



IMPROVING MALE INVOLVEMENT TO  
SUPPORT ELIMINATION OF MOTHER-  
TO-CHILD TRANSMISSION OF HIV IN  
UGANDA: A CASE STUDY

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# Introduction

There is widespread recognition that involving men in maternal and child health services offers important benefits. Numerous studies have demonstrated that male involvement can have a positive impact on the utilization of services such as antenatal care (ANC), facility-based delivery, HIV testing, and prevention of mother-to-child transmission of HIV (PMTCT).<sup>1-4</sup>

This case study is intended for programme managers and health professionals interested in learning about male involvement in the context of PMTCT programmes. It reviews a multi-faceted intervention launched by the *Optimizing HIV Treatment Access for Pregnant and Breastfeeding Women (OHTA)* to increase male involvement in three regions

in Uganda (East Central, North East, and South West); encompassing policy change through service delivery. By implementing both community and facility-based activities focused on strengthening male involvement as part of a comprehensive PMTCT strategy, the programme aims to strengthen support for male participation in antenatal care (ANC), HIV testing, and HIV treatment.

Led by UNICEF and funded by Sweden and Norway, the OHTA Initiative works in collaboration with the National Government, EGPAF, Mothers2Mothers, CUAAM and Baylor Uganda. For more information about the OHTA Initiative, visit <http://childrenandaids.org/partnership/optimizing-hiv-treatment-access>



Map of OHTA-supported regions in Uganda

# Background

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The 1994 Cairo Conference on Population and Development urged that *efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning...[and] maternal and child health.*

Today—over 20 years after the Cairo Conference—the importance of gender in maternal and child health is widely acknowledged, however in many settings male involvement remains weak. Programmes continue to focus primarily on women, despite the fact that men can play a critical role in women's access, uptake and continuation of services. In many cultures, especially in sub-Saharan Africa, men are the primary household decision makers and studies have shown that reproductive health decisions are often influenced by male partners.<sup>5-6</sup>

In Uganda, male involvement in PMTCT has been limited and many pregnant women attend maternal health services unaccompanied and unsupported by their partners. A 2010 study found that among 388 men whose spouses were attending antenatal care at Mbale

Regional Referral Hospital in Eastern Uganda, only 5 per cent accompanied their spouses to the antenatal clinic. The study revealed that barriers to male involvement were related to lack of male-friendly services, socio-economic factors and cultural beliefs.<sup>7</sup> Although Uganda has made significant progress towards the goal of eliminating mother-to-child transmission of HIV, the final push towards zero will require intensified efforts of proven strategies, such as increasing male involvement.

A recent review commissioned by UNICEF and supported by the Governments of Sweden and Norway concluded that there is strong evidence that male involvement improves health care use and outcomes for PMTCT and that adding community-level strategies to engage men may have a greater impact than pursuing facility-based strategies alone.<sup>8</sup> Similarly, a position paper issued by the World Health Organization (WHO) concluded that there is evidence of significant health benefits of male participation in HIV Counselling and Testing (HTC), ANC and PMTCT.<sup>9</sup> Strengthening male involvement can also yield benefits to their own health by providing opportunities to address their health needs.

# The Initiative

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The process involved four stages:

1. Launch of a National Male Involvement Strategy to lay the policy groundwork to support male involvement initiatives,
2. Focus group discussions to better understand cultural and other contextual factors that impact male involvement in these settings
3. Implementation of male involvement strategies
4. Monitoring of activities to assess progress and make program adjustments

## Stage 1: Launch of the National Male Involvement Strategy

In November 2014, the Government of Uganda launched a National Strategy for Male Involvement in Child Health, Sexual and Reproductive Health Rights (SRHR), including HIV/AIDS. The strategy development was led by the Ministry of Health and involved a number of partners: the Ministry of Gender; Labor and Social Development; the Ministry of Education; local NGOs; the National Youth Council; UN Agencies; development aid agencies and academic institutions.

The National Strategy provides a policy framework and guidance in the following areas:

- **Capacity building and supportive supervision** for delivery of quality male-friendly services
- **Coordination, networking and partnerships** for promoting male involvement
- **Research and documentation** of male involvement and participation programmes and lessons learned
- **Monitoring and evaluation** of male-friendly health services
- **Communication and community engagement** for male involvement
- **Leadership and accountability** at all levels

Following the launch of the Strategy, the OHTA Initiative facilitated a series of workshops in eight districts in the South West region to disseminate the strategy. Workshop participants included health managers, district government officials, civil society, and opinion and religious leaders.

