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Stern, E; Pascoe, L; Shand, T; Richmond, S (2015) Lessons learned from engaging men in sexual and reproductive health as clients, partners and advocates of change in the Hoima district of Uganda. *Culture, health & sexuality*, 17 Suppl 2. S190-205. ISSN 1369-1058 DOI: <https://doi.org/10.1080/13691058.2015.1027878>

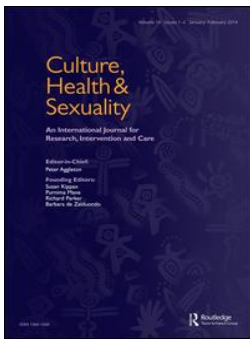
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To cite this article: Erin Stern, Laura Pascoe, Tim Shand & Samantha Richmond (2015) Lessons learned from engaging men in sexual and reproductive health as clients, partners and advocates of change in the Hoima district of Uganda, *Culture, Health & Sexuality*, 17:sup2, 190-205, DOI: [10.1080/13691058.2015.1027878](https://doi.org/10.1080/13691058.2015.1027878)

To link to this article: <https://doi.org/10.1080/13691058.2015.1027878>



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Published online: 08 May 2015.



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## Lessons learned from engaging men in sexual and reproductive health as clients, partners and advocates of change in the Hoima district of Uganda

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*(Received 21 October 2014; accepted 7 March 2015)*

This study examined the impact of a three-year intervention project conducted in the Hoima district of Uganda, which sought to engage men in sexual and reproductive health as clients, equal partners and advocates of change. Structured surveys with 164 self-reported heterosexual men aged 18–54 years were used to assess knowledge and attitudes towards sexual and reproductive health. Data from these were analysed using Stata and SPSS. Additionally, five focus groups were conducted with the female partners and male beneficiaries of the project and with project peer educators. Four interviews were conducted with project staff and male beneficiaries. Data from these and the focus groups were analysed using a thematic approach. Following the intervention, a significantly greater number of men accessed, and supported their partners in accessing sexual health services, had gained sexual and reproductive health awareness, reported sharing domestic duties and contraceptive decision-making, and displayed a decreased tolerance for domestic violence. It was more difficult to assess men's involvement and behaviours as advocates of change, which sheds light on the complexities of a gender transformative project and the importance of evaluating such projects from both men's and their partners' perspectives and at different levels of the male involvement model in sexual and reproductive health.

**Keywords:** HIV prevention; masculinities; sexual and reproductive health; South Africa; gender transformative programmes

### Introduction

Since the International Conference on Population Development in Cairo in 1994, it has been recognised that men have a crucial role to play in the advancement of sexual and reproductive health. Notwithstanding this global commitment, there is limited understanding of how to successfully promote men's sexual and reproductive health at programmatic and policy levels. Available studies on engaging men tend to be quantitative, short-term and emphasise clinical outcomes, with little exploration of the processes of change for male programme beneficiaries or direct engagement with how women's experiences are potentially impacted by the programme (Dworkin et al. 2013). Programmes that take a gender transformative approach and that seek to undermine gender inequitable norms and practices are especially difficult to evaluate as there are inadequate strategies and indicators to assess the complex transformation of gender norms and related behaviours (Greene et al. 2006).

The concept of hegemonic masculinities, which refers to ideal norms and practices that men are encouraged to subscribe to in a particular context, has been drawn upon to

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necessitate gender transformative efforts to improve men’s sexual and reproductive health. Much research has, however, demonstrated a link between men’s beliefs in patriarchal norms that privilege male power, HIV-risk behaviours and men having used violence against an intimate partner (Kauffman et al. 2008; Wade 2008; Barker et al. 2010). Men who equate masculinity with risk-taking and sexual dominance over women have been found to be more likely to contract a sexually transmitted infection (STI) and have negative attitudes toward condom use (Noar and Morrokoff 2002; Peacock et al. 2009). Sociocultural norms that portray contraceptive use, childcare and parenting as women’s responsibility can also limit men’s willingness and likelihood to participate in reproductive responsibilities, including pregnancy prevention (Kaida et al. 2005; Campo-Engelstein 2013). Moreover, the demand for toughness and expectations of being stoic in the face of illness can prevent men from accessing healthcare (Peacock et al. 2009). While there is widespread agreement that a gender transformative approach is the most effective means to achieve gender equality and better health outcomes, there is a lack of clarity on what a ‘gender transformative’ approach actually entails, programmatically or at a policy level, particularly in relation to sexual and reproductive health.

***The Learning Center Initiative-Reproductive Health Uganda programme***

Against this background, this paper seeks to address some of the gaps in the available literature by assessing the influence of a gender transformative approach that used a male involvement model to promote men’s sexual and reproductive health. The male involvement model in question, introduced by Greene et al. (2006), underscores the need to engage men at three intersecting levels: as clients, as equal partners and as advocates of change. This model recognises the influential role men can have on sexual and reproductive health and that increasing men’s access to and utilisation of related services without addressing gender inequality might consolidate men’s power over women’s reproductive and sexual decision-making. This model also operates at different levels to address individual, relationship and community factors.

