Sweden
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2gether 4SRHR

Summary Findings From A Rapid Situational Assessment of
Sexual and Reproductive Health and Rights Needs Among Men and Boys in:

UGANDA

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Background:

Men and boys have diverse sexual and reproductive health and rights (SRHR) needs, that often remain unfulfilled due to a number of barriers, such as male stoicism, reluctance to admit ill health, restrictive access to health facilities, negative stereotypes of male clients among providers and services that do not cater to their needs, and a lack of agreed-upon standards for delivering sexual and reproductive health (SRH) clinical and preventative services to men and boys.

In recent years, key regional commitments on SRHR in East and Southern Africa have begun to consider the needs of men and boys more intentionally. At the country level, there has been ample attention to the need to involve men more substantially and constructively in health issues. In 2019, the government launched a male involvement strategy and male involvement guidelines for service delivery. Before this, a Male Action Group (MAG) initiative had been started in selected districts in 2012 with a view to improve women's access to maternal health services. An interim evaluation found that this initiative had acted as a catalyst for reproductive health promotion and was subsequently scaled up to other parts of the country[1]. The country's comprehensive approach to male involvement is a departure from the conventional maternal health programmes in the region, which have largely placed the responsibility on women of reproductive age to bring their partners to programme sites, and with little acknowledgment of men's own needs and potential agency to bring about normative change.

Rationale for the rapid situational assessment:

Men have a shared responsibility, as partners and parents, for decisions around contraception, preventing sexually transmitted infections (STIs) and HIV and promoting SRHR in their communities. However, little is known of the extent to which:

- National policies and strategies incorporate male engagement or have dedicated male engagement strategies.

- Male social and gender norms and behaviours determine SRH outcomes of men and boys; and men and boys are accessing SRHR services.

Global, continental and regional commitments on male engagement

promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.

African Union Initiative on Positive Masculinity

is a commitment by Heads of State and Government; the private sector; religious and additional leaders; academia; civil societies; women and youth to accelerate the prevention and elimination of viol all levels. It includes a commitment to ensure that the necessary policies measures are put in place by Member States to address any form of impunity.

The East and Southern Africa Ministerial Commitment on the education, health and wellbeing of young people

Recognises that boys and young men are central to achieving gender equality and ultimately in the prevention of new HIV infections, early and unintended pregnancies, gender inequality, and child marriage.

[1] United Nations Joint Programme on Population (UNJPP). (2013). Government of Uganda/ United Nations Joint Programme on Population (JPP) Mid-term Evaluation (MTE). Kampala, Uganda: UNJPP

To respond to these questions, the 2gether 4 SRHR Programme, a Joint United Nations Regional Programme that aims to improve the SRHR of all people in East and Southern Africa, commissioned the Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal to undertake a rapid situational assessment of the SRHR needs of men and boys in five countries in the region, including Uganda.

The purpose of the assessment was to examine the extent to which national laws, policies and strategies integrate issues relating to men and boys and to assess the structural, social and behavioural drivers that facilitate or impede the uptake of SRHR services by adolescent boys and young men aged 18 to 34 years. This was followed by a validation meeting convened with representatives of the countries who reviewed the findings. This brief summarises the key findings of the rapid assessment, the policy review and inputs received during the validation meeting.

Methodology:

The 2gether 4 SRHR is a regional programme with applied learning in countries. Uganda was included as one of the countries because of its involvement in the 2gether 4 SRHR Programme. The rapid situational assessment[2] followed a mixed-methods approach.

Study site and Sampling: The Kyankwazi (rural) and Wakiso (urban) districts were purposively selected, in collaboration with the 2gether 4 SRHR Programme. Rural and urban settings were included to ensure that the lived realities of adolescent boys and young men with regards to SRHR in these settings would be captured. Adolescent boys and young men were sampled from the two districts. For the quantitative survey, 50 adolescent boys and young men who were involved in SRH programmes and 50 adolescent boys and young men who were not involved were sampled in each district.

Recruitment: Participants were recruited both within programmes and outside programmes. For in-programme recruitment, participants were recruited by health workers of the district local government and implementing partners assisted the research team from the clinics until the required sample size was attained. In the Wakiso district participants were recruited from Nabweru Health Centre III (government-aided) and Nurture Africa clinic (implementing partner). In the Kyankwanzi district, participants were recruited from the Ntwetwe Health Centre IV clinic and Butemba Health III clinic. These two clinics are government aided. Their implementing partner is Mildmay Uganda.

