4% of health service providers interact with males every day in their work. Providers are also more likely to interact with teenage girls than boys. In comparison to females; males are more likely to seek health services in latter age sets.

The type, mode, who and place of services offered may influence take up by males. In the study, the proportion of providers who reported to offer SRH to girls is much higher than boys. Noteworthy is that 49% and 40% of the providers do not offer information on maternal health/care during pregnancy and menstrual regulation/abortion/post abortion care services respectively to male clients. Similarly 31% of the providers do not offer information on family planning services to male clients. Information on prevention of gender based violence is not offered to unmarried male clients. This trend is observed in most services scrutinized.

The level of SRH service take up may also be influenced by efficient provision which is closely related to training. Client health seeking behavior which may be influenced by both client intrinsic and extrinsic factors (lack of information on adolescent SRH issues, sexuality, inadequate socialization skills, SRH service affordability and rigidity in accepting provider advice, ignorance of available SRH services, rigidity in health seeking behavioral, unwillingness to take advice from female providers, language barriers, inability to disclose health problems and denial of health status).

Study results show that providers have extensive training in SRH service provision. However 79% wanted training in abortion/post abortion care and 74% wanted training in adolescent reproductive health services. Overcoming this hurdles and change in provider attitude and knowledge through health education to both the youth and adult men, both at the community and facility levels. Gender sensitivity in service provision has also assisted in overcoming these barriers. Use of IEC materials to educate the public is also a good mode of accessing men with health information. Facilitation in cases of affordability of SRH services encourages more males to seek health services.