The model below (Figure 1) was used as the basis for programme development, implementation and evaluation for the Learning Center Initiative (LCI), which was funded by the Swedish Association for Sexuality Education (RFSU), managed by Sonke Gender Justice (South Africa) and implemented by Reproductive Health Uganda (RHU) from 2011 and 2013 in the Hoima district of Uganda. Reproductive Health Uganda is a non-profit organisation and member of the International Planned Parenthood Federation (IPPF), which has independently operated in Uganda since 1957. Reproductive Health

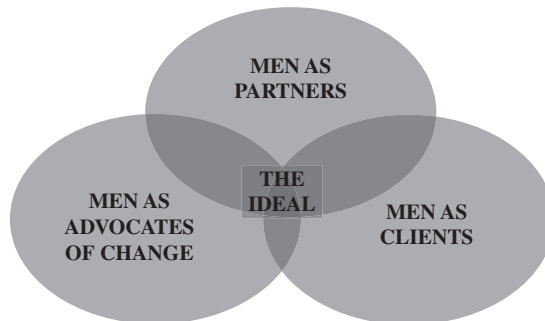


Figure 1. Male Involvement Model.

Uganda delivers sexual reproductive health information and services, including family planning, post-abortion care, maternal and child health and STI and HIV treatment, prevention and care, with a focus on the poor and marginalised communities across 17 branches in Uganda. A participatory workshop involving RHU, Sonke Gender Justice and RFSU was held in Johannesburg at the end of 2010 to reach collective agreement on the objectives and premises associated with the male involvement model employed. Afterwards, RHU developed workplans for the LCI programme based on this model, but adapted to the local context, and received feedback on these from Sonke Gender Justice and RFSU. Throughout the duration of the project, information, technical assistance and support was regularly provided to RHU by Sonke Gender Justice and RFSU via ongoing telecommunication support and at least two site visits per year.

With respect to men as clients, the LCI-RHU project sought to increase men's access to relevant sexual and reproductive health services and better meet their related needs. Many existing services are perceived as 'unfriendly' towards men as partners or clients, and there is a lack of sexual and reproductive health infrastructure targeting men, including policies, services and opening hours (Peacock et al. 2009; Pascoe et al. 2012). Other identified barriers for men and women to access SRH services in Uganda include a lack of privacy and confidentiality (Kipp et al. 2007). Moreover, RHU's analysis of the national and regional reproductive health reports in Uganda indicated very low levels of male involvement in sexual and reproductive health and revealed that there is no specific policy on male involvement in this domain in Uganda.

In response, the LCI-RHU hosted clinic days that targeted male attendance every Saturday at the RHU clinic in Hoima from 2012 onwards, although women who wished to access services on these days were also welcomed. Services offered included voluntary medical male circumcision (VMMC), reproductive planning, testing and treatment of STIs, including HIV, which were provided free of charge. Male clients could choose whether they preferred to be seen by a male or a female service provider. Monitoring on behalf of the RHU clinic revealed that most men preferred male service providers for STI management, but female service providers for family planning and general sexual and reproductive health provision, which speaks to the importance of having both available. The LCI-RHU trained and supported RHU clinic staff to make sexual and reproductive health services friendlier and more accessible to men. The LCI-RHU also offered testing of HIV and STIs at men's workplaces, which was valuable given the evidence that men access HIV services more when they are community-based (Shand et al. 2014). The project partnered with relevant Hoima-based non-governmental organisations, including Marie Stopes Uganda, Little Hospice Africa and the Infectious Disease Institute. These organisations were encouraged to refer male clients to the LCI-RHU if they did not have the time or resources to attend them. One two-day workshop was held with local stakeholders and another two-day workshop was held with national stakeholders, including the health department, gender department, religious leaders and cultural leaders, to advocate for national health plans to fund and create a policy that constructively engaged men in sexual and reproductive health.

The LCI-RHU provided sexual and reproductive health education to men through a variety of media, including at churches, football tournaments, using community outreach, drama, the distribution of posters, monthly radio programmes, bi-weekly community sensitisation meetings and media briefs to local media houses. A resource centre for sexual and reproductive health information provision was established at the RHU office in Hoima, which had Internet access to specifically attract young people and was managed by full-time project staff to ensure accessibility and relevance. Peer education was also

implemented to encourage men to access sexual and reproductive health services and address any misunderstandings. A total of 120 peer educators from the Hoima community were identified through the RHU network and were offered five days training with a subsequent refresher training every year. There were also monthly peer educator meetings aimed at enriching their sexual and reproductive health knowledge and community engagement skills and to discuss experiences and challenges. In all, 67 peer educators remained active throughout the LCI-RHU, which was due to some peer educators moving away from Hoima, but mostly because of a lack of financial remuneration.