For out-of-programme recruitment in Kyakwanzi and Wakiso districts, research assistants recruited participants from football playgrounds, Ludo (board game) gatherings, boda-boda (motorbike) taxi stages, marketplaces, bar surroundings, and disco tech surroundings in the community. In Kyankwanzi, the district health inspector and youth leaders helped in the mobilization of participants. In the Wakiso district, the local youth leaders supported the research assistants to mobilise the participants.

For the focus group discussion, different adolescent boys and young men from those participating in the survey in the two districts were recruited. Participants were recruited at various places in the community, for example at taxi and bus ranks, in business centres, marketplaces or at clinics. Researchers were supported by local administrators, chiefs, civil society programme managers, and health service providers during the recruitment process. During participant selection, there was an attempt to balance the focus groups between younger groups (younger than 26) and older groups of men (27 to 34 years).

In the same districts, providers of (adolescent) SRH services and SRH programme implementers were identified through snowball sampling[3]. At national level, four government officials and policymakers were identified via snowball sampling. The Ministries of Health and Education were represented in the sample, as well as large civil society organizations working on SRHR and operating on a national scale.

Ethical clearance was obtained from the University of KwaZulu-Natal (BREC/00003894/2022) and from the AIDS Support Organisation Uganda (TASO-2022-138).

[2] Rapid situation assessment (RSA) refers to a methodology that uses a combination of qualitative and quantitative data collection methods. RSA draws on a variety of data sources to arrive at an understanding of certain health problems and of structures and services to address those problems and then formulating responses to deal with them. See United Nations Office for Drug Control, Crime Prevention, and United Nations International Drug Control Programme. Demand Reduction Section. (1999). Drug abuse rapid situation assessments and responses (No. 36-37). United Nations.

[3] Babbie, E. R. (2020). The practice of social research. Cengage AU

Data Collection:

The assessment used various data collection methods including:

A quantitative face-to-face survey:

administered 200 adolescent boys and young men. The survey was conducted face-to-face and contained questions on participants' socio-demographic information, most recent sexual experiences, experience of intimate partner violence, experience with HIV and SRH programmes, mental health, masculinity norms, and stigma among others.

Key informant interviews:

Semi-structured interviews were conducted with six individuals, and focused on the provision of clinical and non-clinical services in accordance to the global package for men and boys, challenges and successes of serving adolescent boys and young men, the use of evidence-based approaches, guidelines and innovations to inform programme interventions and approaches, and the impact of COVID-19 on services and programmes on SRH. Four policymakers were interviewed to understand the current SRHR policy context, the use of data to inform policy, budgeting implications, innovations and challenges around scaling up approaches for adolescent boys and young men.

Focus group discussion:

Five focus group discussions were conducted each with 5–10 adolescent boys and young men. They were facilitated by two researchers. Questions focused on social norms and expectations of being a man, participants' experiences with sexuality education, and SRH services and programmes, and the contextual challenges (including the impact of COVID-19) that supported or hindered participants (or their peers) to meet their own needs and the needs of their partner in SRH and to be a 'change agent' on SRHR in their community.

Key Findings:

Sample characteristics:

The median age for the sample of adolescent boys and young men in Uganda was 27 years old, less than half had completed secondary schooling (46.3 per cent). Approximately half the sample was rural based (49.8 per cent). Just over half (52.2 per cent) of the households had sufficient food in the previous 12 months.

Men as clients:

Most adolescent boys and young men had access to HIV testing and counselling services (99.5 per cent), male circumcision services (95.6 per cent) and STI testing services (95.6 per cent) in their community. Very few adolescent boys and young men indicated they had access to information and counselling on sexual dysfunction (7.9 per cent) and sexual myths and cultural barriers to SRH in their community (12.8 per cent). Just over one fifth (21.2 per cent) indicated they have access to vasectomy services in their community and just over one third (36.5 per cent) had access to information and counselling and treatment for cancer of the male reproductive organs available in their community.

Men as partners:

Just over one third of adolescent boys and young men indicated they would support their partner to access HIV services (39.4 per cent), while more than half (54.2 per cent) of the adolescent boys and young men would support their partner to access pregnancy services. Approximately two thirds (66.5 per cent) indicated they would support their partner to access safe abortion services.