## Stage 2: Dialogue and focus group discussions

Although general social, cultural and structural barriers to male involvement have been widely documented, local barriers to male involvement in this specific context were not well known. In an effort to strengthen the collective understanding of these barriers—and to better target interventions—OHTA implementing partners conducted focus group discussions with local leaders, community members and community health cadres in

select districts. The discussions probed attitudes and socio-cultural beliefs regarding male involvement in RMNCH and PMTCT

services, with the aim of better understanding and addressing specific barriers. Findings from these discussions are summarized in Table 1.

**TABLE 1:** Findings of focus group discussions in select OHTA-supported districts, Uganda

Barrier	Findings from focus group discussions
<b>Clinic Factors</b>	
Long wait times	Long wait times at health facilities were viewed as a waste of time. Men felt “redundant and bored” while they waited for their partners
Attitudes of health care providers	Men believed health care workers have negative attitudes towards men who accompany their spouses
Lack of services for men	There were no male-specific services offered at MNCH units at health facilities
<b>Community Factors</b>	
Gender norms	Prevailing gender norms consider pregnancy to be a woman’s affair
Stigma	Men feared that their peers would consider them to be “weak” or “bewitched” if they accompany their partners to clinic visits
<b>Individual Factors</b>	
Lack of knowledge	Men expressed limited knowledge about PMTCT and MNCH services and why it is important that they attend these services with their partners
Financial constraints	Transport costs are more difficult to cover for two family members (couple)
Lack of time	Men felt they had little time to attend antenatal clinics, due to jobs and other factors
Attitudes of health care providers	Men believed health care workers have negative attitudes towards men who accompany their spouses

### Stage 3: Design and introduce Male Involvement strategies

In response to the barriers emerging from the focus group discussions, OHTA implementing

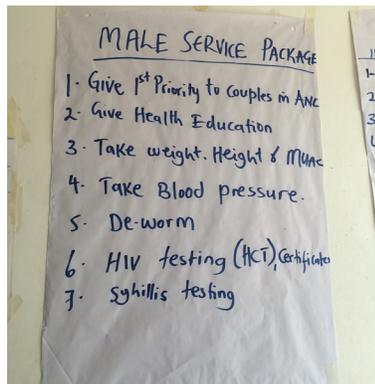
partners worked with local health structures and communities to design and introduce a comprehensive package of male involvement strategies in 43 facilities (see Table 2)

**TABLE 2:** Strategies to increase male involvement in PMTCT in select OHTA-supported sites, Uganda

<b>MNCH Settings</b>	<ol style="list-style-type: none"> <li>1. Male health service package offered at facilities</li> <li>2. Extended ANC clinic hours and services provided on weekends</li> <li>3. ANC days scheduled to coincide with Market Day</li> <li>4. Prioritization for couples</li> <li>5. Dedicated male/family support groups for PLWH</li> </ol>
<b>Community Level</b>	<ol style="list-style-type: none"> <li>6. Collaboration with community leaders</li> <li>7. Use of existing community health worker cadres</li> <li>8. Male champions/motivators and male action groups</li> </ol>

### Intervention 1: Male health service package

During the focus group discussions, community stakeholders emphasized the importance of engaging men at health facilities so that they



Services offered at a facility in Ibanda district, SW Uganda

feel the visit was a good use of their time. In response, EGPAF developed a male service package offering free health screenings for men during ANC visits, including HIV and STI screening; deworming; blood pressure and blood sugar evaluation; and general medical exams.

OHTA project staff and district trainers conducted quarterly mentoring visits for staff at facilities introducing the package using a standardized mentoring tool.

Program data shows that sites that implemented the male health service package saw couple testing rates increase from 12 per cent in 2013, to 16 per cent in 2014 and 20 per cent in 2015.

### Intervention 2: Facility hours

The focus group discussions revealed that typical ANC clinic schedules can be a barrier for men. Due to work demands, men may have difficulty accessing services during traditional clinic hours on weekdays. To address this, 96 OHTA-supported facilities have shifted or extended antenatal clinic hours, or modified client flow to facilitate easier and faster access for men.

### Intervention 3: ANC Days

Focus group discussions also revealed that scheduling ANC days to coincide with events that are of interest to men, such as market days, can promote male involvement and help rationalize household transportation expenditures.

Some facilities in the cattle-herding region of North East Uganda have synchronized ANC days with trading times in local livestock markets to increase convenience for men.

### Intervention 4: Prioritization for couples at clinics

An initial strategy involved prioritizing couples at the clinic. In 2014, a national health facility survey commissioned by OHTA found that 86 per cent of surveyed facilities prioritize women who present for antenatal care with their partners by attending to them first in the queue.<sup>10</sup> While facility staff believe this has increased antenatal attendance and HCT of couples, there have also been unintended consequences. For example, it was noted that some women bring men other than their partners, including; “paying boda boda (local motorbike taxi) drivers small sums of money to act as male partners” (Health worker).