Engaging men as equal partners was particularly pertinent to the context given evidence suggesting that men's discussions with their partners about reproductive planning in Uganda is generally poor (Kaida et al. 2005). The Uganda Demographic and Health Survey (2006) showed that almost half of all married women had not discussed reproductive planning with their partners the year preceding the survey, and among married women using contraception, 17% were using it without their husband/partner's knowledge. Pool et al.'s (2000) interviews and focus groups with men in South-Western Uganda found that many men expressed a vested interest to be in control of their female partners, including their use of contraception. Moreover, the IPPF (2008) review of sexual and reproductive health programmes in Uganda noted that those involving men tended to target them solely as clients. To address this gap and engage men at this level, the LCI-RHU established workshops to challenge unequal gender roles by explaining the harms of certain gender norms to men and women and the benefits of more equitable alternatives. The workshops also functioned to challenge men's use of violence against women, to encourage men to communicate openly with their partners about sexual decision-making and sexuality, to support their partners' needs, including accessing sexual and reproductive health services, and to share domestic duties with their partners. The workshops included local health service providers, religious leaders, cultural leaders and local couples, who were invited to share their experiences with sexual and reproductive health service utilisation and domestic responsibility. The LCI-RHU also established six community clubs with a majority of male, but some female, participants to support income-generating activities (IGAs) of their choice, which included brick-laying, poultry and pig keeping and saving schemes.

The LCI-RHU engaged men as advocates of change through peer educators encouraging men's participation in the promotion and delivery of sexual and reproductive health. Male project participants were invited to share their personal experiences and testimonies in community groups and on radio programmes. Community leaders, including prominent religious and political leaders, were encouraged to publicly support men's positive attitudes towards sexual and reproductive health and gender equality. Church platforms were also used as advocacy spaces where peer educators could discuss male involvement and its benefits to men and women.

## **Methods**

### ***Participants***

In 2012, a structured survey was conducted in three sub-counties within the Hoima district of Uganda where the LCI-RHU project operated. The peer educators conducted the surveys door-to-door using a systematic sampling whereby every sixth household was selected. The sample size for each district was allocated to the sub-counties proportionate to their population size. Although no men refused to be interviewed, some men were not available at their households during the selection process. When

certain men could not be reached, interviewers were advised to select the next immediate household. A total of 170 men aged 18–54 years completed the survey, but after data cleaning, only 164 interviews were eligible to be analysed. Although participants were not asked whether they had received RHU services, the RHU-LCI was active in all three districts, so an assumption was made that participants probably included some men who had been part of the LCI-RHU.

For the end of project evaluation in 2014, five focus groups were conducted in the same three sub-districts of the Hoima district, which included one focus group with LCI-RHU peer educators, two focus groups with female partners of men who had been primary recipients of the LCI-RHU project and two focus groups with male participants in the LCI-RHU project. Focus group participants were selected and recruited through four LCI-RHU peer educators, and each focus group consisted of 10–12 participants, disaggregated by gender. Each peer educator was asked to recruit three men and three women from the local community to participate in the focus groups. As a result of limited time and resources but a desire to sample more in-depth perspectives on the project, four semi-structured interviews were also conducted, three with LCI-RHU project staff and one final interview with a male project participant.

### ***Procedures***

The quantitative surveys that were completed in 2012 were initially designed by IPPF Southeast Asia and adapted for context by staff from Sonke Gender Justice and LCI-RHU. The questionnaire had pre-coded responses and was translated into the local Lunyoro language. The questionnaires examined sexual and reproductive attitudes and practices of men, including those around STIs, HIV, contraception, abortion and gender equality. All survey respondents provided written consent to their involvement in the survey after peer educators had first explained the objectives, risks and benefits of the study to them. Staff of LCI-RHU selected peer educators who were appropriately trained on ethical procedures and administration of the questionnaire to conduct the survey. Once completed, questionnaires were double entered using Epidata version 3.1 to ensure the accuracy of the data capturing process. Data entry and analysis was conducted by a doctorate student based in the Department of Statistics at Makerere University. The RHU project manager and a RHU colleague checked completeness of the questionnaires on a daily basis and provided regular feedback to the peer educators for quality control.

The qualitative research conducted as part of the end of project evaluation at the beginning of 2014 was collected to ascertain the extent to which the project objectives had been reached, as well as to highlight challenges and best practices and to provide recommendations to inform sustainability plans for the project. The Sonke Gender Justice Monitoring and Evaluation Manager and the International Programmes Specialist from Sonke Gender Justice conducted the focus-group discussions and interviews in English, which were translated into Lunyoro by the LCI-RHU project manager. These were audio recorded and the English translation of the data was transcribed verbatim. While the dyadic interaction provided by the individual interviews was appropriate for this research, focus groups were valuable for assessing how men's attitudes around involvement in sexual and reproductive health and towards gender equality are influenced by the social nature of group interaction (Bauer and Gaskell 2000). Informed consent was acquired from all participants, who were informed that their responses would remain anonymous and confidential, as well as the voluntary nature of their participation. All participants' names are pseudonyms.