Men as change agents:

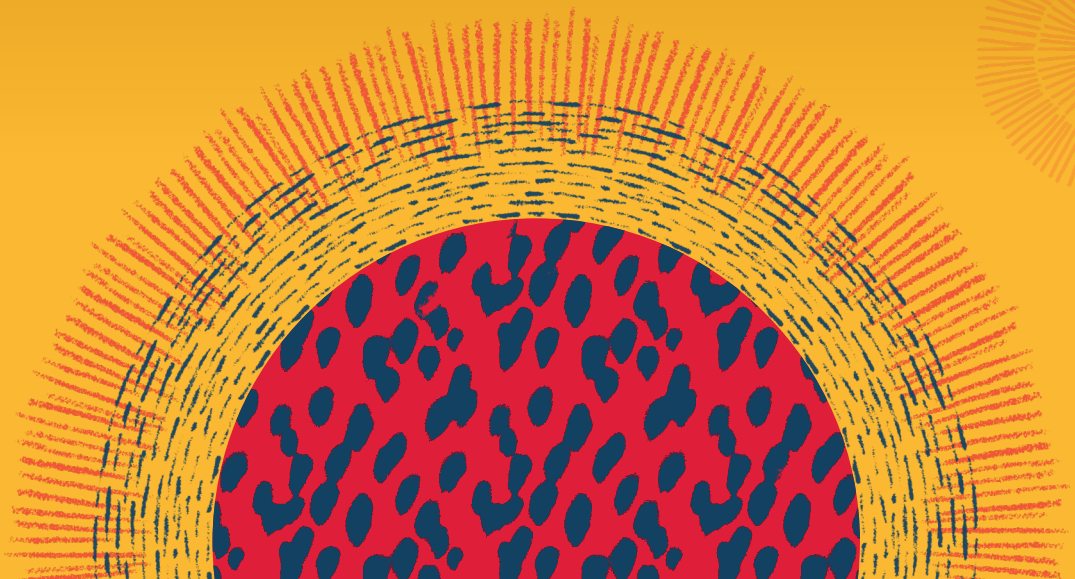
A minority (5.9 per cent) of adolescent boys and young men were involved in a health-focused non-governmental organization (NGO) in their community.

Psychosocial characteristics:

A minority (15.9 per cent) of adolescent boys and young men indicated they had perpetrated at least one form of intimate partner violence. The median gender equitable scale score is 32 (range: 25-45), where a higher score means more equitable scores. The vast majority (77 per cent) of adolescent boys and young men agreed with the statement that most people with HIV are supported by their families when they disclose their HIV status. A minority (2 per cent) indicated they felt sad all of the time (5-7 days per week) in the previous month and 1 per cent per cent felt lonely all of the time in the previous month. A minority (11.9 per cent) of adolescent boys and young men also indicated they occasionally felt lonely (3-4 days per week) in the previous month. Nearly half (47.8 per cent) indicated they occasionally (3-4 days per week) felt hopeful about the future in the previous month.

Table 1: Indicators from the quantitative survey for adolescent boys and young men in Uganda, 2023 (N=200)

Men as clients:	Median/ %
Per cent indicating HIV testing and counselling available in community	99.5
Per cent indicating voluntary medical male circumcision is available in community	95.6
Per cent indicating STI testing is available in community	95.6
Per cent indicating information and counselling on sexual dysfunction available in community	7.9
Per cent indicating information and counselling on sexual myths and cultural barriers available	12.8
Per cent indicating vasectomy services are available	21.2
Per cent indicating information, counselling and treatment for male cancers of the reproductive organs available	36.5
Men as partners:	
Per cent indicating they would support partner to access HIV services	39.4
Per cent indicating they would support partner to access pregnancy services	54.2
Per cent indicating they would support partner to access a medically safe abortion	66.5
Men as change agents:	
Per cent indicating they were involved in health-focused NGO	5.9
Psychosocial characteristics	
Per cent perpetrated intimate partner violence	23.4
Median score on Gender Equitable Men Scale (Range)	32 (20-42)
Per cent agree that most people are supported by their families when they disclose their HIV status	60
Per cent of respondents that felt sad all the time (5-7 days per week) in the previous month	1.5
Per cent of respondents that felt lonely all the time (5-7 days per week) in the previous month	1.0
Per cent indicated they occasionally felt lonely (3-4 days per week) in the previous month	11.9
Per cent indicated they occasionally felt hopeful about future (3-4 day per week) in the previous month	47.8



Key Findings from the policy review

The health policy environment in Uganda is attentive to the SRH needs of men across the life span and contains a number of key documents that can be marked as exemplary in East and Southern Africa.

