JAS Programme

Joint Advocacy for Sexual Reproductive Health and Rights in Uganda

NATIONAL STUDY ON MEN, MASCULINITIES AND THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) REALISATION IN UGANDA

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CEHURD
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CONTENTS

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ACHPR African	Charter on Human and Peoples' Rights
ANC	Antenatal Care
CAO	Chief Administrative Officer
CDO	Community Development Officer
CEHURD	Centre for Health, Human Rights and Development
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
CBO	Community Based Organizations
CJ	Chief Justice
CSOs	Civil Society Organisations
CRC	Convention on the Rights of the Child
DHO	District Health Officer
DRC	Democratic Republic of Congo
FGDs	Focus Group Discussions
FP	Family Planning
GBV	Gender Based Violence
GCACI	Global Comprehensive Abortion Care Initiative
GWED- G	Gulu Women Economic Development and Globalization
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICESCR	International Covenant on Economic Social and Cultural Rights
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Device
IMR	Infant Mortality Rate
JAS	Joint Advocacy Program
JCC	Justice of the Constitutional Court
JSC	Justice of the Supreme Court
KII	Key Informant Interviews
LC	Local Council
LRA	Lord's Resistance Army
MOH	Ministry of Health
MGLSD	Ministry of Gender, Labour and Social Development
NGO	Non-Government Organisations
PWDs	People with Disabilities.
RHU	Reproductive Health Uganda
ROU	Republic of Uganda
SDGs	Sustainable Development Goals
STIs	Sexually Transmitted Infections
SRHR	Sexual Reproductive Health Rights
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
VHTs	Village Health Teams
VSLA	Savings and Loans Association
WHO	World Health Organisation

1.0 Introduction

Center for Health, Human Rights and Development (CEHURD), is a not-for-profit research and advocacy organisation founded in 2007 with a strategic focus on promotion of health and human rights and social justice interests of populations in Uganda and in the East African region. CEHURD's particular mission is to advance rights of vulnerable communities through an integrated programme of litigation, advocacy and action research. Under its Joint advocacy programme for Sexual Reproductive Health and Rights (JAS Programme), CEHURD commissioned a national study on masculinities and SRHR to inform its long-term focus on building a progressive social movement that boldly challenges deep-seated social structures that affect realisation of Sexual Reproductive Health Rights (SRHRs). Notably, masculinities – conceived in this study as "social practices and cultural representations associated with being a man" (Pilcher & Whelehan, 2004), are understood to influence policy and planning, availability, accessibility acceptability, and quality (AAAQ) of health services generally and SRHR services in particular.

1.1 Background to Sexual and Reproductive Health and Rights in Uganda and beyond

During the past few decades, a rights-based approach to sexual and reproductive health has evolved globally, on the African content and locally. Scholars such as Ahlberg and Kulane (2011: 313) argue that "[the] rights approach stipulates that as individuals we have the right to the highest attainable standard of health, including the right to life and survival, the right to control our sexual and reproductive life, and the right to make reproductive decisions, including the number and spacing of our children, without interference or coercion". The rights-based approach is rooted in the Universal Declaration of Human Rights (UDHR), in particular, the idea that every individual is born with, and possesses the same rights regardless of the differences in gender, age, sexual orientation, social cultural identity and any other difference. However, it is notable that women and men cannot realise their SRHR without also realising broader human rights because rights are inherently indivisible, interdependent and interrelated (Vienna Declaration and Programme of Action, 1993). In effect, realisation of SRHR requires broader conversations with individuals who claim the rights but also duty bearers, development actors and rights activists to ensure that every individual is afforded an opportunity to make rights claims, access and utilize SRHR services and human rights broadly.

In the table below, the report provides a brief history on the evolution of SRHR, the policy and legal innovations and the gendered conversations globally, in Africa and Uganda in particular.

Year	International legal framework	Focus on women/men
1948	The rights approach to SRHR rooted in post second world war human rights debate e.g. the 1948 Universal Declaration of Human Rights (UDHR)	The UDHR, which adopts a universal and indivisible approach to human rights, focused on men at the time. However, the norms therein apply to both women and men. It places civil, economic, social and cultural rights at the same of level. In the context of SRHRs, the UDHR addresses such rights as right to life (article 3); freedom from torture, cruel or inhuman treatment (article 5); equality before the law (article 8); family rights (article 16); property rights (article 17); right to an adequate standard of living, including health care and special care and assistance to motherhood and childhood (article 25); right to education (article 26); right to participate in cultural life (article 27). It has been argued that norms in

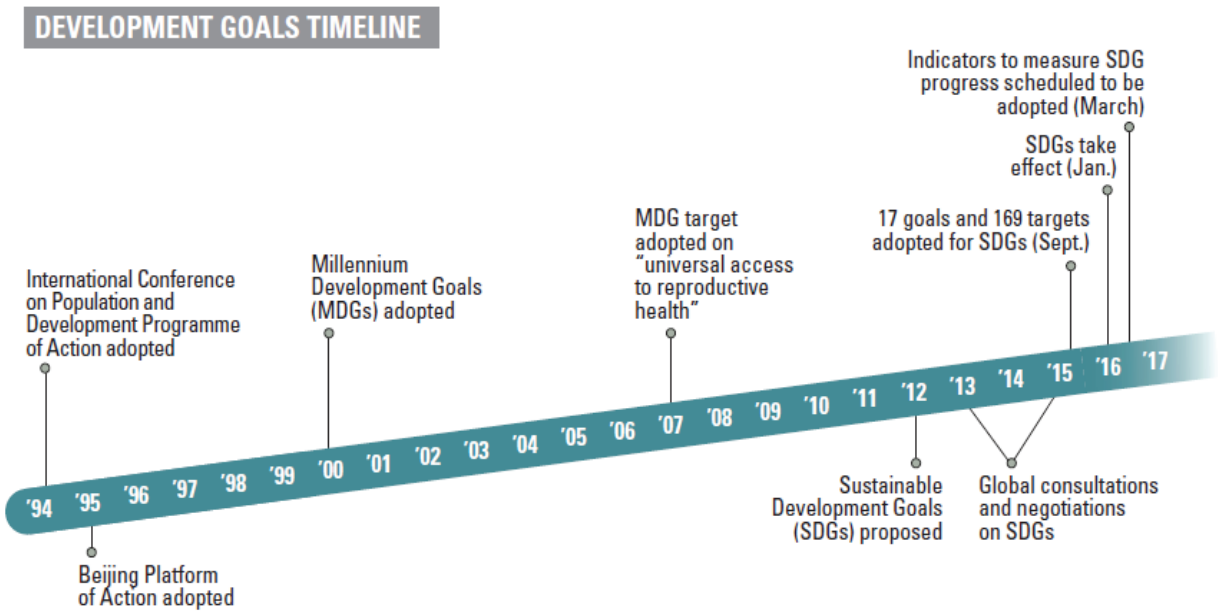
		the UDHR form part of customary international law, which is directly binding on states, including Uganda, without the onerous process of ratification and domestication (Twinomugisha, 2015).
1979	UN General Assembly adopted the Convention on Elimination of all forms of Discrimination against Women (CEDAW). The convention provides the basis for attaining gender equality by ensuring women's access to health care services, including those related to family planning.	Deliberate focus on discrimination against women in all its forms (article 2). CEDAW prohibits discrimination against women in the field of health care (article 12(1)) and enjoins states to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (article 12(2). States are also obliged to pay attention to the situation of rural women including their domestic and other work and ensure that such women, among other things, 'have access to adequate health care facilities, including information, counselling, and services in family planning' (article 14).
1993	The Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in Vienna ('the Declaration'), stressed that '[a]ll human rights are universal, indivisible and interdependent and interrelated' (para 5) and that the 'international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis' (para 5). The Declaration affirmed women's rights as human rights. This meant that women's rights should not be subordinated to cultural, religious traditions or other variables that undermine women's dignity.	The Declaration focuses on both women and men and underlines women's rights as human rights. The Declaration explicitly states: 'The human rights of women and the girl-child are an inalienable, integral and indivisible part of universal human rights' (para 18). The Declaration further called for 'full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels, and [ensuring that] the eradication of all forms of discrimination on grounds of sex are priority objectives of the international community' (para 18). The Declaration also called for elimination of gender-based violence, sexual harassment and exploitation (para 18).
1994	International Conference on Population and Development (ICPD), which marked a paradigm shift from a primary focus on population control to realization of human rights, including SRHRs created a comprehensive framework to realise SRHRs. ICPD+5 plan of Action called for deliberate male involvement – "men to	Focus on interests of women and men in SRHR. The ICPD emphasized the fundamental role of women's interests in population matters and introduced the concepts of sexual and reproductive health and reproductive rights. Reproductive health was defined as 'a state of complete physical. Mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to
1994	International Conference on Population and Development (ICPD), which marked a paradigm shift from a primary focus on population control to realization of human rights, including SRHRs created a comprehensive framework to realise SRHRs. ICPD+5 plan of Action called for deliberate male involvement – "men to support, promote and respect women's sexual and reproductive health and reproductive rights, recognizing the inherent dignity of all human beings. Men should take responsibility for their own reproductive	Focus on interests of women and men in SRHR. The ICPD emphasized the fundamental role of women's interests in population matters and introduced the concepts of sexual and reproductive health and reproductive rights. Reproductive health was defined as 'a state of complete physical. Mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes' (para 7.2). That reproductive health 'implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last definition are the right

	and sexual behaviour and health. Research should be undertaken on men's sexuality, their masculinity and their reproductive behaviour"(UNFPA, n.d.)	of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a health infant' (para 7.2). Reproductive health care was defined as 'the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases' (para 7.2). Reproductive rights cover various human rights that are recognised in international human rights instruments and include 'the basic right of couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the means to do so, and the right to attain the highest standard of sexual and reproductive health' (para 7.3).
1995	Fourth World conference on women in Beijing built on the UDHR, CEDAW,the ICPD and other international instruments and consensus documents to confirm the nexus between women's reproductive health and human rights. Like the Vienna Declaration on Human Rights, the Beijing Declaration and Platform of Action also emphasized that women's rights are human rights (para 14).	Deliberate focus on women and women's rights as human rights. Unlike the previous legal initiatives, the fourth world conference and its outcome – the Beijing Declaration and platform for action - brought to the fore the realization that women share common concerns that can be addressed only by working together and in partnership with men towards the common goal of gender equality around the world. Acknowledging the need to pursue women's rights in "partnership" with men pointed to a newly discovered interest in men as an entry point for reflection on some of the basic tenets and tendencies of Gender and Development (GAD) in theory and practice (Cornwall, 2000). Cornwall points out that the emergence of Gender and Development approach was "peppered with the promise of a new focus, beyond the narrow concern of Women in Development (WID) with women alone. It came into being as an approach that sought to tackle women's subordination through an explicit emphasis on socially and historically constructed relations between women and men" (2000: 18)
2000	SRHR received a boost through the UN Millennium Development Goals (MDGs). Four of the 8 goals focused on promoting gender equality and women's empowerment; reducing child mortality; improving maternal health; combating HIV/Aids. All these ha a focus on reproductive health. 2000 General Comment No. 14 'The Right to the Highest Attainable Standard	Women and men have the right to health, including SRHRs. The state should take measures to 'improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well AS to resources necessary to act on that information' (para 14, General Comment No. 14). The state should ensure protection of women's right to health by devising and implementing measures 'aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to

	of Physical and Mental Health'. It provided an interpretation of article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which obliges states to take steps to ensure the realization of the highest attainable standard of physical and mental health. General Comment No. 14 developed the AAAQ analytical framework. States should ensure that health care facilities, goods and services are available (A), accessible (A), acceptable (A) and of good quality (Q). The facilities, goods and services should be available in sufficient quantities within the state (para 12(a)). Accessibility has four critical elements. Non-discrimination, that is, health facilities, goods and services, must be accessible to all without discrimination with particular focus on vulnerable and marginalized groups (para 12(b)(i)). Physical accessibility, that is, health care facilities, goods and services	a full range of high quality and affordable health care, including sexual and reproductive health services' (para 21, General Comment 14). The state has the obligation to respect, protect and fulfil the right to health, included SRHRs (paras 33-46). Although the state is allowed by human rights law to progressively realise the right to health, including SRHRs, it has minimum core obligations to ensure, among other things, provision of essential drugs and reproductive, maternal and child health care (para 43(d) and 44(a)).
2003	Protocol to the African Charter on Human and People's rights on the Rights of Women in Africa (Maputo Protocol) was adopted. The normative scope and content of SRHRs, which are guaranteed under article 14 of the Maputo Protocol have been elaborated upon by the African Commission on Human and Peoples' Rights (African Commission) in General Comment No. 2. The African Commission has observed that the 'rights to exercise control over one's fertility, to decide one's maternity, the number of children and the spacing of births, and to choose a contraception method are inextricably linked, interdependent and indivisible' (para 24). The African Commission stressed that laws, policies and practices that impede access to contraception/family planning violate the woman's right to life, non-discrimination and health (para 27). States should ensure women and men access to family planning education and information (para 28) and safe abortion services (para 42). The state should 'ensure availability, accessibility and acceptability of procedures, technologies and comprehensive and good quality services' in relation to family planning/contraception and safe abortion (paras 55-57).	The Maputo Protocol, which is the first treaty to focus on women in Africa, provides broader protection for the rights of women, including SRHRs (article 14). These include rights to exercise control over one's fertility, decide one's maternity, the number and spacing of births and choice of contraceptive methods (article 14(1)(a)-(c)); right to family planning education (article 14(1)(f)); right to adequate, affordable health services (article 14(2)(a)); right to safe abortion when pregnancy results from assault, rape or incest or when continuation of pregnancy endangers the life or the health of the pregnant woman (article 14(2)(c)). However, Uganda entered a reservation on article 14(2)(c), which means that the state is not bound to comply with it.