### ***Data analysis***

The survey data was analysed using the Statistical Package for Social Sciences (SPSS) version 16 and 22 and Stata. Descriptive data analyses enabled the generation of frequency distributions and their associated graphs, and bivariate data analyses allowed for the exploration of relationships between variables. Qualitative data was analysed using thematic analysis to reveal the prominent themes identified inductively but informed by the male involvement model. The first author read the raw data several times in order to familiarise herself with the content and its meanings. Text segments were assigned basic codes, and these codes were organised into major trends and crosscutting themes. Illustrative quotes were extracted from the raw data to reflect how men were engaged in sexual and reproductive health by the LCI-RHU at the three levels of the male involvement model.

### **Findings**

A combined analysis of the quantitative data from 2012 and the qualitative evaluation data from 2014 is presented along the three intersecting levels of the male involvement in sexual and reproductive health model.

### ***Men as clients***

#### *Survey findings*

The survey indicated high levels of basic knowledge on issues such as HIV prevention and treatment, as well as existing sexual and reproductive health services and some of the detailed findings are provided in Table 1. However, data also demonstrated men's limited use of these services, as well as an ongoing gap between levels of knowledge and safer-sex practices. The findings also suggest that men had strong awareness of contraception, and the majority reported using some form of contraception with their wives. The majority of respondents were married (88%), Christian (84%), and had never attended school (92%), and 33% of the respondents were engaged in agriculture.

#### *Improving men's demand for and access to sexual and reproductive health services*

As a result of the efforts of the LCI-RHU, project staff observed an increasing trend among men accessing sexual and reproductive health services. As Akia, one of the project coordinators reflected:

There is a shooting trend in terms of men using HIV services. We saw 1000 in 2012 for VCT, but this year, 2013, by September we now have already seen 4766.

Monitoring of the services accessed at the RHU clinic also supports this finding. For instance, 1425 men received STI testing in 2011, and 1688 men received STI testing in 2012. In the focus-group discussions as part of the project closeout evaluation, several female partners of male project participants agreed with this shift, which was attributed to the work of LCI-RHU. In the focus groups and interviews, some participants discussed the efficacy of peer education in tackling damaging norms of masculinity, including notions of men as invulnerable and encouraging men to take responsibility for their sexual and reproductive health. Another project coordinator, Kigongo, remarked:

They assume men are healthy. Men do not need to go to clinics. And then you have a discussion about men and reproductive health issues and they listen and understand the concept. Especially breaking down the model looking at men as patients.



Table 1. Survey findings: men as clients.

| Question  | Yes (%) |
|---|---------|
| Have you ever heard of an illness called AIDS?  | 100     |
| Do you know of a place where people can go to get tested for HIV and AIDS?  | 98      |
| Have you heard about special antiretroviral drugs that people infected with HIV and AIDS can get from a doctor or a nurse to help them live longer? | 94      |
| Can people reduce their chances of getting HIV and AIDS by using a condom every time they have sex?   | 89      |
| Can people reduce their chances of getting HIV and AIDS by having just one uninfected sex partner who has no other sex partners?                    | 73      |
| Apart from HIV and AIDS, have you heard about any infections that people can get from sexual contacts?  | 95      |
| Can you describe any symptoms of infections that people can get from sexual contacts?   | 69      |
| Burning pain on urination   | 63      |
| Itching in private parts  | 61      |
| Genital discharge   | 54      |
| Ulcer/sore on private parts   | 45      |
| Warts of growth on private parts lower abdominal tenderness/pain  | 37      |
| During the last 12 months, have you had an infection that you got through sexual contact?   | 39      |
| During the last 12 months, have you had a sore or ulcer on or near your penis?  | 41      |
| During the last 12 months, have you had an abnormal discharge from your penis?  | 27      |
| The last time you experienced a sexual health problem, did you seek any kind of advice or treatment?  | 57      |
| Knowledge of contraception method   |         |
| Male condom   | 96      |
| Pill  | 95      |
| Injectables   | 93      |
| IUD or loop   | 73      |
| Female sterilisation  | 73      |
| Withdrawal  | 68      |
| Male sterilisation  | 65      |
| Female condom   | 62      |
| Rhythm method   | 57      |
| Other   | 31      |
| Are you or your wife currently using any contraceptive method?  | 66      |

The IGAs were identified as a major incentive for men and women's involvement in the project and in some cases, assisted their access of sexual and reproductive health services. Some male beneficiaries reported using the money from the IGAs to care for their own and their families' sexual and reproductive health. Some participants indicated that taking sexual and reproductive health services to the community, including to men's workplaces, played an essential role in motivating men's access. Some participants also spoke of VMMC as a successful way to target and promote men seeking sexual and reproductive health services. A few project staff and participants discussed how men felt more comfortable accessing sexual and reproductive healthcare because of the dedicated men's days at the clinic.

The fact that the LCI-RHU sought to improve the quality of sexual and reproductive healthcare for men was perceived as critical given the poor quality of existing services. In a focus group, one male project participant, Gonza, reflected on his negative experience accessing sexual and reproductive health services prior to the LCI-RHU project:

The health centre lacks services for men and are more female dominated. Whenever I go there I used to not receive attention. So we needed maybe be more of a male service package for men.