Highlights of key policies where men and boys are addressed:

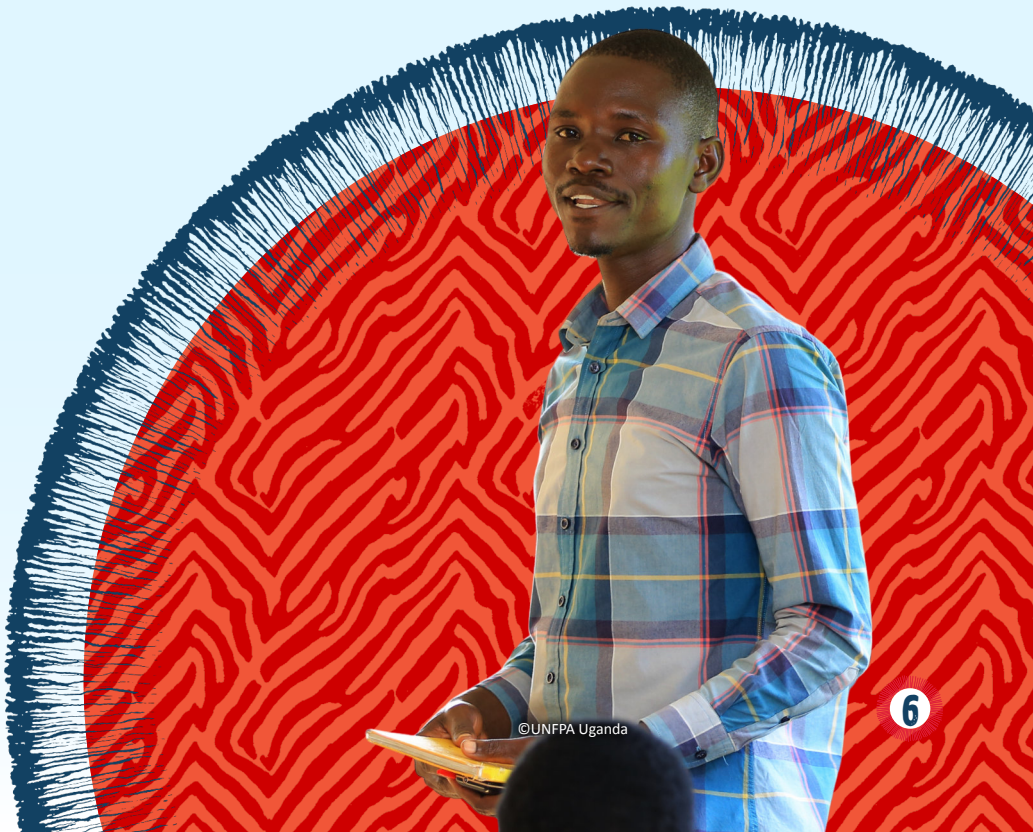
• **The male involvement strategy and male involvement guidelines for service delivery (2019) outline the roles and responsibilities of men and boys in SRHR**, including HIV/TB prevention, care and support. This includes responsible decision-making to realize their own full potential in SRHR, and an active participation in the health and well-being, as well as respect for the rights of their partners and children. **An important component of the strategy is the establishment of MAGs in each community who are expected to spearhead the development of a local workplan for engaging and equipping men to become SRHR change agents in their family and community.**

• **The SRHR Policy (2022 – still to be approved). The policy, underpinned by a rights-based approach, covers almost all elements from the global SRH service package for men and adolescent boys, including the often-neglected services for sexual dysfunction and infertility,** but excluding the male support role in abortion care. In the previous policy (2006), there was mention of the provision of advice and services for terminating a pregnancy or managing complications arising from an abortion to couples in need of such services (p. 45).

• **The revised guidelines for prevention and management of pregnancy in school settings (2020)** have a dedicated section on the expectant father, whereby the boy is expected to take part in childcare after his child is born and is provided with psychosocial support.

• **The Policy on Adolescent Health (2021)** which acknowledges that adolescents are a heterogenous group with different needs for health information, education and services but provides no further guidance on this aspect. This implies that the actual assessment and responsiveness to adolescent health needs across gender, age and other determinants, exclusively relies on the quality of client-provider interaction.

Other gaps noted include the limited evidence base on male-related SRH problems to underpin policy priorities, including an absence of programme evaluation data informing the male involvement strategy.It was also observed that there is limited alignment between male priorities set in different health-related policies, for example, to address violence perpetrated against boys and young men in juvenile detention centres/prisons and the provision of voluntary medical male circumcision, which may compromise policy action in specific areas of male SRH. Most of the reviewed policies, including the comprehensive sexuality education curriculum, are silent on the SRH needs of men who have sex with men and men with trans or non-binary identities. Only HIV and AIDS strategies and guidelines make reference to them.