“Men have responded positively to this innovation and women use this as a tool for convincing their male partners to attend.”

OHTA Implementing Partner

“The first thing men do is to move with their women to the health unit, have their antenatal care together, after which the men can go away doing their own things. They have been involved they have been tested they have been talked to and then also there are some male champions in the markets”

OHTA Implementing Partner

While this strategy aims to incentivize couple attendance by reducing waiting times, it unintentionally penalizes women who are unable or unwilling to come accompanied by their partners; such as those who are single or at risk of domestic violence. Therefore, it may be necessary to reconsider this approach.

#### **Intervention 5: Family Support Groups**

Family Support Groups (FSGs) are a national strategy to help families affected by HIV/AIDS in Uganda utilize services such as PMTCT. FSGs recognize the family as a unit where all members are collectively responsible for each other's health. Led by midwives and peer educators, FSGs meet monthly at health facilities and women are encouraged to include their partners. FSGs also include male champions or male expert clients who encourage other men to remain involved and active in the care of their partners and children. There are 90 healthcare facilities with active FSGs in 21 districts of the Southwest region. OHTA is integrating the male service package into the FSGs, targeting the men that participate in the groups.

#### **Intervention 6: Collaboration with community leaders**

Lack of knowledge of PMTCT, fear of learning one's HIV status, and the perception that pregnancy is a woman's affair are commonly cited barriers to male involvement in PMTCT. *“Some men literally do not understand why they should be attending health care services with their spouses. One mentioned “She is pregnant, I am not! What do you want me at the facility for?”* (Implementing Partner correspondence). Community dialogue and sensitization meetings are an effective means of changing attitudes and raising awareness of the importance of male involvement. Under the OHTA Initiative, sensitization sessions are conducted in facilities and in community settings, such as market places and community gatherings points. Sessions are most successful when community leaders and influential figures are actively involved in mobilizing and encouraging behaviour change.

In nomadic communities in North East Uganda, District Health Teams (DHTs) are working to engage local leaders with support from implementing partners: *“We try to get the kraal leaders because in those communities the elders are listened to. This is one of the way(s) through which one can penetrate into these communities”* (Implementing Partner). Religious leaders also yield significant influence: *“these communities listen so much to the spiritual leaders”* (Implementing Partner).

#### **Intervention 7: Collaboration with community cadres**

Across OHTA-supported settings, Village Health Teams (VHTs) and other peer support

cadres such as community-based mentor mothers and expert clients have been trained to address misconceptions and encourage male involvement in health education sessions at household and community levels. Strategies to prepare men to engage in discussions with peers and raise awareness in their communities are included in both the pre-service training curriculum for mentor mothers and the orientation package for VHTs. Couples are more likely to interact with mentor mothers and VHTs at the community-level than at the facility-level, underscoring the importance of household-level outreach services to reach men.

#### **Intervention 8: Use of Male Champions**

Male Champions are a cadre of peer educators formed and supported by the Ministry of Health, dedicated to promoting male involvement. OHTA funding has sustained this initiative in the South West region, where 385 male champions received a four-day training on community sensitization. As part of the training, participants are taught how to conduct large community dialogue meetings, which they hold quarterly. They are also trained to lead health education talks at the facilities twice a week, using customized job aides with appropriate male engagement messages. Though volunteers, the male champions are provided with bicycles to access the approximately 800 households they cover and manuals to facilitate discussions about nutrition, ANC and birth planning.

When organized and supported effectively, this strategy has proven successful and well accepted by the community. In South West Uganda, most of the selected champions also served as VHTs, and continue to play

the VHT role, whilst integrating the male champion role into their work. This will ensure their continued activity as male champions, even without funding. In the East Central region, where OHTA discontinued the strategy due to competing demands, former male champions *“formed groups as resource persons in their respective communities who continue to sensitize and refer men and their wives to health facilities for services.”* (Implementing Partner correspondence)

#### **Stage 4: Assess progress**

Shifts in attitudes and behaviours are complex and assessing the progress of male involvement in PMTCT is difficult to measure. Couple testing rates are often used as an indicator of male involvement in antenatal care. In the OHTA supported Karamoja sub-region in Northeastern Uganda, couple testing rates doubled from 30 per cent in 2013 to 60 per cent in 2015. The Moroto district in particular, showed significant improvement with couple testing rates increasing over 15-fold—from 5 per cent to 77 per cent during the same period. In South West Uganda, the OHTA-supported Mparo Health Centre IV increased couple testing from 13 per cent in early 2014 when the interventions began to 97 per cent one year later.