*Promoting men’s access to sexual and reproductive health information*

In general, the educational component of the LCI was strongly appreciated by men and women alike, including generating greater awareness of how to prevent acquisition of HIV. As a male focus-group participant, Lutalo, said:

Men used to fear if you have unprotected sex with any women, you contract HIV. But because of continuous teaching now people know how to go and do testing and how to prevent HIV.

Madongo, a peer educator, described the importance of the project’s use of repetitive sensitisations to enhance men’s sexual and reproductive health awareness. Some participants discussed how exposure through a variety of mediums, including peer educators, drama and radio programmes, was particularly effective. Another peer educator, Tombe, described the value of them providing demonstrations of proper condom use:

Some men have used condoms but in a wrong way. The men would say ‘I used a condom’ but their wife is pregnant. These things do not work. And another would say the condoms are weak they burst. So not knowing how to use the condoms we targeted.

Despite this valued education, some men said they could not access or afford condoms, which raises questions about the accessibility of the protection methods needed to act on the education provided.

***Men as equal partners***

*Survey findings*

The survey revealed concerning levels of gender inequitable attitudes among men, including tolerance of violence against women, attesting to the importance of engaging men as equal partners in sexual and reproductive health as indicated in Table 2.

Yet at the same time, some men also displayed some promising attitudes in support of gender equality, including supporting women’s initiation of contraception, although the nuanced power and gender dynamics surrounding how this was negotiated is difficult to understand from the quantitative survey data alone. Some of these findings are detailed in Table 3.

Table 2. Survey findings: men as equal partners (tolerance of violence).

| Question   | Yes (%)     |
|--|-------------|
| A woman should tolerate violence in order to keep her family together  | 45          |
| Please tell me if you think a wife is justified in refusing to have sex with her husband when she knows her husband has sex with other women                               | 37          |
| If a woman cheats on a man, it is okay for him to hit her  | 36          |
| Sometimes a husband is annoyed or angered by things that his wife does. In your opinion is a husband justified in hitting or beating his wife in the following situations: |             |
| If he suspects her of being unfaithful   | 32          |
| If she neglects the house or the children  | 25          |
| A man should have the final word about decisions in his home   | 60          |
| A woman’s most important role is to take care of her home and cook for her family  | 51          |
| Changing diapers, giving kids a bath, and feeding the kids are the mother’s responsibility   | 51          |
| A man needs other women, even if things with his wife are fine   | 43          |
| In a couple, who do you think should have the greater say in each of the following decisions: the husband, the wife or both equally:                                       | (% husband) |
| Making major household purchases?  | 58          |
| Deciding how many children to have?  | 30          |

Table 3. Survey findings: men as equal partners (gender power and dynamics).

| Question   | Yes (%) |
|--|---------|
| When is the women justified to ask her husband to use a condom?                                |         |
| When she knows her husband/she herself has any problem in the genital area                     | 77      |
| When she does not want to have baby  | 70      |
| Please tell me if you think a wife is justified in refusing to have sex with her husband when: |         |
| She knows her husband has a sexually transmitted disease                                       | 73      |
| She is tired or not in the mood/experiencing discomfort and pain                               | 66      |
| I would be outraged if my wife asked me to use a condom  | 26      |
| Women who carry condoms on them are 'easy'   | 38      |
| In my opinion, a woman can suggest using condoms just like a man can                           | 65      |

### *Promoting gender equitable attitudes and roles*

In both the focus groups and interviews, it was described how, as a result of the LCI-RHU efforts, men became more involved in family planning, including escorting their wives to access sexual and reproductive health services, and in their partner's natal and care delivery. A project coordinator, Rokani, remarked how this finding could be attributed to the fact that couples counselling and testing was strengthened through the project, providing a safe space for couples to discuss issues such as HIV status disclosure. In one focus group with women, it was expressed that couples counselling and testing could also significantly undermine the stigma of a female partner testing HIV-positive:

If the lady finds herself HIV-positive, the man can chase her from home. But if they go for the testing together and maybe the lady is positive and the man is negative, they can be given information and counselling on how to handle the situation.

There was some consensus that couples counselling and testing could lead to increased communication and joint sexual decision making and responsibility, as discussed by one male focus-group participant, Ndahura:

After testing he finally got the courage to go and share with his wife after testing. Then when they tested they were happy. Before they tested together they were not actually one, and they would not share anything. There was a lot of bickering and fighting at home. But the start point was testing and sharing responsibilities increased more.

Couples counselling and testing was also used to encourage men to become more actively involved in decision-making about family planning with their partners. In the focus groups, some women reported that as a result of the project, their husbands were less likely to be the sole decision-makers about the timing and size of families. As Nyangoma said:

Now I can use tablets. Before I refused to go for family planning but he is the one who encouraged me. Now there is freedom to space our children very well. Before my husband would tell me to produce a baby every year.