Addressing male health-seeking barriers and service gaps:

Multiple barriers impede the uptake of SRH services by men and boys in Uganda. Focus groups revealed a lack of information about which services are available and where, particularly among adolescent boys, and community programmes directly targeting them. **According to informants, STIs were one of their most pressing SRH needs.** Yet there was an understanding that health facilities were unable to largely bring this group into care and prevent further transmission. Furthermore, there was little room within the current HIV/STI programmatic focus to meet the needs of boys for information on sexual maturation, and **one recurrent topic in both the focus groups and interviews was the apparent practice of older women grooming boys with hardly any experience in a sexual relationship.**

Gender role expectations formed an important barrier in timely health-care seeking among men. Many informants referred to a combination of the male breadwinner role, and strong masculine role whereby **health-seeking is regarded as time consuming and a sign of weakness**. The lack of a male health worker and/or proper space for men to raise their issues or accept a physical exam in (mostly public) health facilities were raised as disabling factors of male service utilization.

There were also multiple experiences with under-the-table payments, where health workers took advantage of the young men's urgency to obtain medical attention. Some participants also drew into question the reliability of test results and the efficacy of drugs provided in the public sector. Moreover, persistent drug shortages generally dissuaded male clients to consider these facilities as their first port of call and instead put their reliance on alternative providers, such as traditional healers, private pharmacists or trusted relatives with knowledge of herbal medicine.

Little patience with the health system, coupled with a persistent belief that pregnancies are women's business, was found to keep men from actively engaging as partners in pregnancy care. Interviewed clinical staff labelled it as ignorance ("men do not know their role in reproductive health matters") but in a focus group with boda-boda drivers, men admitted being aware of their responsibilities. However, the urgency to earn money and perception that health facilities would keenly let you wait served as arguments to easily discharge oneself from the male partner role.

> ***Me, I don't have to go, even if I know it's my responsibility. The main thing is to give her money and go to the hospital [to drop her off]. You know us men, you have to rush for work, but they will keep you waiting at the government health faciliy if you happen to escort her.***
>
> *-Uganda, Focus groups, participant 6.*

Sensitivities on issues emerged on the subject of homosexuality and around the long-awaited SRHR policy. Focus groups were largely dismissive of boys or men with same-sex sexual attraction, however, controversies seemed to be more extensive than this. Interviewed facility staff indicated that their work had become more challenging with all the negative attention around SRH services in the country.

Promising practices

The assessment found the following as promising practices for engaging men and boys in Uganda:

• **The strategic documents on male involvement, and the practice of MAGs** are of wider interest to the region. Efforts to roll out the strategy include capacity strengthening of health workers at project-supported health-care facilities, health worker supervision to ensure services are male-friendly and non-discriminatory, health education talks at facilities to increase male involvement, and improvements in data collection using a register for male involvement.

• **There is an incentive for a health check for men who escort their spouse to antenatal care.** Unfortunately, a funding shortfall has affected the implementation of the strategy and thus best practices need to be solicited from specific places where donor-level support was made available, such as in Namayingo, Gulu, Amudat and Kampala. This was not within the scope of this assessment but recommended as a next step.

It will be particularly interesting to see if the presence of MAGs has successfully influenced men to expand their involvement in SRHR. Traditionally, men's participation has focused on supporting their spouse and child. However, the goal is to see if MAGs have encouraged men to also recognize the benefits of engaging in SRHR for their own education and service needs. A recent publication on the MAGs provided a series of recommendations to improve the functionality of the MAGs, including linking them to the Women Action Groups, which seem to be more firmly embedded in Ugandan communities[4].

Key recommendations:

The following recommendations are informed by the rapid assessment, the policy review as well as the validation meeting:

• Support the Ministry of Health to develop a costed implementation plan for the national strategy for male involvement.

• Develop an essential benefits package, seamlessly integrated into the male engagement plan.

• Support the revision of the monitoring and evaluation frameworks to effectively measure the pillar of men as clients was deemed pivotal.

• Develop a scoping report to map programmes addressing gender and social norms for boys and men, conduct a baseline survey to identify and measure harmful gender and social norms, and scale up change agents in more districts to address gender and social norms effectively.

[4] Mwije, S. (2018). Men and maternal health: The dilemma of short-lived male involvement strategies in Uganda. Health Care for Women International, 39(11), 1221-1233.

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