2015	Sustainable development Goals – Goal 3 on ensuring good health and wellbeing and goal 5 on Gender equality and women's empowerment are all linked to realisation of SRHR	The Sustainable development goals have an explicit focus on gender equality and empowerment of Women. The focus on men remains implicit.
2016	General Comment No. 22 on the Right to Sexual and Reproductive Health. The Committee on Economic, Social and Cultural Rights (CESCR) stated that the right to sexual and reproductive health is an integral part of the right to health (para 1) and is 'indivisible and interdependent with other human rights' (para 10). The state should ensure that sexual and reproductive health services are available, accessible, acceptable and of good quality (paras 12-21). The state also has on obligation to respect, protect and fulfil the right to sexual and reproductive health (paras 39-48). The state should repeal or eliminate laws, policies and practices that criminalize sexual and reproductive health services (para 49(a)). The state also should 'guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups' (para 49(c)). The state should also take measures to 'prevent unsafe abortions and to provide post-abortion care and counselling to those in need' (para 49(e)) and to 'provide medicines, equipment and technologies essential to sexual and reproductive health' (para 49(g)).	The SRHRs tackled by General Comment No. 22 and the Nairobi Statement include contraception/family planning; maternal health care; safe abortion care; freedom from sexual and gender-based violence; and access to sexual and reproductive health information.
2019	Nairobi Statement on ICPD25: Accelerating the Promise. States pledged achieve, among others, 'universal access to sexual and reproductive health and rights as part of universal health coverage' (para 1); zero preventable maternal deaths and maternal morbidities (para 3); access for all adolescents to comprehensive and age responsive education (para 4); addressing sexual and gender based violence (para 4).	

While analyzing SRHRs in the context of sustainable development goals, Alanna Galati (2015: 78) illustrates some of the above global frameworks on SRHR in the trajectory below.



Uganda has ratified a wide range of international and regional human rights treaties related to the enjoyment of the highest attainable standard of physical and mental health ('right to health'). These include the International Covenant on Economic, Social and Cultural Rights (ICESCR, article 12), the Convention on the Elimination of All forms of Discrimination against Women (CEDAW, article 12 and 14), the Convention on the Rights of the Child (CRC, article 24), the Convention on the Rights of Persons with Disabilities (CRPD, article 25); the African Charter on Human and Peoples' Rights (ACHPR, article 16); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol, article 14); the African Charter on the Rights and Welfare of the Child (article 14). These international conventions and legal frameworks matter because they are intended to drive the allocation of global financial and human resources, and to help direct nations' and donors' policy priorities. Indeed, these frameworks set the agenda for nation states, development actors, the donor community and civil society organisations on what ought to be done and how. Nation states ratify these frameworks and such commit to frame policies and actions that foster compliance to these global agendas.

In effect, Uganda has drawn upon some of these legal frameworks to inform its national policy and legal frameworks. Although the Constitution of the Republic of Uganda (Republic of Uganda, 1995) does not explicitly provide for the right to health in the Bill of Rights (chapter four), including SRHR, it contains provisions that have a bearing on SRHR. The state is obliged to ensure access to health services to the people (Objective XIV and XX). The Constitution also includes an inclusive clause (article 45), which in effect provides that the mere fact that some rights are not included in the Bill of Rights does not exclude their application in the country. Thus, it has been argued that the right to health, which is not expressly stated in chapter four, is by virtue of article 45 recognised and thus justiciable (Twinomugisha, 2020).

The justiciability of the right to health, including key components of SRHRs such as maternal health care, have been tested in Ugandan courts. In Centre for Health, Human Rights and Development & Others v. Attorney General (Constitutional Petition No. 16 of 2001), the petitioners petitioned the Constitutional Court seeking declarations to the effect that the non-provision of essential maternal health commodities in public health facilities and the unethical conduct and behaviour of health workers towards expectant mothers are inconsistent with the Constitution and a violation of the right to health and other related rights namely, women's human rights, the right to life, and freedom from torture, cruel, inhuman and degrading treatment.

The respondent Attorney General raised a preliminary objection that the matters before court raised a political question. According to the Attorney General, the petition required the court to make a judicial decision involving and affecting political questions. That in doing so, the court would in effect be interfering with the political discretion of other branches, namely, the executive and the legislature. She further contended that in order to determine the issues in the petition, the court has to call for a review of all the policies of the entire health sector and make findings on them, yet implementation of these policies is the sole preserve of the executive and the legislature. She prayed that the petition should be dismissed because the questions that informed it are not justiciable, that is, they are not capable of being decided by court. In reply, counsel for the petitioners argued that the preliminary objection was misconceived as the question to be determined was whether the acts and omissions are in contravention of the Constitution and not the determination of a political question.

The court agreed with the Attorney General and struck out the petition. The court stressed the importance of separation of powers in the implementation of policies and stated as follows: "Much as it may be true that government has not allocated enough resources to the health sector and in particular the maternal health services, this court is … reluctant to determine the questions raised in this petition. The Executive has the political and legal responsibility to determine, formulate and implement policies of government … This court has no power to determine or enforce its jurisdiction on matters that require analysis of the health sector government policies, make a review of some and let alone their implementation. If this court determines the issues raised in the petition, it will be substituting its discretion for that of the Executive granted by law…."

The petitioners appealed the decision of the Constitutional Court (Supreme Court Appeal No. 1 of 2013). The Supreme Court held that the petitioners had raised questions of constitutional interpretation within the ambit of article 137 of the Constitution. Thus, the Constitutional Court should hear the petition in order to determine whether the allegations therein entitle the petitioner to the redress sought. Kisaakye, JSC observed that the political question doctrine has limited application in Uganda's current constitutional order and the Constitutional Court was established to hear disputes where private citizens allege that action or inaction by the Executive or Parliament contravenes or is inconsistent with the Constitution. Katureebe, CJ stressed that where a citizen alleges that a health policy or actions and omissions made under that policy contravene the Constitution, the Constitutional Court has a duty to determine whether such action or omission indeed contravenes the Constitution. The learned Chief Justice also emphasized that the notion of separation of powers is not absolute. He observed that since the petition raised constitutional issues regarding the right to health and medical services under National Objectives XIV and XX of the

Constitution respectively, the Constitutional Court would have to consider where the right to health falls under the Constitution and whether government had taken 'all practical measures to ensure basic medical services' as required by National Objective XX. The Chief Justice agreed with the Constitutional Court that questions of negligence and the attitude of health workers towards patients did not require constitutional interpretation and would be properly handled in the High Court. In a unanimous decision, the Supreme Court ordered the Constitutional Court to hear the petition on its merits.

Following the order of the Supreme Court, the Constitutional Court heard and unanimously allowed the petition. The court held that the Government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health, right to life and women's rights. That government's omission to adequately provide emergency obstetric care in public health facilities which results in obstetric injury subjects women to inhuman and degrading treatment. Barishaki Cheborion JCC reaffirmed that the right to health is a fundamental right which states ought to respect, protect, uphold and promote. Emphasizing the indivisibility of human rights, the learned judge stated that '[t]he right to health, life and human dignity are inextricably bound. There can be no argument that without the right to health, the right to life is in jeopardy'. He further stated: "The right to health, human dignity and life of women [are] protected both under international law and our Constitution. The right encompasses access to adequate maternal health care. … Maternal health has a direct relation to the physical attributes of women and as such their reproductive health forms an integral part of the health of a woman and for this reason, it is conceived as part and parcel of human rights of women. The right to health of a woman forms an integral part of her right to life, right to equality, right against torture, cruel, degrading, and inhuman treatment".

The court ordered the government to prioritize and provide sufficient funds in the national budget for maternal health care; to ensure that staff who provide maternal health services are fully trained and all health centres are fully equipped; and to complete and submit to Parliament a full audit report on the status of maternal health in Uganda. The court awarded the 3rd and 4th petitioners a total of 155,000,000 shillings for general and exemplary damages.

Uganda has also had successive health policies that have a bearing on the right to health, including SRHRs. For example, the 2006 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights defines reproductive health as a 'state of complete physical, mental, and social well-being in all matter related to the reproductive system, its functions and processes. It includes sexual health, the enhancement of life and personal relations, counselling and care related to reproduction and sexually transmitted diseases. Reproductive health, therefore, implies that people are able to have satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so' (para 2.1). Sexual health is defined as 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence' (para 2.2.1). According to the Guidelines and Standards, reproductive rights 'embrace certain human rights that are already recognized in international human rights documents and national laws' (para 2.3). These rights include, the right of all couples to decide freely and responsibly the number, spacing and timing of their children; the

right to information regarding sexual and reproductive health; the right to attain the highest standard of physical and mental health; and the right to make decisions concerning reproduction, free of discrimination, coercion and violence (para 2.3). The Guidelines and Standards also provide that women can get services for termination of pregnancy under the following circumstances: severe maternal illness threatening the health of the pregnant mother; severe foetal abnormalities; HIV-positive women requesting for termination; and rape, incest and defilement (para 4.13). However, these circumstances must be exercised within the ambit of the law. The Constitution of the Republic of Uganda provides that no person shall terminate the life of unborn child unless authorised by law (article 22(2)). Presently, the abortion law in Uganda prohibits abortion and related services (sections 141-143 of the Penal Code Act) except for saving the life of the mother or the unborn child (section 224 of the Penal Code Act).

The Second National Health Policy (Republic of Uganda, 2010) commits the State to "provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels". The policy emphasizes the right to the highest attainable level of health. Citing the national constitution, the policy indicates, "[the] Constitution guarantees rights of all people in Uganda to access basic health services". The policy further draws on client-centered approaches to health service provision and commits the state to ensure equal access to the same health services for individuals with the same health conditions as well as respect for promotive health aspects of cultures and traditions of the people while discouraging negative practices and behaviours that undermine individual's health and wellbeing.

The Health Sector Strategic Plan III 2010/11-2014/15 (Republic of Uganda, 2010) also contains specific sexual and reproductive health (SRH) intervention such as access to family planning, labor and delivery care, including emergency obstetric care (EmOC). The Uganda One Health Strategic Plan 2018-2022 (Republic of Uganda, 2018) also contains multisectoral interventions with a bearing on promotion of the right to health, including SRHRs. The 2012 Adolescent Health Policy Guidelines and Service Standards (Republic of Uganda, 2012) are aimed at mainstreaming adolescent health concerns in the national development process by providing and increasing availability and accessibility of appropriate, acceptable, affordable, quality information and health services to adolescents.

Despite the fairly elaborate commitments in the legal and policy frameworks above, there are glaring gaps in the implementation of SRHRs. In particular, there is an astounding lack of deliberate focus on men, masculinities in the context of SRHR.

1.2 Inadequate Policy and Programme Focus on Men and Masculinities in SRHR

There are indeed, as illustrated above, policy and legal frameworks that define and outline national focus on SRHR in Uganda and beyond. In one of its reports, CEHURD acknowledges that despite these commitments in policy and strategy, "Women and girls in Uganda continue to face difficulties in accessing SRH services" (CEHURD, 2016). In a review entitled "State of Sexual Reproductive Health and Rights in Uganda: Emerging Issues", CEHURD and its partners point out the gap in SRHR policy implementation and identify emerging concerns as, maternal and reproductive health care services and commodities; sexual and gender based violence (SGBV) against women and girls; Discrimination and stigma against Women Living with HIV and AIDS. These findings not only alert us to the inadequate implementation of SRHRs but more so reveal the absence and marginalization of men and masculinities in SRHR policy and programming.

In one of its integrated approaches to health and human rights, World Health Organisation (2017) provides a consolidated guideline on sexual and reproductive health and rights. The guide notes that by 2015, there was an estimated 17.8 million women aged 15 and older living with HIV constituting 51% of all adults living with HIV globally. Furthermore, WHO notes that women living with HIV are disproportionately vulnerable to violence, including violations of their sexual and reproductive rights. Through these statistics, the WHO guide shows that women living with HIV are faced with multiple and intersecting forms of stigma and discrimination. Despite acknowledgement of women as a complex social category with diverse and intersecting experiences, including violation of SRHR, the guidance provided in the WHO Manual remains silent on men's experiences. Comparatively, women's sexual and reproductive concerns are more documented, hence more researched. Various gendered research studies in Sub-Saharan Africa focus on female inequality and inequity, female subordination, customs, and practices that subjugate women to a subservient position in society. Thus, related interventions emphasize such topics as empowering women and reducing their vulnerability. However, enactments of hegemonic masculinity—defined as "the pattern of practice (i.e., things done, not just a set of role expectations or an identity) that allow men's dominance over women to continue" (Connell & Messerschmidt, 2005: 282) — are hardly examined yet they have implications for these interventions in the sexual and reproductive health of women (Nyanzi, Nyanzi-wakholi & Kalina, 2009).