More men in focus groups and interviews reported partaking in domestic duties, which was said to be a noticeable and significant change among the male project participants, their partners and the project staff. As Madongo, a project coordinator, noted:

A man is now free to clean the house, to clean the utensils, to cook, to wash clothes; they feel free to do this. The fact that men report it with pride and mentioning sharing with their partners was amazing.

For some women, men's increased involvement in domestic duties generated their own interest in the LCI-RHU project. Men's greater involvement in domestic duties, the

promotion of their open communication and equal decision-making was said to reduce the levels of domestic violence. As a male project participant, Gonza, explained:

There were no negotiations at home. If I wanted my woman to do it, she must do it. But now I know as equal partners, I need to sit down and understand. That is what has reduced sexual violence because before I would say I want you to do this and if she does not, then we start a fight.

Participants also discussed how men's use of domestic violence was diminished by challenging the idea that men gain respect through inducing fear, and by educating them about their wives' right to refuse sex and/or insist on contraception use. One man in a focus group remarked that the improved understanding of condoms as not necessarily linked to infidelity reduced his use of domestic violence. Several women and men discussed how more open communication about sexual-decision making and sexuality had improved their relationship quality, including their sexual satisfaction. There was some acknowledgment of the fact that female partners were not always supportive of their husbands being responsible for domestic duties and childrearing due to potential repercussions in their community, including the perception that they bewitched their husbands for behaving differently or that this could lower their husband's status.

The need to particularly engage young men as equal partners was emphasised. As Sanyu said in the focus group with women:

When you target adults, sometimes it is too late to change certain aspects. But if this teenager grows up knowing that it is my role to support my wife. To check up with my spouse. It is better when they grow up when they are already aware.

Overall, engaging men at this level was positively evaluated and was said to have led to significant and various changes, from both men and women's perspectives.

### *Men as advocates of change*

There were no survey questions related to how men perceive this aspect of the male involvement model, including men's views around civic participation and community advocacy. Insights from the qualitative data, however, revealed some discussion around the positive influence the LCI-RHU had in supporting men to mobilise other men's involvement in sexual and reproductive health. A male participant, Rokani, noted:

The peer educators encouraged us to change our own attitudes, then be role models. Then we shall be the best preachers of the community and walking the talk. I am seeing the environment change from this preaching, which then changes others.

There was also some consensus about how seeking support from key stakeholders and community leaders, who themselves are usually men in the context, was essential for encouraging men's involvement in sexual and reproductive health. Engaging religious leaders to encourage men to take responsibility for their sexual and reproductive health was said to be particularly important given that they could act as barriers to its promotion. Yet, overall, the qualitative data provides the least pronounced results for how the LCI-RHU engaged men as advocates of change.

### **Discussion**

Overall, findings from this evaluation reinforce the importance of engaging men as clients, equal partners and advocates of change. The study further supports the findings in existing literature that gender transformative programmes can have a positive influence on

relationship equality and health both for men and for women (Peacock, Khumalo and McNab 2006; Barker, Ricardo, and Nascimento 2007; Dworkin et al. 2013).

Regarding engaging men as clients, the use of multiple communication and implementation strategies, including community outreach and the hosting of male targeted clinic days, was found to attract a greater number of male clients than prior to the project's implementation in the area. This is congruent with findings in the literature, including a review of 58 sexual and reproductive health interventions engaging men, which found that a multi-pronged approach was more likely to change behaviours among men and boys than single-focus interventions (Barker et al. 2010). Peer education was also particularly effective in promoting men's sexual and reproductive health awareness, which has elsewhere been found to be a valuable way to improve men's sexual health, such as increasing condom use, delaying sexual debut and decreasing the likelihood of multiple concurrent partners (Foss et al. 2007; Cornish and Campbell 2009). Sexual and reproductive health projects are more likely to be effective if the messages are tailored to men's values and needs, with relevance to their sociocultural context (Ntshebe, Pitso, and Segobye 2006). Thus, creating spaces for men to express their concerns and barriers to sexual and reproductive health as occurred in this project, and understanding individual's processes of change as ongoing and iterative, are key components for engaging men as clients. Findings also undermine the idea that men inherently prefer male service providers, as some men in this study preferred female service providers and female peer educators were also viewed as effective.

In terms of engaging men as equal partners, sexual-health couples counselling and testing was said to be a particularly effective way to promote gender equality and open sexual decision making, which is in keeping with recommendations from other studies (World Health Organization 2012; Stern, Clarfelt, and Buikema 2014). For some participants, men's increasing willingness and responsibility to do domestic chores, as promoted through the community workshops, was attributed to their decreased tolerance of gender-based violence. Kaye et al.'s (2005) study in the Wakiso district of Uganda also found that the major factors triggering violence were failed negotiations of sexual relations and disagreement concerning the division of labour within the household. The IGAs supported men to care for their own and their families' sexual and reproductive health, a finding that has been documented elsewhere (Barker et al. 2010).