Success is attributed to the synergistic effect of male involvement strategies; active, early VHT outreach at community and household-levels and early referral to antenatal care. Whereas in other facilities, only after women come to antenatal care are follow-up actions taken to encourage partner participation, in the community around Mparo health clinic, VHTs refer couples to antenatal

care as soon as pregnancy is evident.

Male Involvement is not restricted to participation in antenatal care; it also involves informal care provided to their partners and support for continued participation in maternal and child health services. While it is difficult to attribute changes in health care utilization to male involvement strategies alone, the strategies influence both utilization and continuity of care. Facilities in South West

Uganda have shown measurable improvement in attendance of four or more antenatal care visits, increasing from 62 per cent to 88 per cent of pregnant women in facilities that implement focused antenatal care and male service packages. OHTA implementing partners in the region suspect this is an indication of successful shifts in attitudes in partner support for health care and increased male participation in their partner's health.

## Lessons Learned

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- Cultural beliefs may be difficult to change and typically do not change quickly.
- Outcomes of male involvement strategies may not be observed immediately. Male involvement programs should consider a long-term time timeline for changes in outcomes, continuously adapting based on feedback.
- Community engagement and mobilization is critical to the success of any male involvement strategy.
- Commitment and involvement of key political and religious leaders and other persons of influence in communities is critical to the success of male involvement.
- Male involvement should be one strategy in a package of interventions to improve results.
- Using couple HIV testing rates alone as an indicator of male involvement may overlook more nuanced shifts in attitudes and behaviours. Other indicators that represent improved utilization and continuity of care should also be monitored to assess changes in care seeking.
- When evaluating male involvement strategies, it is important to assess unintended consequences.

# Conclusion

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The adoption of a national male involvement strategy in Uganda provided the strategic direction to enhance male involvement in RMNCH/eMTCT interventions. Shifting cultural attitudes and beliefs takes time, and requires the development of culturally sensitive and informed strategies at both facility and community-levels. While challenges remain, there is now an increasing awareness of the importance of male involvement through

community sensitization and mobilization across regions. Male involvement in RMNCH in Uganda has been facilitated through the provision of male service packages; changing clinic hours; peer support and male champions; collaboration with community leaders and better engagement of community health cadres. Further implementation research and evaluation are needed to better understand the most effective strategies and conditions.



# References

1. Aluisio, A., Richardson, B. A., Bosire, R., John-Stewart, G., Mbori-Ngacha, D., & Farquhar, C. (2011). Male antenatal attendance and HIV testing are associated with decreased infant HIV infection and increased HIV free survival. *Journal of acquired immune deficiency syndromes*, 56(1), 76.
2. Brusamento, S., Ghanotakis, E., Tudor Car, L., van-Velthoven, M. H., Majeed, A., & Car, J. (2012). Male involvement for increasing the effectiveness of prevention of mother-to-child HIV transmission (PMTCT) programmes. *The Cochrane Library*.
3. Reece, M., Hollub, A., Nangami, M., & Lane, K. (2010). Assessing male spousal engagement with prevention of mother-to-child transmission (pMTCT) programs in western Kenya. *AIDS care*, 22(6), 743-750.
4. Peltzer, K., Jones, D., Weiss, S. M., & Shikwane, E. (2011). Promoting male involvement to improve PMTCT uptake and reduce antenatal HIV infection: a cluster randomized controlled trial protocol. *BMC public health*, 11(1), 778.
5. Morfaw, F., Mbuagbaw, L., Thabane, L., Rodrigues, C., Wunderlich, A. P., Nana, P., & Kunda, J. (2013). Male involvement in prevention programs of mother to child transmission of HIV: a systematic review to identify barriers and facilitators. *Syst Rev*, 2(5).
6. Dudgeon, M. R., & Inhorn, M. C. (2004). Men's influences on women's reproductive health: medical anthropological perspectives. *Social science & medicine*, 59(7), 1379-1395.
7. Byamugisha, R., Tumwine, J. K., Semiyaga, N., & Tylleskär, T. (2010). Research Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: a cross-sectional survey. *Reproduc Health*, 7, 12.
8. Gulaid, L. Community-Facility linkages to support the scale up of lifelong treatment for pregnant and breastfeeding women living with HIV: A conceptual framework, compendium of promising practices and key operational considerations. UNICEF. June 2016.
9. Ramirez-Ferrero, Eric, Male Involvement in the Prevention of Mother-To-Child Transmission of HIV. World Health Organization, 2012. [www.who.int/reproductivehealth/publications/rtis/9789241503679/en](http://www.who.int/reproductivehealth/publications/rtis/9789241503679/en), accessed 31 October 2014
10. UNICEF, ICAP, Uganda Ministry of Health. (2014) Optimizing HIV Treatment Access for Pregnant & Breastfeeding Women: Uganda Assessment Findings. New York.

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