Studies on men and masculinities in Africa indicate ways in which the analysis of men's subjective experiences remains marginal (Cornwall, 2000). In some cases, the focus on men in gender analysis features occasionally, and when it does, it tends to be in the guise of men as the oppressor, as custodians and perpetrators of male domination and as obstacles to equitable development (Frosh, Phoenix & Pattman, 2002; Shefer, Ratele, Strebel, Shabalala & Buikema, 2007; Shefer, Stevens & Clowes, 2010). Representations of men in relation to women often portray polarized relations (Mwiine, 2018) in which men are constituted as figures women struggle with, fear, resist or resent.

More recent development discourses centrally call for involvement of men in gender equity activism and programming as a precondition to achieve equality (Mwiine, 2019). Male involvement in gender

responsive SRHR within NGOs programmes, health centers especially those with antenatal care services and other women's rights organisations. Most of the programmes on male involvement are closely linked with international development partners such as UN Women and UNFPA. For instance in June 2020, UN Women launched a media campaign dabbed "MEN AT WORK FOR GENDER EQUALITY AND WOMEN's EMPOWERMENT" . During the launch UN Women – Uganda office and its sister agencies reiterated the role of men in enabling negotiation of edge-old patriarchal norms and bringing about gender change. At a programme level, the study interacted with Reproductive Health Uganda (RHU) and the activities the SRHR-centered organisation has carried out activities to strengthen male involvement in SRHR in the Hoima, Arua, Lira, Mbale, Kampala and other parts of the country. In Gulu district, Gulu women Economic Development and Globalization (GWED-G) implemented a male involvement approach across its women's rights programmes in the Acholi sub-region. In partnerships with local stake-holders men have been involved as agents of change, equal partners and clients through for example gender focused discussions and male only information and testing days at local clinics. Religious leaders and politicians act as agents for change and have been endorsed as male champions for SRHR as part of the project. Results stemming from the project include men's increased use of SRHR services (especially HIV counseling and testing and safe medical male circumcision), increasing shared child-care and greater male involvement in the immunization of children. Sensitization and information dissemination has also reportedly led to an increased demand for SRH services by men.(Sonke Gender Justice Network, Cape Town, 2012).

While these community centered initiatives are increasingly making visible and gradually legitimizing the focus on masculinities in SRHR, there are scenarios in which the involvement of men is not primarily about men's sexual reproductive needs and interests but as a conduit and tools to promote women and girls' reproductive health needs. In other cases, some men are celebrated in problematic ways as "champions" of gender equality (Mwiine, 2018; Mwiine, 2019), labels that have the potential to reproduce masculine hegemony.

Notably, it is not uncommon for policies and programmes on SRHR to be dominated by conversations on women and girls' rights to access and use reproductive health amid loud silences on the place of men in accessing SRHR. Later in the report, we share the dominant narrative on women and SRHR as well as inadequate examination of varied and complex roles, norms and social expectations associated with being a man and how these facilitate or constrain realisation of SRHR. The report argues that absence or marginal focus on experiences of men and masculinities in SRHR constrains a broad understanding of the influence of difference forms of masculinities on the realisation of SRHR.

2.0 Study Focus and Research Methodology

This study sought to center notions of masculinities in the analysis of SRHR policies, programmes and advocacy. The study explores the aspect of masculinities, that is, how masculinities are constructed, represented in different cultural contexts in Uganda, the different forms masculinities take, the changes in men's behaviour and practices. The study then assesses the impact of different forms of masculinities on the framing of policies, programmes and advocacy on SRHR and the implications certain masculinities have on the uptake of reproductive Health services. The study objectives are indicated in the side bar.

Study Objectives

General objective: Examine the impact of masculinities on the realisation of SRHR in Uganda

Specific Objectives

1. Examine cultural and historical construction of masculinities in selected Ugandan communities.
2. To explore the various forms of masculinities amongst the youth and adult men.
3. Examine the influence of masculine norms and expectations in realisation of SRHR.
4. Recommend ways of nurturing progressive

2.1 Research Methodology

The study drew on qualitative methods of engagement and knowledge production. The study's conceptual scope included a historical examination of some of the socio-cultural and religious contexts and their framing of masculinities. These historical reflections were aimed at revealing the complex formations of masculinities – how men's gendered identities are constructed, enacted, legitimised and how these (diverse masculinities) influence (e.g. hinder or facilitate) claiming and benefit from SRHRs. The study focused on prospects of change in masculinities and the possibilities sexual and reproductive rights activists have in transforming harmful 'naturalised' male behaviour.

Geographically, the study was national in nature, picking up on regions with dominant cultural patterns that represent different cultures in Uganda. Particular districts were selected in traditional regions of West Nile with the Lugbara culture; Eastern Uganda with Busoga and Bugisu; Western Uganda with Ankole culture, Central Uganda with Kiganda Culture and Lango and Acholi sub-regions.

In total, ten (10) districts including Kampala metropolitan city were selected as indicated below.

- Northern Region: Gulu and Lira districts
- West Nile Region: Arua District
- Eastern Region:- Kamuli and Mbale Districts
- Western Region:- Isingiro and Mbarara Districts
- Central Region:- Wakiso, Buikwe Districts
- National level Conversations – Kampala metropolitan city

In each of these communities, the study team focused on discussing with district officials with technical and political mandates on SRHR issues, women's rights organisations and community based organisations promoting SRHR, community members in their locality (located through a selected sub-county) and religious and traditional leaders. Often sub-counties visited were selected on purpose with the guidance of the District Health Officials. Sub-counties visited included those that had posted higher cases of sexual abuses among sexually active populations e.g. areas with high rates of teenage pregnancies, or early marriages or a community hosting a health center 3 where reproductive health services are provided.

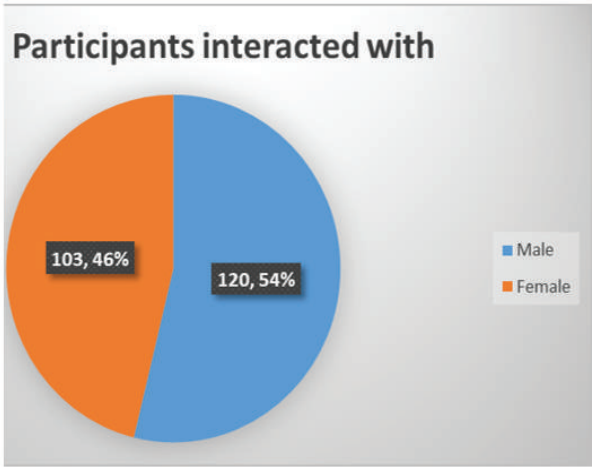
Categories of participants interacted with

Category	Prospective Category of participants	Methods
National Level	Ministry of Health official Ministry of Gender, Labour and Social Development CSOs SRHR/Male Engagement	5 interviews
Every District	District leadership – LCV/CAO District Community Development Office District Health Office (DHO)/Health inspectors Cultural leaders/ Clan leaders (2) Religious Leaders Youth Leader Academicians LCIII Chairperson LC I chairperson Village health team member (VHT) Health center III (in-charge/ Midwife) Elders - women and men (4) CSOs on SRHR e.g. Reproductive Health Uganda (RHU), Marie Stopes Actors in the male-engage strategy Women's rights organisations 2 FGDs (male only/Female only, each composed of 8 people)	At least 13 interview participants per district 2 FGDs per district Male FGD (8 men) Female (8 women)
	Estimated district- level participants	29 participants per district

In total, the study focused on 223 participants, 54% (120) of whom were males and 46% (103) females (See Appendix 1 on the list of Participants interacted with).

LIST OF RESPONDENTS BY DISTRICT

NO	District	Male	Female	Total	% M	% F
1	Mbarara	12	11	23	52	48
2	Isingiro	18	11	29	62	38
3	Wakiso	15	14	29	52	48
4	Gulu	16	15	31	52	48
5	Arua	16	12	28	57	43
6	Lira	16	14	30	53	47
7	Kamuli	15	9	24	63	38
8	Mbale	11	13	24	46	54
9	Kampala	1	4	5	20	80
	Total	**120**	**103**	**223**	54	46



2.2 Data collection methods/Tools

Secondary data collection methods

The study analyse secondary data such as international conventions, government policies, Action Plans, national strategies and reports on SRHR. Other secondary sources included analysis of academic research studies and advocacy reports and strategic interventions from civil Society Organisations and their networks on sexual reproductive and health rights. The study particularly focused on studies that document community based initiatives that have engaged with men and masculinities in SRHR, the approach they draw on, good practices and constraints they encounter.

Primary data Collection – process and methods

The study collected primary data through one-on-one interview conversations with key informants – government officials, community development officers, actors from CSO and CBOs, religious leaders. These interviews engaged participants on their cultural understanding of who a man is, norms and expectations of manhood (and womanhood), prospective changes in ways of living up to ideal forms of being men (and women) (See appendix 2 on the interview Guide). These interviews were complemented with Focus Group Discussions (See Appendix 3 on FGD guide) (of local community people) to enhance a collective voice on social cultural and symbolic constructions of different forms of masculinities, covert forms of resistance towards realisation of SRHR, and suggestions on how to change men and boys' social roles and expectations towards sustainable SRHR programmes. As we show later, one-on-one interview conversations and Focus Group Discussions were not only avenues of knowledge production but also as spaces of advocacy and awareness creation on the influence of masculinities in the realisation of SRHR.

Media Mapping

The research team participated in mapping dominant conversations in the media (print, electronic and social media) on sexual and reproductive health conversations. This mapping involved research team members posting on a group WhatsApp (opened for this purpose) any story, pictures, adverts on men and women's access to SRH services or the contemporary constraints to the realisation of SRHR. Media mapping also included taking photographs of images, noticeboard posts or any form of public message that would enable understanding of the status of men, masculinities and SRHR in the communities visited. Notable were the media conversations of constrained access to reproductive health services during Covid-19 pandemic lockdown manifesting in rampant teenage pregnancies.

In the image above, shared by one of the researchers, Reproductive Health Uganda (RHU) provides an insight on the link between family planning and the attainment of SDGs relating to environmental protection, reduced deforestation, promoting manageable families and gender equality as well as reduced hunger.

3.0 Study Findings

This section shares findings from the communities visited. Findings shared are a result of historical reflections on the cultural construction of men and masculinities. Construction of masculinities is closely examined in discursive contexts of culture, age, marriage status, religion, economic activities in the communities visited, availability of RSHR services in the community, histories of war and post-conflict situations, border politics and the attendant mixed cultures, and many other social contexts. Dominant social cultural, religious and economic contexts that animated conversations on men and SRHR include the following.

Contexts that inform the analysis

- The patriarchal nature of Ugandan communities. Men tended to dominate consultative positions from which we intended to get participants e.g. district leadership, cultural leadership, religious leaders among others.
- Agricultural communities had particular dynamics that animated the making of masculinities. In Kamuli, our conversations on SRHR were uniquely influenced by the economy of Sugarcane growing.
- Dominant cultural contexts. In Easter Uganda, Mbale, the communities were uniquely organised around narratives of traditional male circumcision locally known as imbalu.
- In Lango and Acholi Sub-region, the dominant context was about the Lord's Resistance Army War (LRA) that lasted for more than 20 years. This protracted war and the post-conflict perils greatly shapes the conversations on constructions and representations of men and masculinities and its impact on SRHR.
- In West Nile, conversations on men were moderated by the dynamics of a mixed population of refugees from across the borders with Democratic Republic of Congo (DRC) and South Sudan.
- In central Uganda, the cultural vibrancy around Buganda kingdom featured particularly unique through the linguistic construction of men. Participants in Buganda region drew commonly on proverbs and sayings as cultural and symbolic ways of understanding who men are. Central Uganda (Buikwe district) was informed by the histories of HIV, sex work and mobile populations around fishing communities.
- Other contexts that inform the study's conversations on SRHR include participants' religious backgrounds, education level, and marital status among others.

The report draws on these socio-cultural and economic fluidities to examine the construction of masculinities and their influence on SRHR policy, programmes and advocacy.