Some women also discussed how their interest in and appreciation of the LCI-RHU was sparked by the beneficial IGAs. Securing women's ability to gain income could in itself challenge gender norms by promoting the acceptance of both men and women as financial providers (Sideris 2004). Lakwo (2006) found that rural women microcredit clients in Uganda experienced improved decision-making power within their households and gained greater ownership over some household assets typically controlled by men. This could also ease the burden on men, congruent with dominant masculinity roles, to be the sole financial provider or main breadwinners for their female partners in the context of severe unemployment (Walker 2005). The findings therefore demonstrate the critical importance of including women in male involvement in sexual and reproductive health programmes, both as potential beneficiaries and as an essential perspective to incorporate into project implementation and evaluation. Some men spoke of their wives' resistance to transforming gender norms and roles, which supports the suggestion that women can and often do play a role in reinforcing hegemonic norms of masculinity (Hearn 2004). By foregrounding masculinity and femininity as social constructs that could be challenged, the project was able to alert men and women to the costs of certain gender norms and the benefits of more equitable gender relations.

Although some men reported efforts to mobilise other men to be involved in sexual and reproductive health and to challenge gender inequality, engaging men as advocates of change was the least notable and measurable change of the three levels, which has been noted elsewhere (Greene et al. 2006). This may be partly attributable to the fact that men may support gender equality 'in the abstract, which may be related to social desirability, yet are not as willing to undermine patriarchy and control as strongly in practice' (Ratele 2014, 512). To be effectively engaged as advocates of change may require emphasising that to fully support gender equality, men may lose some of their gender power in the short-term, and to appreciate the benefits of more equal societies in the longer-term (Ratele 2014). Developing improved measures to support and evaluate men as advocates of change is critical for programmatic sustainability, particularly given men's roles as gatekeepers to women's sexual and reproductive health and that men may need continuous support to maintain changed behaviours and attitudes in support of gender equality (Dworkin et al. 2013). It would be useful to measure community members' attitudes around civic participation and community advocacy, including social and psychological propensity for this, which could provide a stronger basis for programmes and policies to engage men as advocates of change. Overall, the findings demonstrate the need to better understand how change on one level of the male involvement model affects or interrelates with other levels, and the importance of evaluating change, and the influencing factors, at the three levels of the model separately.

### ***Implications***

It is important to note that while educational programmes have had some success in sexual behaviour change, people may fail to integrate increased awareness and changed attitudes into their everyday life if their broader environment is not addressed (Campbell 2004). Importantly, the LCI-RHU sought to not only address men's knowledge and attitudes related drivers of poor sexual and including gender-based violence, but also structural factors, including gender-based violence, poverty and sexual and reproductive health policies. Addressing institutional barriers to men's sexual and reproductive health, such as inadequately resourced health systems and insufficient policies, is integral to improved health for all (Shand et al. 2014; Hawkes and Buse 2013). Moreover, this project was contextually led, adapted and owned, which is critical for ensuring programmes are relevant to local sexual behaviours, attitudes and preferences (Sternberg and Hubley 2004). To further improve programmes' contextual relevance, Greene et al. (2006) argue that measures and concepts such as 'gender transformative' should initially be explored through focus groups with community members and discussions with knowledge informants, and that agreed-upon concepts should be defined in questionnaires in order to improve their validity and cultural appropriateness.

### ***Limitations***

While none of the authors are Ugandan, all had extensive experience working in the areas of gender and sexual and reproductive health in Africa, including Uganda, and the third author undertook regular calls with staff and site visits to review the extent to which project deliverables had been met, and to agree on strategies with LCI-RHU to continuously improve project implementation. To minimise a biased interpretation of the findings, the authors also opened the analysis process to verification by the Ugandan RHU-LCI project manager, who also translated the focus-group discussions and oversaw the collection of the quantitative data.

The authors aimed to be sensitive about the presentation of the findings and were self-critically aware of and reflexive of their positionality. This is particularly important given that some research in the area of sexual and reproductive health and masculinities has tended to pathologise African sexualities and be disengaged from or dismissive of African cultures (Morrell, Jewkes, and Lindegger 2012; Ratele 2014). Nonetheless, the use of Sonke Gender Justice staff and the LCI-RHU programme manager as qualitative data collectors could have biased the findings as participants may have felt compelled to report positively on the project. Another limitation could have arisen from the fact that the peer educators were responsible for selecting focus-group participants, which may have introduced both selection and reporting biases. The survey is limited for only examining the perspective and attitudes of primarily married men, and not women, which would have allowed for a comparison of men and women's attitudes towards sexual and reproductive health. The surveys did not document which participants were part of LCI-RHU, which would have been useful in assessing shifts in behaviours and attitudes from the evaluation data. Moreover, the limited survey sample cannot be said to be representative of Ugandan men. Yet, the survey still provides valuable insights into local men's attitudes and awareness of sexual and reproductive health and gender equality at the point of time when the project occurred.