3.1 The status of SRHR in Uganda

In 2018, Ministry of Health in partnership with other stakeholders that include development partners, Civil Society, district health teams and participants from the health facility level, developed a National Standards for Improving the Quality of Maternal and Newborn care (2018). This national guiding framework is adapted from the World Health Organisation Standards for maternal and new borne care of 2016, aimed at achieving high quality care at the time of childbirth. In this guide, the ministry of health elaborates on the national status of maternal and child health, highlighting milestones in improved coverage of facility based deliveries. The ministry further noted decline in maternal and child mortality rates over the last five years. Maternal mortality ratio currently stands at 336 per 100,000 live births from 438 per 100,000 in 2011, infant mortality rate (IMR) is at 43 per 1,000 live birth from 54 per 1,000 live birth in 2011 and under 5 mortality rate is at 64 per 1,000 live births from 90 per 1,000 in 2011 (UBOS, 2016; Ministry of Health, 2018: 9). The ministry further developed simplified but intensive guidelines on the management of the most common obstetric/neonatal conditions that contribute to the reduction in maternal and neonatal mortality. Despite these milestones, the ministry noted slow reductions in maternal and neonatal mortality rates. In other studies on sexual and reproductive health, there is notable poor status of SRHR in Africa despite impressive progress in developing legal and policy frameworks to guide delivery of SRHR services (Ahlberg & Kulane, 2011: 316).

3.2 Sexual and Reproductive Health Services in Uganda

Sexual and reproductive health services remain one of the core areas of focus in the health sector. According to the districts visited, a wide range of partners in the country provides sexual and reproductive health services. Actors pointed out included the ministry of health, district health teams, referral hospitals, government health centers at different levels, village health teams, private health care providers such as clinics, non-governmental organisations with health programmes. Among others. Most common specialized SRHR service providers in the districts visited included Reproductive Health Uganda and Marie Stopes. These work closely with government health systems to provide information as well as treatment related to sexual and reproductive health care.

Most of the SRHR services included information sharing on family planning – “a voluntary informed decision made by an individual or a couple on when to start having children, how many, interval and when to stop” (Reproductive Health Uganda, n.d.). Family planning is achieved with contraceptive methods. In addition to family planning, participants cited sexual and reproductive health education that people access at the health facilities or throughout reach programmes by different health providers. While sexual and reproductive health rights entails a combination of different aspects – sexual health, sexual rights, reproductive health and reproductive rights – participants, both in the community and some of the service providers synonymously used SRHR to imply one’s bodily integrity and the reproductive health choices individuals make with the assistance of contraceptives.

Participants in Reproductive Health Uganda talked about comprehensive Reproductive health package to mean family planning services (which is the central focus of managing reproduction) including additional health services e.g. prevention of HIV/AIDs and other STIs or gender based violence, to enable the effectiveness of family planning. The broader focus on family planning and closely related health concerns such as HIV programmes, STIs, Gender based violence points to the realisation that SRHR may not be achieved in isolation of broader human rights. For instance, the right

to choose the number and spacing of children cannot be realised in the context of gender-based violence. Or, an individual or a couple may not effectively use a method of family planning such as Intra uterine Device (IUD) when they are infected with a sexually transmitted infection. Integrated and comprehensive nature of SRHR services is demonstrated in the picture below.

SRHR and the human rights approach

Sexual and reproductive health services are provided in the context of a human rights approach. Most SRHR service providers mentioned being guided by principles of non-discrimination, universal access to rights based SRHR information and services to the vulnerable and underserved communities especially young people, and respect for individual choices. In some of the facilities sexual and reproductive health rights that guide service provision were well displayed. These included:

- Right to information and Education.
- Right to freedom of thought.
- Right to health care and health protection.
- Right to decide whether or when to have children.
- Right to life.
- Right to be free from torture and cruel treatment.
- Right to choose whether or not to marry and to found and plan a family.
- The right to privacy.
- The right to equality.
- The right to liberty.
- The right to freedom of assembly and political participation.

This rights approach, is further reiterated by the 2003 Protocol to the African charter on Human and peoples' rights on the rights of women in Africa. In its Article 14, on health and reproductive rights, the protocol - which Uganda signed in 2003 with a reservation of the right of access to medical abortion (article 14(c)) - calls on state parties to ensure that the right to health of women, including sexual and reproductive health is respected and promoted. Accordingly, these rights included; the right to control their fertility; the right to decide whether to have children, the number of children and the spacing of children; the right to choose any method of contraception; the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS, among others. The protocol further urges States to take appropriate measures to:

a. Provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;

b. Establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;

c. Protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

It is notable that while the human rights approach is reflected within the work of SRHR in communities, there are constraints that hinder people's ability to claim these rights and use sexual reproductive services. For instance, there is a deliberate focus on women's health and rights amid inadequate articulation of the place of men and men's role in the realisation of sexual and reproductive health yet men remain key social actors in decisions that affect sexuality and ultimately sexual and health rights at the household level and beyond. It is also notable that while the protocol talks about legal contexts in which abortion could be carried out, there is an overwhelming silence (possible suppression of narratives on abortion) on the subject in communities of practice. The only available conversation is limited to SRHR service providers offering post-abortion services. The silence could be partly explained by the criminalization of abortion whereby service providers, women and girls fear prosecution for abortion related offences. Abortion remains prohibited in Uganda, except under certain circumstances. The Constitution of the Republic of Uganda states: 'No person has the right to terminate the life of an unborn child except as may be authorized by law' (article 22(2)). The Penal Code Act criminalizes attempting to procure, or knowingly supplying things to procure an abortion or miscarriage (sections 141-143). However, the Ugandan penal regime does not absolutely prohibit the termination of pregnancy. The Penal Code Act states:

> *A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon a person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case (section 224).*

In spite of this section 224, which provides a therapeutic defence to a health worker, who in good faith and with reasonable care and skill performs a surgical operation to preserve the life of a pregnant woman, heath workers may fear to carry out termination of pregnancy due to the heavy penalties imposed by the law, which range from three to seven years (sections 141-143). Due to criminalization of abortion, many women and girls lacking access to safe and legal abortion may turn to unsafe abortion practices. Unsafe abortion may be carried out by unqualified and unskilled health persons or practitioners or in unhealthy environments which may lead to death or injury to women and girls who go through it. Consequently, unsafe abortion significantly contributes to the maternal mortality and morbidity in the country (Twinomugisha 2015: 51-54; Nteziyaremye, 2020: 343).

SRHR service provision points to a wider gap between the rural communities and urban communities, adult and youth populations. In most regions visited, urban areas had a variety of SRHR service providers including governmental and non-governmental institutions, with a variety of sexual and reproductive health products on offer e.g. regular medical checkups, youth friendly corners (services) as well as medical clinics that provided alternative SRHR service support. Some of the rural areas the research team visited depended on outreach programs by service providers (such as RHU, Marie Stopes) who are located in urban areas. In these areas communities not only grapple with stronger cultural beliefs and values that resist use of reproductive health service e.g. sex education and family planning, they too struggle with drug stock outs, long distances to health centers, heavy work burden among other challenges. For instance in Lira, the research team picked expired male condoms that were still being dispensed at the health center. In the sections that follow, the report focuses on examining social and cultural construction of who a man is, the different forms of masculinities and how these enable or constrain policy framing, advocacy, access and uptake of sexual and reproductive health services.

3.3 Men, Masculinities and the SRHR

One of the key questions that guided this national study was who is a man? This question often sounded casual and ordinally to most of the men and women we met and held conversations with. In Arua, an old man in Vurra sub-county asked whether it was worth travelling 600 kilometers (from Kampala) only to ask people things as obvious as who a man is. Yet it was one of the revealing questions, as it opened up taken-for-granted histories, cultural knowledge, diversity and the fluidity of men and men's experiences, expectations and practices across time and cultural spaces.

Idealized hegemonic forms of masculinities

In response to the 'obvious' question- who is a man – participants drew from culture, language, economic activities, religion, the past and present social, cultural and political contexts to define who a man is. While we visited districts with difference is cultures and historical experiences, there were commonalities in the expectations, roles and norms that defined who a man is. In the excerpts below, we share different views on men and their social identities.

> *A man is someone who is married, knows how his children feed, how they sleep, if they are sick he takes them to the hospital, makes sure his children are immunized, a man has the*

responsibility of educating his children. Has land and can till it and get food for the family and children other than wandering in trading centers. There are men who are married, … having many children, and you find the children don't have enough food at home and they start roaming around, they have failed to go to school, that one is not a real man. … **(Female KII, Mbarara).**

One who provides for the family. You re a man by what you do for the family. Those who don't provide are not men. You are not a man because of trousers. Roles expected of a man include providing for family, providing shelter and ensuring that children have school fees **(Male KII District official 3, Mbarara).**

Has a family, responsible, with people to look after. A person of 18 years and above. … One who can carry heavy things, off-loading and loading fish, lifting people to put them in a boat. Man has to fish, ride boda-boda. One who is not married has no problems and responsibility to make one a man e.g. paying school fees… from creation as male and 35 years and above **(Male FGD, Buikwe).**

These are just few of the communities' perception of who a man is. Notably, marriage was identified as a central factor in one's identity as a man. In this expectation, one who identifies as a man, is presumed to occupy a position of power especially by having people under him (e.g. wife and children) as well as responsibility to look after them. In Isingiro, a local businessman highlighted the centrality of sexual ability in defining manhood by emphasizing that a man is one who has the potential to "kusigura" – to propose a sexual relationship, convince and win-over a woman, bring her home and pay bride price. He further indicated that "to be called a man one needs to father a child. A man who does contrary is "ekifera" (coward). Men who are cowards apparently end up handing over household headship to the wife.

Sometimes traditional ideals of being a man override other social aspects such as one's education level. "In Kamuli, some educated men are also being governed by the tradition /culture when it comes to SRHR/S. It is common to find a family in Kamuli with more than 40 kids, i.e. one woman having 26 children (KII with Principal Assistant Secretary, Office of Assistant Chief Administrative Officer, Kamuli District). Despite the advancement in the level of education, the number of wives and children is still a defining factor of being a real man.

'Sugarcane culture' and the making of hegemonic masculinities in Busoga

While in Kamuli district, the study established sugarcane plantations as one of the dominant economic activity in the area. The research team was also advised that if they were interested in SRH status, one of the areas to visit was a sub-county (Bugulumbya) with sugarcane plantations. Notably, communities around sugarcane plantations experienced high rates of early marriages and teenage pregnancies especially during Covid-19 pandemic. We were also alerted to a young secondary school male student (Reagan) who had won an essay competition by writing about sexual activity among young sugarcane cutters. The young man had apparently written an essay recommending installing condom dispensers in sugar cane plantations to respond to hyper-sexual activity among this category and prevent

pregnancies and the spread of HIV.

The research team visit in Bugulumbya sub-county was greeted with numerous stories of sugar cane cutting and how this activity is increasingly becoming a rite of passage into young masculinities. One of the religious leaders we talked to termed social dynamics around these plantations as constitutive of "sugarcane culture". This culture involved the following discursive practices.

a. Young men drop out of school around 13 or 14 years, form smaller peer groups that start sugarcane cutting. THEN they get some money, little yet enough to make them admirable young men.

b. The money gives them ability to get girlfriends, whom they buy chapattis for, among other goodies. We are told the common stories among the boys while they are cutting sugarcane, are on girls.

c. Then sex in sugarcane plantations sets in, which in most cases results in teenage pregnancies, and early marriages at times.

d. Amidst young boys working to become men, we were told stories on how earning money, getting a girlfriend, marriage and fathering children were key markers of masculinity. Men in this region are recognised by large numbers of children. An official in the Chief Administrative officer's office told us, of a man with 33 children, whose target is to beget 100 children, and how polygamy is a normal cultural practice.

When these cultural practices are added up, that is young masculinities in sugarcane cutting combined with a general culture of multiple sexual relationships, you start to see SRHR concerns coming through. Women in a focus group discussion noted that while “omusadda” in his home ought to be the final decision maker, massive men have abandoned family responsibility. "Abassadda bafuuka baana. Basigariza kwambala mpale zoka!! This is translated as “men/husbands have become like babies. They are left with putting on trousers”. On of the women in a group discussion noted: “You buy him a mattress, he sleeps and you cover him too”. Even with these apparent abdications of family responsibilities, women refered to their husbands as "mukama wange" (my Lord).

These social experiences of men alert us to new web of masculinity among sugar cane cutters which is so complex and problematic when it comes to dealing with Reproductive health and rights. For instance, apart from them having multiple sexual relations, they have contributed to the increasing numbers of teenage pregnancies, early marriages, single young mothers and the reproductive complications that come with early childbirth. Sugar cane culture has also contributed to the spread of HIV because these are people who know nothing about Reproductive health, which was the reason Reagan a 16 year old boy in the community advocated for condom dispensers around sugarcane plantations.

The study noted that this is a complex set of cultural repertoires that are nurtured around, sex, sexuality, identity and young masculinities consequently constraining sexual and reproductive health and rights of women and men as well. In the picture below, Reagan distributes condoms to young sugarcane cutters.

Language and the construction of hegemonic masculinities

The study participants were asked about the proverbs that refer to men and a number of proverbs were shared as follows;

Proverbs	Interpretation	Associated meanings
Abasajja ndagala namu	If you move in a banana planation every day, there is a new banana leaf, good leaves don’t get finished	It means that good men are always there, you will see one leaf and you say, I think it is nice, but when you look at another, it is even better than the one you saw first but they are all leaves (Female FGD, Wakiso).
Abasajja mivule	Man are like mahogany trees	Men are expected to strong in all circumstances (Female FGD, Wakiso).
Basajja mivule giwatura negigumiza	A man is compared to mahogany tree- there are at times where it shades off its’ leaves but gets others.	A man is a man. Even in difficulties, he is supposed to remain strong and handle the situation as he provides for his family (Male KII, District Official 3, Buikwe).
Abasajja kiti kyamuwoogo, gyokisula gyekilandira	Men are like a cassava stem, where you throw it, it grows.	Often associated with Men’s sexual activity especially when they have sexual relations in many places
Sibuli ayambadde mpale nti musaja.	Not every man that you see on the road is actually a man, there are people putting on trousers, but not real men.	That means that man is not performing his responsibilities as a man. They will say that man belongs to that family when he is not a man at home. That is a man who will ask for soap for bathing, he tells you how you misuse salt, can you use salt the way you use sugar? he is asking for food when he didn’t leave even 1,000 shillings (Female FGD, Wakiso).
Omwoyo omutitiizi gwalemwa okuwangula omukyala omulungi.	Faint heart never won a fair lady.	This proverb tells men to be outspoken and straight forward in order not to lose on important things in life (Male KII Elder, Wakiso).

Kula zikurabe	When a man grows, has to face problems.	When you are young, you do not experience problems (Male FGD, Buikwe).
Musajja kana kambata kenonyeza koka	Man is like a duckling looks for food itself.	Man has to work for himself (Male FGD, Buikwe).
Musajja takaaba	A man has to persevere and work.	Even when money is not found, a man has to go back home and return following day to work (Male FGD, Buikwe).
Omusajja tagererwa nzaro	You cannot determine number of children for a man	Man is supposed to produce as many children as possible. A disguise for womanizing (Male KII, Town council Official 2, Buikwe).
Omusajja olusala ekyayi, munyera nayika	A man can cause problems for you if you do not submit as a wife.	A man is capable of causing suffering (Male KII, District Official 3, Buikwe).
Enume ekula bigo	A bull has to face challenges as it grows	Unless a man faces problems, he may not be hardened (Male KII, District Official 3, Buikwe).
Omusajja asajalata	A man has to womanize	Man has freedom to have as many women as possible because he is a man and women should not question his promiscuity (Male KII, District Official 3, Buikwe).
Olimara Kunyenya nga keddo?	Are you waiting to start shaking like an avocado tree with fruits?	Told to a man who has delayed to marry (Male FGD, Wakiso).
Basajja fumu	Men are spears	Even if a spear is brought to you, you cannot know the number of animals it has killed implying that you cannot know the number of women a man has slept with (Male FGD, Wakiso).
Omusajja tamwa kantu	Man cannot be denied	You cannot deny a man sex irrespective of what (Male KII, Sub-county Official, Wakiso).
Kasaja rwazi	A man is a rock	Man is a fighter, strong (Male KII Religious leader, Wakiso).
Kasaja katono okanyomera mitara wa muga	Man is only under looked when at a distance	If you see a man from far, that is when you undermine him, but when he gets close, he may beat you (Male KII Religious leader, Wakiso).
"Omusadda kyakoba timuyilamu"	when a man talks, I don't talk back	Masculine authority, power, domination over women
Omushaija abowa'shwera	A man is one who is married	Marriage is identified as a key marker of being a man. One who is not yet married is not man enough

These proverbs and common sayings about men, provide hints on cultural expectations about men, their relationship with fellow men and women as well as the prescribed punishments for doing masculinities outside cultural expectations. Some of the proverbs constitute men around physical strength, authority, headship, decision-making, sexual activity and aggression. The manner in which these proverbs are reproduced in everyday life points to how these stereotypes are deeply ingrained and guide dominant ways of being a man. These proverbs have implications for SRHR services whether these are about women or men themselves. For instance, the perception around men's unlimited number of children (omusajja tabalilwa nzaro) men's as well as women's failure to use family planning.

In Eastern, North and West Nile a man was described with connotations of power, control and domination, as household head, provider of the basic needs of the family and decision maker. Men were symbolically defined as the king of the jungle, full of ego and pride. A female key informant interviewee shared what she termed "Lango ego". "men here will tell you, "I will beat you the 'langi way'. He beats you and sits on your chest. A man in Lango is like the king of the jungle, they have final authority. Culture holds a lot of value around men and you will commonly hear, in our culture, this is how we do our things as men". In an interview, the Assistant chief administrative officer noted that men in Arua are traditionally

proud. “They are so proud. For a Lugbara man to say sorry, I do not know what you will have done. A Lugbara man will knock you on the street and when he realizes that it is a woman, he will turn and insult you. These men are found of bullying women driving on the road”. In a conversation with a male academician from Acholi, it was noted that “in Acholi, being a man is associated with marriage, having children, and being able to look after the children and your wife. In effect, the ability to care and provide for your family gives you the legitimacy to exercise power and control over the family members. Subjects to this power are not necessarily children only but also wives. He further noted that that male provision role comes with exercise of power, i.e. man the provider is culturally expected to “sets rules in the household, enforces rules and ensure compliance”. All these three are aspects of masculine power in the household and failure in any of these social expectations makes one less of a man.

These cultural definitions of who men are in different Ugandan communities resonate with what Connell (1995) termed hegemonic masculinity. Connell uses the concept hegemony to elaborate on the gender hierarchies in which different categories of men and women find themselves. She argues that at the top of this gendered hierarchy is ‘hegemonic masculinity’ – “the culturally dominant ideal of masculinity centred around authority, physical toughness and strength, heterosexuality and paid work”. This is the ideal masculinity few men live up to in real life, but which is the basis and motivation of being a man. Connell notes that below this idealized form of masculinity can be different forms of male behaviour, which are buttressed by subordination of weaker men, and women and girls at the very bottom of the hierarchy.

3.4 Between the ‘ideal’ and ‘real’ masculinities

Constructions of men and masculinities were commonly framed around patterns of social cultural power, economic roles of provision, headship of homes, decision-making and physical strengths. While these seemed to cut across time and cultures in Uganda, we asked participants whether these men were indeed in their communities. Almost all participants indicate that men in real life did not fit into the ideal descriptions. They pointed to changing relations amongst men and women and contexts in which some of the men exhibit progressive behaviour while majority have regressed and are ‘no longer’ ‘real men’. The dominant language of “men of these days” in most of the conversations attests to the realisation of changing masculinities, which points to differences in men’s behaviours of the past and contemporary times.

- In Kamuli, women FGD decried the increasing men’s relegation of household headship, care and provision. Women talked of men who no longer provide for their households. In their local dialect, they noted “abassada bafuuka baana. Kati bakulabirila” (that men have become like babies/children; they are looked after by their wives).
- In Lira and Gulu, participants decried increasing men’s irresponsibility especially as adult men turn to alcohol drinking.
- Changes in men’s authority, responsibility and care for the households was apparently characterised by abandoning of marriages or marrying more than one wife and the wives competitively look after their husband.

- There are reports that men are increasingly withdrawing from agriculture and provision and care for families especially when women in their lives started to experience economic forms of empowerment.
- Women increasingly heading households whether on temporal basis with absentee husbands or on payment basis.
- There are reports of men using family resources e.g. selling food to get money for alcohol.
- In Gulu, there was decry of men who are mobile because of polygamous marriages that limit resources but also time to take care of their families. "Some of us men have become beggars from our wives because of poverty. For example there are some men among us who are too poor/helpless and whom their roles are just keeping the home while their wives are in the market looking for money". Men FGD Bungatira Sub County Gulu district)

Collapsing masculinities

These and many stories shared from men and women pointed to the overwhelming changes communities and men in particular are experiencing. Tensions in household gender relations resonate with what Dolan (2002) once termed as collapsing masculinities. Dolan coined the concept of collapsing masculinities while discussing a persistent trend in the post-war northern Uganda, in which, men were failing to meet their roles and expectations because of the disruptive experiences of war in the region. Accordingly, men's inability to live up to prescribed expectations was responsible for increasing forms of gender violence in homes, and experiences of masculine vulnerability, all of which have an impact on access and uptake of SRH services. For instance, among adult men, economic makes it difficult to pay school fees and associated costs, thus undermining one of the key responsibilities of the 'masculine' role as the household head and provider.

There were many subtle but impactful scenarios of men's failure to live up to idealized/ normative forms of masculinity. In Acholi for instance, participants noted that "A good number of men have lost power and influence in their families due to prolonged stay in the camp – encampment de-masculinized men. They lost the primary means and resources for the construction of masculinities, that is, the ability to provide" (Male Academician, KII). The participant then elaborated on the different changes that men have gone through in the Acholi sub-region, as indicated below.

1. Hegemonic masculinities: There are men who still have resources and are able to provide for their families. These are men who can exercise absolute authority.
2. Positive masculinities: There are men who are able to provide and share responsibilities with their wives – especially the educated – but these also have aspects of wanting to be dominant over their wives because of culture

3. Collapsing masculinities: There are men whose response is of despair and wastefulness. They drink alcohol, they are resigned, they experience an overwhelming sense of loss. Some of these have gone as far as committing suicide. Some of these have lost control over households. For these, power is slowly but steadily drifting towards women. "A woman has now become a man"

These three categorisations give a glimpse of how complex, changing and at times overlapping masculinities can be.

"Paracetamol men - masculinities"

Further discussions about men and health revealed a glaring gap in terms of men and their interface with health care system. In Lira for instance, Sharon, a female youth shares with the study team on how Langi men are culturally defined as physically strong and health. She revealed culturally defining myths that a man does not fall sick. "I have an uncle a 43-year-old-male uncle with 4 children who says he has never been in the hospital. Men will tell you, they are busy working to provide for the family. They do not have time to get sick". This attitude of arguing that men have no time to get sick makes sickness look like a woman's deliberate choice. And because they 'do not get sick', they remain distant to health care systems. They seek health care neither for themselves nor for their wives and children. This way, traditional ways of manhood constrain access to health care and more so to Sexual and reproductive health services.

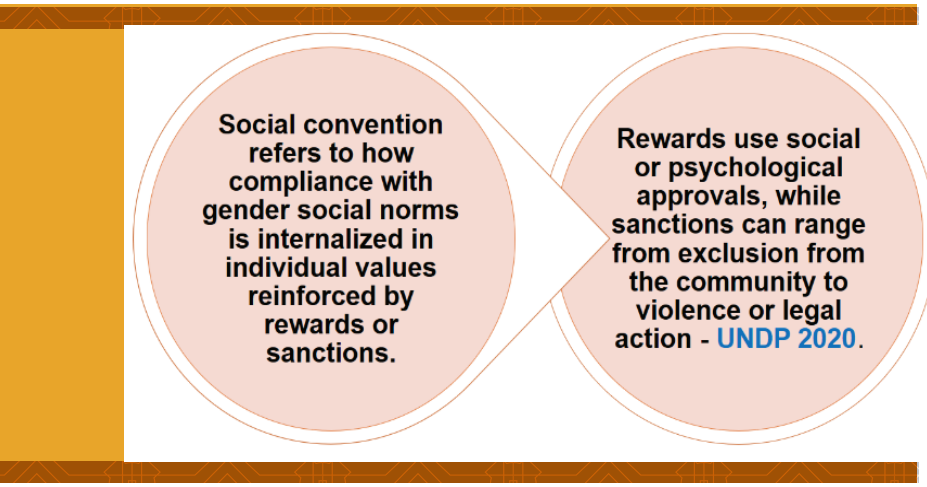
However, participants in Lira and Gulu as well as eastern parts of Uganda (Kamuli and Mbale) talked about ways in which men negotiate their denial of sickness and weakness. In order to perform strengths and power amid sickness and to avoid what majority men termed as wasting time at the health center, men turn to pain killing as a means of sustaining themselves. In an interview with a young female resident of Lira, she termed men who perpetually thrive on 'killing pain' as "paracetamol men" – Paracetamol masculinities. Accordingly, these are men, who survive on paracetamol or other painkillers. "When they get some pain, they take painkillers, others will tell you, this is just hangover". There are dominant narratives around men and how they casually practice self-medication. A CDO in Mbale had this to say "You go to any drug shop, just even stand there, even when you are not going to buy anything, you will hear 'musawo ntabulira ko' (This relates to male clients requesting private clinic attendants to give them a combination of medicine that would cure self- diagnosed illness).