Since the evaluation component of the study relied on self-reports, there may be a bias in the perspectives provided without observing men's actions in their relationships, families and communities after the intervention (Dworkin et al. 2013), which is useful to assess 'men's ambivalent attitudes toward gender equality and distance between concept and practice' (Ratele 2014, 511). Moreover, the small scale of the evaluation, including the number of qualitative interviews, is a major limitation to the study. Without a randomised control group or pre- and post-intervention design using the same indicators, confidence of how the change in men's gender-related attitudes and behaviours was directly affected by the project is limited. More long-term, large-scale evaluations to measure men's attitudes towards gender equality and how this affects the depth and sustainability of behaviour change and gendered power dynamics are required (Sternberg and Hubley 2004; Barker et al. 2010; Bonnell et al. 2012).

## **Conclusion**

Despite significant limitations, this study makes an important contribution to the literature for unpacking the value of the male involvement in sexual and reproductive health and for identifying ways to further develop and refine such approaches. The scale up and improvement noted here provides foundations for a stronger theoretical base with respect to gender transformative sexual and reproductive health interventions with men, which can critically allow for more adequate comparisons and lesson sharing across the field.

## **Acknowledgments**

We would like to acknowledge the male and female participants and peer educators who participated in the study. Thanks to RHU, particularly Sophie Baumgartner, and her colleagues who implemented the research and the LCI project in Uganda, as well as Nathan Tumuhamy. Nathan and Bill Elur helpfully provided detailed information and answered queries of the RHU programme. We would also like to acknowledge IPPF Southeast Asia, particularly Jameel Zamir, who developed the initial survey used, and Zinhle Nkosi, the Monitoring & Evaluation manager at Sonke Gender Justice, and Lucinda van den Heever, the International Programs Specialist at Sonke Gender Justice, who facilitated the evaluation of the LCI-RHU project. Thanks to Olov Berggren and Agneta Falck from RFSU, the funders of this project.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Funding

This work was supported by the Swedish Association for Sexuality Education (RFSU).

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## Résumé

Cette étude a examiné l'impact d'une intervention de trois ans dans le district de Hoima en Ouganda, dont l'objectif était de faire participer les hommes à la santé et aux droits sexuels et reproductifs en tant qu'usagers, partenaires égaux et partisans du changement. Des enquêtes structurées ont été utilisées pour évaluer les connaissances et les attitudes concernant la santé et les droits sexuels et reproductifs. Les données proviennent de questionnaires auxquels 164 hommes s'identifiant comme hétérosexuels et âgés de 18 à 54 ans ont répondu. L'analyse quantitative a été effectuée avec les logiciels STATA et SPSS. Cinq groupes de discussion thématique ont été conduits avec les bénéficiaires masculins du programme, des partenaires féminines et des pairs éducateurs impliqués dans le projet. Quatre entretiens ont été conduits avec des membres du personnel et des bénéficiaires masculins. Les données de ces entretiens et des groupes de discussion ont été analysées dans une

approche thématique. Suite à l'intervention, le nombre d'hommes accédant – et aidant leurs partenaires à accéder – aux services de santé sexuelle, sensibilisés à la santé sexuelle et reproductive, déclarant participer aux tâches domestiques et aux décisions concernant la contraception et se montrant moins tolérants vis-à-vis de la violence domestique a considérablement augmenté. L'évaluation des attitudes des hommes en tant que partisans du changement s'est révélée plus complexe. Cette difficulté met en lumière les défis inhérents à un projet de transformation des genres et la valeur d'une évaluation de tels projets basée sur les points de vue des hommes et de leurs partenaires.

## **Resumen**

El presente estudio examina la incidencia de un proyecto de intervención implementado en el distrito de Hoima en Uganda, cuyo objetivo se orientó a involucrar a los hombres en el ámbito de la salud y los derechos sexuales y reproductivos, en tanto clientes, socios iguales y partidarios del cambio. Con este objetivo, se aplicaron encuestas estructuradas a fin de valorar el conocimiento y las actitudes de los hombres en relación a la salud y a los derechos sexuales y reproductivos. Los datos, procedentes de 164 hombres que se autorreportaron como heterosexuales, cuyas edades oscilan entre 18 y 54 años, se analizaron de forma cuantitativa mediante el uso de Stata y de spss. Asimismo, se conformaron cinco grupos de enfoque integrados por sus parejas mujeres, por los hombres beneficiarios del proyecto y por los educadores pares participantes en el proyecto. Además, se realizaron cuatro entrevistas con el personal del proyecto y con los hombres beneficiarios. A partir de la intervención y como resultado del proyecto se constató que un número más elevado de hombres accedió a los servicios de salud sexual y apoyó a sus parejas en el mismo empeño, elevó su nivel de conciencia sobre la salud sexual y reproductiva, manifestando compartir tanto las labores de la casa como las decisiones respecto al uso de anticonceptivos y mostrando menos tolerancia hacia la violencia doméstica. Sin embargo, fue más difícil valorar las actitudes de los hombres como partidarios del cambio, lo cual pone de manifiesto las complejidades inherentes a un proyecto de transformación de género y las ventajas que implica la evaluación de proyectos semejantes tanto desde la perspectiva del hombre como desde la de su pareja.