Masculinities, social norms and health outcomes

Conversations on men and masculinities in the context of SRHR highlighted the deep rootedness of social norms and values that guide men and women's everyday conduct, particularly those that are harmful not only to women but also men. The study established collectively agreed upon, informal standards and rules that members in respective community visited agreed to and adhered to. Participants alluded to sets of punishments incurred for acting out of the expected norms as well as rewards to those who behaved 'appropriately'. In her definition of gender, Butler reminds on how gender is "basically innovative affair, although it is quite clear that there are strict punishments for contesting the script by performing out of turn or through unwarranted improvisation"(1988: 531). These group norms regulate behaviours on the basis of whether one is female or male. In its 2020 Human

Development report entitled Human Development Perspectives: Tackling Social Norms: A Game changer for gender inequalities, UNDP points out that "the family norms, and experiences from childhood create an unconscious gender bias" (UNDP, 2020: 10)

For instance, among the Bagisu in eastern Uganda, the norm of male circumcision greatly influences the masculine identity. Young men who brave the hardships and candidly bear the pain of the knife on the circumcision grounds are applauded by men and women members of the community and rewarded with unlimited and unquestioned authority not only the household but also the entire society. In the central Uganda region – commonly among the Baganda – norms that privilege masculine power and sexual domination were expressed through everyday linguistic constructions. Proverbs and sayings provided one of the subtle ways through which ideal forms of masculinities were symbolically constructed, represented and legitimised as the acceptable ways of being a man. Amongst the Lugbara of West Nile, men's relationship with women was reportedly deeply ingrained in the 'separate' socialisation of boys and girls. Participants talked about ways in which young boys are taught not to closely relate or associate with girls. That gender socialisation often drives girls and boys apart. They argued "in Arua, we have married men and women who cannot walk together hand-in-hand. One walks ahead of the other even when they are going to the same function/place". He added that, "Lugbara people do not want to prepare for a baby who is still in the stomach, for fear that the baby may die. This leads to inadequate preparation. On delivery of the baby, medical staff will ask for items to use but the couple has nothing. The man will say "let me go and sell my goat which is in the veranda, I will bring the money tomorrow after the market" (District Health official, Arua District). These myths, norms and values not only legitimise differences amongst women and men, they too have wider implications for human health and SRHR in particular.



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There is an emerging global conversation on social (gender) norms particularly as the world celebrates 25 years since Beijing platform for action. Key points in this narrative (drawn from the 2020 UNDP human development report indicate that:

- Gender disparities are a persistent across the globe. Despite remarkable progress in some areas, no country in the world—rich or poor—has achieved gender equality. All too often, women and girls are discriminated against in health, in education, at home and in the labour market—with negative repercussions for their freedoms.
- The world is not on track to achieve gender equality by 2030. The Human Development Report's Gender Inequality Index (GII)—a measure of women's empowerment in health, education and economic status—shows that overall progress in gender inequality has been slowing in recent years.
- Beyond what is measured, there are unac¬counted burdens behind the achievements: the double shift at home, the harassment in public transportation, the discrimination in workplaces, and the multiple hidden con¬straints that women face.
- Progress towards some aspects of gender equality getting slower and more difficult. For instance, "In the 50 countries where adult women are more educated than men, they still receive on aver¬age 39 percent less income than men—despite devoting more time to work".
- Social norms are central to the understanding of these dynamics.
- A social norm will be stickiest when individuals have the most to gain from complying with it and the most to lose from challenging it. Social norms have enough power to keep women from claiming their legal rights due to pressure to conform to societal expectations. Social norms can also prevail when individuals lack the information or knowledge to act or think differently. Because of intertwined social dynamics, challenging discriminatory norms that impede gender equality and women's empowerment requires acting on more than one factor at a time.
- Reproductive health, which gives women agency and control over their own body and fertility, still has much room for progress

  Adopted from the 2020 Human Development Perspectives: Tackling Social Norms: A Game changer for gender inequalities, UNDP, UN Plaza, New York, NY 10017 USA

We need to note that while UNDP ably articulates ways in which social norms constrain gender change, the restrictive potential of these norms is not limited to women and girls. As the study has indicated, norms around masculinities have greater impact on the uptake of SRH services whether these are by women or men. This position is reiterated by MenEngage, a global platform promoting involvement of men in gender equity campaign. In their work "Masculinity and Changing Power) MenEngage (supported by UN Women and UNFPA) indicate that:

> *Throughout the world, there are still strong social and cultural norms that perpetuate power imbalances between men and women. While men usually have more agency than the women in their lives, men's decisions and behaviors are also profoundly shaped by rigid social and cultural expectations related to masculinity. Broadening the discussion about how gender norms affect both women and men helps us to better understand the complex ways that rigid gender norms and power relations burden our society, and to more effectively engage men and boys in reflections about inequalities and change (MenEngage: Men, Masculinities, and Changing Power: A Discussion Paper on Engaging Men in Gender Equality From Beijing 1995 to 2015)*

Conversations on masculinities, the social norms that legitimise these identities and the health outcomes that result from men's and women's struggles to comply to these norms remind us that social norms matter for policy making on gender. "If social norms are sticky and determine either the improvements or the pace towards gender equality, then little space is left for policies designed with such purpose. If, on the other hand, social norms can change, it becomes essential to understand the relationship between social norms and outcomes and policies"

In the section below, the report looks at how changing and different forms of male norms, behaviours and practices (masculinities) influence ways in which policies around SRHR are framed and ultimately on the advocacy, access and uptake of sexual and reproductive health services.

Gender Inequality Index: Regional dashboard

	Gender Inequality Index	Maternal mortality ratio (deaths per 100,000 live births)	Adolescent birth rate (births per 1,000 women ages 15–19)	Share of seats in parliament (% held by women)	Population with at least some secondary education (% ages 25 and older)		Labour force participation rate (% ages 15 and older)	
					Female	Male	Female	Male
Region	2018	2015	2015–2020	2018	2010–2018	2010–2018	2018	2018
Arab States	0.531	148.2	46.6	18.3	45.9	54.9	20.4	73.8
East Asia and the Pacific	0.310	61.7	22.0	20.3	68.8	76.2	59.7	77.0
Europe and Central Asia	0.276	24.8	27.8	21.2	78.1	85.8	45.2	70.1
Latin America and the Caribbean	0.383	67.6	63.2	31.0	59.7	59.3	51.8	77.2
South Asia	0.510	175.7	26.1	17.1	39.9	60.8	25.9	78.8
Sub-Saharan Africa	0.573	550.2	104.7	23.5	28.8	39.8	63.5	72.9

Source: Human Development Report Office (see table A4).

Source: 2020 Human Development Perspectives: Tackling Social Norms: A Game changer for gender inequalities, UNDP

3.5 How Masculinities influence on SRHR

In their complex and diverse nature, norms, expectations and practices associated with being a man have wider implications for SRHR. This influence is assessed in terms of understanding how masculinities inform the kind of Policies and programmes on SRHR, the nature of advocacy, interests and actors in promoting sexual health and rights. The report notes that while some of the attributes and social identities of men enable access and usage of SRHR services, a wider array of masculine behaviours and idealized forms of doing masculinity constrain realisation of SRHR.

a. The 1994 International Conference on Population, Development, and its conversation on the role of men in facilitating positive male role models in parenting. The report previously noted how the ICPT+5 plan of Action called for deliberate male involvement – "men to support, promote and respect women's sexual and reproductive health and reproductive rights, recognizing the inherent dignity of all human beings. Men should take responsibility for their own reproductive and sexual behaviour and health. The plan for action called for research to be undertaken on men's sexuality, their masculinity and their reproductive behaviour"(UNFPA, n.d.)

b. In 2013, ministry of Health developed National Implementation guidelines for Male involvement in Sexual and Reproductive health and rights, Child Health including HIV/AIDS in the Health Sector (2013) and services standards for sexual and reproductive health and rights (2012). Along this strategy, the ministry adopted innovative approaches to have couples come for Anti-Natal Care together (WHO-Uganda, 2014). Health centers visited under this study attested to encouraging men to attend antenatal care with their wives. Women who were accompanied by their husbands were given priority attention.

c. In 2017, Ministry of Gender labour and Social Development, in partnership with UNFPA-Uganda, developed The National Male Involvement Strategy for the Prevention and Response to Gender Based Violence. One of the Strategic objective is to promote transformation of harmful gender norms and practices that perpetuate gender based violence. Prevention of GBV is an aspect of the comprehensive SRHR package.

d. Other strategies that work with men and change agents and champions of progressive change were noted among the SRHR service providers. For instance, Reproductive Health Uganda cited engaging men across its branches throughout the country. Particular attention is noted in male involvement strategies in Bushenyi, Arua, and Kapchorwa. In one of the reports, RHU writes "Reproductive health Uganda (RHU) …has strong male engagement strategies, including involving fathers through positive parenting interventions and encouraging men to support women's economic empowerment". RHU further integrates men into women groups and trains them on a positive parenting programme called Programme P. Some of these men today, reports RHU, have become examples to other men in their communities and are slowly inspiring more men to join the groups, helping break the cycle of GBV". There was also noticeable cultural shifts in terms of how men and boys view gender roles in their communities.

3.5.2 Progressive masculinities nurtured through women's grassroots movement

In Gulu - Gulu Women economic Development and Globalization (GWED-G) – a local women's rights organisations runs women's grassroots movement composed of women Village Savings and loans Association/Schemes (VSLA) through which women's social capacities are built. The idea of building a grassroots movement of women's rights is to enable women demand their rights from duty bearers. GWED-G works with women VSLAs not only to empower women economically but to work with these groups as spaces where women organize, collectively gain voice and demand social accountability; psychosocial healing especially from effects of war; collective and individual agency and avenues to groom women leaders in politics and other spheres of life. This grassroots movement works with Male engage strategy that looks at men in a comprehensive manner:

1. **Men as partners** – for change to happen, there is need to address male dominance – work with a theory of change to explore what needs to change among male behavior. Working beyond narrow and universal focus on men as perpetrators of women's oppression, GWED-G believes that every woman has a supportive man (whether a father, husband, uncle, friend, son, any) in their lives. They demystify derogatory labeling of men as alcoholics arguing that men are not always drunk, absentee fathers, and abusive. Focus on men as partner, looks at how to improve relations amongst women and men.

2. **Men as peer educators,** as champions, as role models – men reaching out to fellow men in male dominated spaces. Building capacities of men, promoting alternative ways of being and doing masculinities.

3. **Men as Vulnerable Clients. GWED-G works with men as clients in particular acknowledging masculine vulnerability.** This particular strand of the movement building looks

> out for men that are vulnerable – abused men, male victims of state violence, domestic violence. This involves provision of Psychosocial support and counseling for men because men get stressed, go drink, and become less productive and violent – leading to prohibition of SRHR access and use; suicidal mentalities. After war, some men needed economic support just like women, but women's rights organizations were only targeting women empowerment e.g. through VSLAs (Adopted from the interview with Director GWED-G).

At the community level, participants identified men who support their wives and female kin in accessing and using SRHR services. They pointed out men who make joint decisions on family planning, men who accompany their wives for anti-natal care and childbirth, take children for immunization as well as participate in domestic care work, men who provide finances to their wives to access reproductive health services. Other men do give permission to their spouses to access health care, in particular SRH services. While these actions might look like minor and obvious, they are strongly contentious decisions amongst people of reproductive ages. For instance, a woman's permission from her husband (or the lack of couple consent) to access and use family planning services is one of the outstanding determinants of whether women can effectively claim their SRHR. Additionally, it is notable that men who are supportive of SRHR are fewer compared to those who are reluctant or out rightly resist use of SRH services in their families. Yet, these few progressive men provide important prospects for improving men's role in access and uptake of SRHR services. These progressive men/ masculine behaviours were reportedly common among recent married couples, or couples that are educated.

Despite these progressive ways through which men work towards promoting access to SRHR, these positive masculine practices are not without cost, particularly in cultures where men are expected to exhibit power, control domination over other weak men, women and girls. In all the communities for example, men who exhibited supportive behaviour towards women and SRHR services were labelled, ridiculed, and laughed as half men, not a full man, not men enough, cowards (ekifeera) and other demeaning labels. The director GWED-G Noted that the focus on masculine vulnerabilities is one of the most resisted aspects of the comprehensive approach to male involvement, especially by women's rights organisation who look at it as a diversion of resources and gender focus from women who are the majority of the oppressed. An official from the Ministry of Gender expressed her reservation on deliberate focus on men in SRHR. She noted, "Personally, I am pissed off by those kinds of research (special programmes for men). It is like we are becoming apologetic of what we are meant to achieve. I don't believe in special treatment for men." She added that men have their rights, they are the powerful and in control and ought not to be focused on. Such resistance to deliberate efforts to understand men's experiences in SRHR and beyond are not unusual. However, they have the potential to produce men as ungendered, constitute gender relations as about women, to marginalise and silence men's experience and consequently produce masculine resistance to programmes such as SRHR.

In an interview, a male change agent under the GWED-G male involvement strategy expressed the kind of stigma they aced from other men. He noted:

We faced a lot of stigmatization from our fellows when the initiative [of working with men as champions] had just started. There are instances where instead of being with our fellow men maybe

for farming or drinking we take our women or children to the hospital. When we go back to our male circles, they ask where we have been. We were often abused as "lubwolo" (fools). Some men were asking if we were going to continue with this foolishness forever (Male KII- Gulu).

These are some of the costs of performing positive masculinities which deviate and seek to transform traditional and harmful forms of masculinities.

3.6 Masculinities that Hinder policy framing, access and uptake of SRHR

3.6.1 Feminization of SRHR

There is a dominant view that sexual and reproductive health rights discourse, whether in policies, programmes or everyday activities, is about women and girls. There are for instance, very few contraceptive methods that target men. In one of the handbooks "plan a manageable family for a better life", Reproductive Health Uganda, GCACI and IPPF provide a brief about the benefits of family planning. On this short list, the handbook gives seven benefits to the mother and baby and only one benefit to the father of the baby i.e. family planning "lightens the burden and responsibility when the supporting the family". In effect, policies and programme intervention tend to construct and represent SRHR dominantly as an issue of maternal health and new born and less about men. When men are drawn upon, they are constituted as secondary actors, who only come in to 'help' accompany women rather than as individuals who have central stakes in making informed reproductive health choices. Men commonly draw on these feminine centered approaches to SRHR to drag their feet in enabling access and uptake of SRHR.

In a group conversation with women in Kamuli district, Bugulumbya sub-county, women revealed how couples hardly discuss matters to do with sexual and reproductive health. Men reportedly ask their wives; "am I the one who gets pregnant?" Men's resistance to collective discussions on SRHR points to the common perception that matters related to reproductive health are about women. Participants also pointed out reproductive health trainings, sensitisation and information sharing that target women and girls only, ignoring women and young boys. We also encountered information communication materials and advertisements on SRHR which popularly focus on women and girls as the central beneficiaries of maternal health. In these media images, men are either silent or overtly constituted as problematic figures that young women and girls struggle with, as the perpetrators of sexual oppression e.g. teenage pregnancies, early marriages, sexual abuse. Conceptualisation of SRHR as about women and less about men constitutes gender as about women and further normalizes the polarities between women and men. It is notable that even when programmes engaging men in SRHR are on the increase, men are still distant from women. Some sit separate from their wives at the health center, or are requested to sit under the tree shades as their wives undergo medical procedures.

In Arua, men's distant relationship with women and its consequent effect on SRHR was attributed, in part, social cultural norms and values. The district Health officer, Arua shared on how "young boys are taught not to closely relate or associate with girls. Gender socialisation often drives girls and boys apart. In Arua, we have married men and women who cannot walk together hand-in-hand. One walks ahead of the other even when they are going to the same function/place". These norms have eventual effect on women and men closely interacting and collaboratively making decisions especially about sexuality and health.

There are SRHR organisations that are also perceived as female-only spaces, which limits men from approaching these facilities. In Mbarara, In-charge Marie Stopes had this to say:

> *People always perceive us an organisation that deals with women, that is what they perceive, they think Marie stopes deals with women in family planning. We are telling them we are dealing with men and women and children because we are dealing with different types of illnesses. But the majority of the clients are women because they are coming for family planning, they are coming for STI management and other sexual reproductive health. Men rarely come but when they come still, they are shy they think they are out of place, they think Marie stopes is dealing with women. But we try to bring them on board. We tell them it is for everybody please get involved. When you manage a woman, this woman is sleeping with a man so any time this man will again transmit the infection. So we try to involve men. When a woman comes, we tell her to tell her husband that he also needs treatment. We sometimes see them coming then they also get involved in their wives management.*

This conversation revealed realities around men's reluctance to access institutions, which posture or are perceived as women-only spaces but also the intricate link between women and men's sexual and reproductive health needs. For example the idea that for an effective treatment of STIs one needs to target women and men as well. Photographs that depict silences and /or invisibility around SRHR are shared below.

These images provides insights into the dominant narrative of women, girls and children and their centrality in maternal health and men's explicit absence from these conversations. In the first picture, it is notable hat even when there are efforts to bring men into reproductive health programmes, they are practically kept at a distance, separate from their wives in health care institutions. The study met many cases where men felt they had less or nothing at all to do with going to the health units for SRHR services.

3.6.2 Traditional masculinities and men's health seeking behaviours

Men's poor health seeking behaviours is an issue that has been widely researched in Africa and beyond. In their work masculinities and men's health, Olanrewaju and others (Olanrewaju, Ajayi, Loromeke, Olanrewaju, Allo, et al., 2019) argue that the nexus between masculinity and men's health-seeking behaviour is a multifaceted global discourse which has been quite enlightening when viewed from varying perspectives. They add, "cultural and patriarchal norms continually impact the chauvinistic character of men with regards to their health" especially when masculinity is demonstrated through avoidance or negligence of health care and promoting unhealthy behaviours. In societies where traditional masculinity remains the dominant identity for men, healthcare is strictly seen as a feminine construct where females who are usually being described as weaker vessels, require health services regularly while men are resilient and do not need health care services or are not often referred to as "fallen ill". While this study was exploring men's health seeking behaviours in Nigeria, a west African community, the findings closely resonate with men's experiences of health seeking in Uganda's diverse community.

3.6.3 Men are too busy to fall sick

In all the communities we visited, there was a dominant narrative that men are household heads, they work to sustain their families. As such, they are always busy and do not have time to fall sick. The provider role coupled with traditional constructions of men as powerful, strong and less emotional combine to constrain men from seeking health care, including access and utilization of SRH services. Participants noted a number of assumptions that guide men's reluctance to interface with health centers and consequently trivializing health care in general

- Men are busy and mind about making money and making ends meet
- Men are impatient and cant adhere to medical procedures
- Men fear long queues at the health centers
- Men assume to that if their wives are okay maybe they are okay. This is especially so, in cases of HIV/AIDS and other sexually transmitted infections. If a woman is negative, the man will assume he is also okay.
- Men tend to access health services when they are very ill- they rely much on pain relievers and self- treatment.

Interviewer: *We were told that men fear to come especially when their wives are going to give birth, or when they are going to take family planning methods or when they are sick generally or even escorting their wives for antenatal care.*

Interviewee:

Because they think when they reach hospital they may get tested also maybe for HIV or STIs and they find they are sick which they don't literally like. They fear getting tested generally. They test you and say see you are sick, men usually don't want to be told they are sick. Because they fear treatment or because they get stressed when they are told they are sick or they worry about the costs of management or the interruption in their work schedules (KII with in-charge Marie Stopes Mbarara).

These were some of the common assumptions that men and women alike shared about men who seek or fear to seek for health care or refuse their wives from seeking for medical care because they did not strongly believe in health care systems. Behind these assumptions were the underlying constructions of men as physically strong and the fear to be seen as weak and vulnerable. In Isingiro, a religious leader from the Islamic faith noted that men do not speak out to religious leaders when they are faced with health challenges. In Arua, RHU in-charge noted that men fear to open ups especially when they come for their first time for antenatal care. *"The complex process at the first ANC visit which includes testing and so many questions also prevent men from accessing SRHR. Some think SHR services waste a lot of time yet they have many things to do".* First visits are often full of questions that men might find intrusive. These ask about one's sexual history, their sexual activity, whether one has more than one sexual partner, the number of children one has, the history of any known chronic illnesses, among others.

Critical reflections on rampant men's fear to access health services pointed to a clash of discourses. On the one hand is the masculinity discourse which operates on exercise and demonstration of power and physicality and on the other hand the medical discourse with procedures that render medical clients 'objects' of investigation. Participants pointed out how the procedure and the practices in the health institutions generally objectify and render vulnerable their medical 'clients', how patients present with the fear of the unknown health condition (do not know whether you are HIV+ or negative). The health center also operates long queues often of women and children on first come-first-serve basis. Patients are subjected to instructions that render them subordinate. All these medical practices erode the masculine power and privilege of men (who, in the context of the households enjoy immense pride are prioritized, knelt before, pampered, etc) ultimately reducing the possibility of frequenting the health center.

3.6.4 Men and the normalization of multiple sexual partners

In most of the communities we visited, ideal men are defined by having multiple sexual partners. Sexual activity is a key defining attribute of being a man. In Mbarara, we were told a common saying that "Omushaija abowa'shwera" (a man is one who is able to marry). In Mbale, the traditional practice of male circumcision is dotted with sexual praise of men. In Arua, men reportedly draw on the dominant Islamic faith and culture to marry more than one wife. The more wives one has, the higher the competition amongst wives over him. These hyper-sexualized practices center men in decisions regarding sexuality. Indeed a participant in Arua noted that All SRH issues rest on sex yet men are the controllers of this, they are the ones who ask for sex even when you are cooking, they are

A forty-year-old man in Bugweri district is nursing horrific injuries after his wife hacked off parts of his genitals over spending the night at his co-wife's home. The woman reportedly accused the victim Bashir Mukaire of spending the night at his co-wife's yet he was supposed to be at her home

responsible for the decisions of their women in regards to SRH. Men's normalized multiple sexual partnerships increase the possibilities of child birth and the associated SRHR concerns such as spread of HIV and other STIs as well as sexual and gender based violence. Very recently, media reported a case in which a woman chopped off genitals of her husband accusing him of spending the night at his co-wife's home yet he was supposed to be at her home (Kibumba, 2021)

3.6.5 "Omussada kyakoba nzena kyenkoba": Masculine authority and its effect on uptake of SRH services

Men were noted as key stakeholders in decisions regarding sex, sexual and reproductive health. Participants we talked to in all the communities shared about authorial, dominant and suppressive power that men possess over women and children. Men's authority included granting or refusing women permission to seek for SRH services, to have a say on whether to use family planning or not, determine the number of children they and their wives can have.

- In Kamuli, the Basoga shared a common saying that "Omussada kyakoba nzena kyenkoba" (meaning that "whatever a man say, is what I go with")
- In Arua, participants talked of men having ultimate authority on the children to give birth to.
- In Mbale, a man who has been circumcised (been at the circumcision grounds) wields more authority over other uncircumcised men, boys and women. His decision is final
- In Lira, decision-making, especially on childbirth was dictated by culture through traditional leaders. Reference was made to the Lango cultural leader's call to the population to give birth and how this compromised women's access and utilization of SRH services. "The cultural leader "won nyaci" is quoted to have a slogan that "dano omito nywali" meaning "people should give birth we want children". This impedes the uptake of SRH especially Family planning (Official in RHU, Lira).

"Cows paid in bride price are still producing"!

In Arua, men cherish childbirth and tie this to bride price. Wives were particularly reminded that as long as the cows paid for bride price are still producing, a woman could not go on family planning. District health official recalled a male tax collector in one of the prominent markets in Arua who engineered a rumour to de-campaign implants.

> *"He circulated the rumour in the market that all the implants that women had were going to expire in the next few days. On expiry, they would bust out of the women's bodies. Many women ran to the hospital to remove the implants. So, we went to look for him with police and told him to undo what he did. He was a taxi collector and had a lot of power and authority. He is a traditional man who has paid 12 cows and would want 12 kids"*

Similar thoughts were encountered during group discussions with women, in Vurra sub-county. One noted, "men have got primitive behaviour especially if one gave bride price while marrying for example 5 cows, he says the animals are increasing in number, why do you, as a woman, want to stop bearing children?" Repeated thoughts around association of 'productive cows' to women points to how deeply entrenched, these social practices are and how constraining they can be towards women and men's access and use of family planning services.

3.6.6. Traditional male circumcision in Mbale as a hindrance to SRHR

Traditional male circumcision or Imbalu as is commonly known, was characterised as both a rite of passage to manhood but also a process that often compromises access and use of sexual and reproductive health. One of the elders described the process of male circumcision as "the most important culture aspect yet the most chaotic". The process includes a series of days in which young male candidates go dancing around the community, accompanied by community members. In these ecstatic moments young men and girls in processions engage in random sexual activity. The process also includes heavy drinking of local brew (Malwa). On the circumcision ground, boys who are undergoing the cultural right are expected to exhibit an extreme sense of bravely, often characterised by suppression of all forms of emotions. One cannot cry or wink during the cutting. "You must be strong and determined because some people fear to get to the ground and it's a shame to the family and the entire community". During circumcision, your father gives you a stick to hold on across your shoulders as you stare into the chanting and expectant crowds. You have to look at your father without blinking until he blows a whistle to show that the cutting has been completed without an incident. If you blink the eyes, then it's a disaster. He will ask you, "you man, how dare you fear the knife?" If you cried and blinked eyes during circumcision, it is a disaster, you will become the talk of the society, even aspiring for any leadership position, people will be like aah, what are you talking about?

Community development officials noted a direct link between the practice of imbalu and the worsening SRHR. They cited cases where the rite of passage produced men as authoritative decision makers in their home, inspiring early sexual activity amongst circumcised men, encouraging random sexual activity during dancing processions. Some participants also pointed to practices where recently circumcised young men are encouraged to engage in sexual cleansing i.e. to have sex with any woman, including old women. In such a case, the man would not have any further sexual relationship with such a woman.

> *The preparation for circumcision and after circumcision has become a problem in access and utilization of SRHS for instance, after circumcision among the teenagers, there is a lot of sexual activities. The teenagers want to test how it is after circumcision in relation to how it was before circumcision. They will say, we want to test, shall we test in condoms? (KII with Probation officer, Mbale district)*

These cultural practices not only produce traditional masculinities animated by hyper-sexuality, they also inculcate a cultural of sexual abuse, increase possibilities of sexually transmitted infections and prospects for unplanned pregnancies.

3.6.7 Women 'sneak out' for SRHR services

There was an overwhelming narrative on how women "sneak out" of homes, marriages, relationship to seek for family planning services. The idea of sneaking points to women's negotiation of men's resistance to the use of these services. Stories of women who go to seek for SRHR services were from all the regions of the country that the study covered. As such, these stories reveal the pervasive male resistance but also women's agency as they negotiate these resistances. Below, the study shares voices from across the districts on how women sneak out, why and the implications of these covert mechanisms of seeking SRHR services.

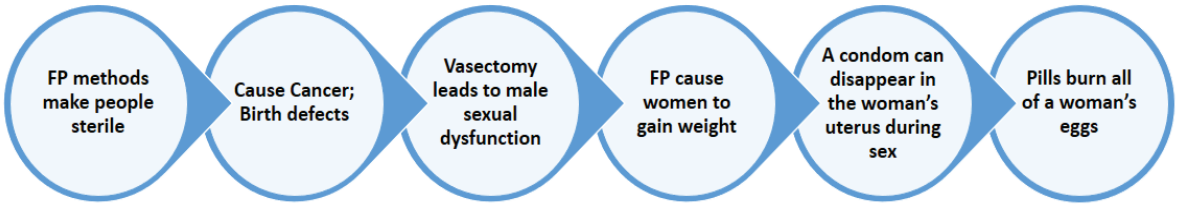
- Women sneak out and receive family planning but once the man comes to know, it leads to domestic violence (Probation office, Arua)
- Women who sneak to SRHS providers often prefer to use concealed methods of family planning that their husbands and those opposed to SRHR may not easily notice (female youth, Arua).
- Women run to the hospital for family planning when they have already decided what method they want. They will run there and say "njagala akaweta" (I want IUD), after sneaking from home and because clinics are money minded, they just put and say "kanagwelamu eyo" (Male, Chairperson Bugulumbya male action group).
- A woman going for family planning behind the husband's back "akikola ngayebilila" (she does it in hiding).
- Many women steal Family Planning because of the restrictions put by their men. They prefer the most secretive methods such as injectables because they cannot be detected by the men. We have received cases of men using razor-blades to remove implants or pushing their hands into the woman's vagina to remove IUD rings, if their women accessed the services without their consent (In-charge RHU, Arua)
- There are notable increasing trends of women demanding for the removal of IUDs in Lango sub-regions – men are behind the removal

Reflecting on the contexts in which women sneak out on their husbands to access family planning services, participants characterised women's moves as acts of agency especially with increasing rates of women neglecting family responsibilities. They argued that women's choice to go for family planning without an absentee husband's permission is more about women negotiating patriarchal resistance from individual men, religion, culture and traditions, and as act of responsibility since it is women to take care of the children they give birth to. Despite this argument on women's agency, sneaking out was reported as having dire consequences on women's health. That is, negotiating patriarchal resistance (husbands and in-laws resistance) to usage of SRH services, it increases

possibilities of women accessing and using methods that may not be medically appropriate for their bodies. Women prefer methods that are convert (e.g. injectable, IUD) and not easy to trace rather than methods that resonate with their bodies and health statuses. This behind-the-scenes practice compromises women's right to choose an appropriate contraceptive method.

3.6.8 Misconceptions about family planning

The above forms of male (and female behaviours) also inform a host of myths and misconceptions which hinder access and utilization of SRHR services. There is, for instance a misconception that family planning causes cancer, infertility or that once a woman uses family planning to help space children, when she resumes, she will give birth to abnormal children. Common myths and misconceptions around family planning include the following.



In a conversation with Mary, a female youth and a Change-Champion and volunteer with Uganda Youth and Adolescent Health Forum (UYAHF) in Kampala, access and usage of SRHR especially among the youth is affected by massive stigma, myths, and misconceptions around use of contraceptives. She argues that youth who seek to use reproductive health services e.g. family planning are seen as prostitutes, sexually loose and a spoilt generation. In effect, there are limited facilities with youth friendly services. For example, old people in charge of service provision look ta youth as sexually spoilt. Additionally conversations on Sexuality remain enshrouded in secrecy and cultural taboos consequently limiting women and youth access and utilization of these services.

3.7 Cultural limits to access and usage of SRHR services

The report has indicated ways in which different cultures construct and position women and men in ways that limit access and usage of SRHR. Beyond cultural constructions of masculine and feminine identities, the study recorded cultural myths that hinder women and men's uptake of reproductive health service. For example, in an interview with the District Health Officer in Arua, it was noted that:

> *"Amongst the Lugbara, people do not want to prepare for a baby who is still in the stomach, for fear that the baby may die. This leads to inadequate preparation. On delivery of the baby, medical staff will ask for items to use but the couple has nothing. The man will say "let me go and sell my goat which is in the veranda, I will bring the money tomorrow after the market" (KII with DHO, Arua).*

These and many other cultural myths hinder people from planning for families, making decision on the number of children to have and how to care for these. Often culture intersects with religion in ways that complicate access to reproductive health care.

3.8 Religion

There are notable progressive voices regarding the role of religion in promoting sexual and reproductive health. For instance religious institutions are increasingly taking on conversation on family planning through specific departments such as Fathers Union, Mothers Union groups, marrieds fellowship groups, pre-marriage counseling sessions, among other aspects. Religious leaders are also active partners, often invited by women's rights groups. During the UN Women launch of the media campaign on "men at work for gender equality and women's empowerment" June 2020, religious leaders actively participated and committed to support efforts to women's empowerment. As a representative of the inter-religious council, the male religious leader from the Islamic faith reiterated:

> *We are quite honored to be part of this memorable occasion. … Today in Uganda the question of women emancipation is no longer questionable. We see that women are part and parcel of all the development programs. We in the Inter-religious council have equally taken on addressing gender gaps. We now constituted women's representatives into our operational boards and committees. We have a representative of faith and youth, at Uganda Moslem council equally we have instituted a secretariat for women and youths. And we have gone a long way that in each of our respective religious fraternity have embarked on to education institutions that offer bursary to youths, women and male equally. … We therefore appreciate the efforts geared towards this direction and we would like to pledge our total commitment and support to this endeavor….*
> **(Islamic leader who represented the Mufti of Uganda)**

Beyond religious leaders and their networks (e.g. the inter-religious council) as critical actors, some religious groups give their congregants a chance to make individual choices whether to access SRHR or not. In some churches, religious leaders admitted to sharing information on SRHR especially among the married couples.

The media also pointed to the Archbishop of the Church of Uganda, (His grace Kazimba Mugalu) calling on women to use contraception during covid-19 lockdown to avoid unwanted pregnancies. In an article that run in the Guardian, "Archbishop of Uganda urges women to use contraception during lockdown" (Okiror, 2020) the faith leader is quoted as saying: "I am really concerned [that] after [this] coronavirus situation we will have many, many women who will be pregnant. Actually we need to be careful. I want to call upon you women don't forget to use your contraceptives because we don't want [you] to have unwanted pregnancies,".

While the Archbishop's comments were welcomed by some of the reproductive health rights actors, other people termed these as a personal position rather than a view of the church of Uganda. Indeed, a cautious religious approach to SRHR and the gender equality agenda as a whole is not new. In the UN Women campaign for gender equality, the religious leader who committed religious institutions to promoting gender equality intoned the commitment with a contrasting caution:

However usually our major precautions are that respect to values need to be taken seriously. Values have no compromise, we should not allow the misconceptions or the myths that accompany this kind of women emancipation to rule over for instance we emphasize in the religious fraternity that equality is not uniformity. Yes, we are equal but we still remain who we are, men remain men and women remain women. We should not try to overtake these differences we need to respect that. We would like to see women as progressive but still combining their responsibility both at household and their respective offices. It is unfortunate when we see the statistics broken marriages because of increased level of people working especially the women and this is a problem. I think that ought to be looked at seriously. As we do this, we also need to take caution of cultural invasion. Yes we are one in this movement but really we are who we are because of the differences that God created us with so cultures everywhere are respected but even cultures locally need to be respected. Therefore we need to put all that in consideration otherwise we in the religious fraternity we are hand in hand with you to emancipate the women, to have the women to offer the services because even God Almighty need this equal as far as the spiritual interventions are concerned.

The above perspective, conveyed by a religious leader on the launch of a campaign to promote women's empowerment highlights, in discursive ways, the caution, the reservations, the shifting commitments, and the likely undercover social norms that slow the gender equality progress. For instance, while he publically commits to the goals of gender equality, he resists in almost an equal measure:

1. Women's economic independence especially when he states religious discomfort with "broken marriages", which he attributes to increasing number of working women.
2. He applauds women's progress in the public sphere but feels this has got to be combined with what he calls "their responsibility in the household" - a move to re-domesticating women.
3. He expresses his anxiety with what he terms "cultural invasion" which can be exemplified through thoughts that rights especially SRHS manifest as western modern disrespectful imposition over African local cultures.

Reservations of this nature pointed to how deeply rooted religious resistance towards SRHR can be. Such resistance is further exacerbated by people's strong belief in religion and how these beliefs influence people's choices in everyday life.

In effect, the study noted diverse religious faith and their fluid positions on SRHR. Notably there was a general view from different faith – Islamic, protestant, catholic faith, among others – that God is the author of human life, the planner and provider of the family necessities. These religious beliefs had implications on whether women and men could use reproductive health services. Some of these beliefs are listed below:

- There is existing literature that points to Islamic faith and its resistance to family planning. In an article "Morality, justice and gender: reading Muslim tradition on reproductive choices" Sa'diyya Shaikh (2011: 346) traces resistance to family planning in Qur'an. She argues, "opponents of family planning often base their rejection of contraception and abortion on their reading of the following verse: 'Kill not your children, on a plea of want, we provide sustenance for you and for them…" The idea that God provides for our families and there we need not to worry about how many children was dominant among Muslims as well as some Christian leaders.

- Christian religious leaders also expressed reservation on open preaching about SRHR on the pulpit. For some, SRHR such as condom use were judged on moral grounds as sinful and unacceptable.

- Some religious leaders acknowledged selective use of family planning. Majority approved use of natural methods of family planning, which included 'withdrawal, observing safe days as well as breast feeding. They often equated other modern methods to enabling termination of life.

The above examples show how religion is a barrier to the uptake of SRH services. In an interview, a clinical officer RHU, Lira talked about how "the religious discipline prevents women from accessing family planning. You may find that some want to take up Family planning it is as if they have to first seek permission from these religious leaders" (Clinical Officer, RHU, Lira). In Mbarara, a religious leader shared with the research team on how the bible hardly allows contraception.

> *The bible does not allow family planning but for HIV testing and treatment we encourage people to go. The bible says that Jesus came so that we may have life in its fullness. We emphasize that people go for HIV testing and if you find yourself positive, you go for treatment so that you live. And if you live longer you help your family and the church at large. But if you teach family planning on a pulpit you will have deviated from what the bible teaches. When God created Adam and Eve he said have children, multiply and fill the earth. … If the lord sees that you cannot manage a certain number of children, he will close the womb. If you preach to people and say have children whom you can manage to take care of, it means you doubt God's ability, because God puts a way to raise these children.* ***(Lay reader, of a local church of Uganda, Mbarara district)***

3.9 Institutional limitations towards access and uptake of SRHR services

Beyond masculinities and their obstruction to SRHR services, participants identified challenges that might hinder usage of these services.

Barriers for women and men to access SRH services

During data collection, the research team inquired about the barriers that could be encountered by male

and female clients as they endeavor to access SRH services. Some of the reported barriers were at partnership level, health facility related such as limited health facility supplies, health facility related charges, absenteeism of health workers, distant health facilities, negative perception of health worker about PWDs, health facility delays, rudeness of health workers, lack of SRH information, lack of male focused SRH services at health facilities. In addition, there were hindrances due to myths about SRH services, cultural beliefs, religious restrictions, limited partners supported male targeted SRH and personal behaviors.

Partnership level constraints

Listening from the district official, most of the implementing partners come to provide services in districts with already selected areas of operation. This was said to be a problem in that most of the partners tend to be in similar locations serving same population, where as other communities lacked in service provision

> *Development partners come with their specific agenda and particular areas/locations to operate from. It is against this background that the district health team agrees with partners on how to proceed. Some few partners ask to be guided on where to go (Male KII District Official 4, Wakiso).*

Health facility supplies constraints

There were also constraints reported that were related to limited supplies at the health facilities especially drugs. They reported that where drugs tend to be available, they are in limited quantities that a patient can only be given part of the doze and is advised to buy the rest of the doze from private pharmacies. This was reported to be a serious challenge to accessibility and utilization of SRH services given that most of the community members tend to be constrained financially. It was reported that the situation that has been worsened with the Covid19 pandemic with its related movement and curfew restrictions. In addition, it was reported that some of the free medical supplies that tend to be available in the health facilities are of poor quality.

> *Most of challenges in government health facility is because drugs tend to be less. Like I got infection, when reaching health facilities, I explained what was worrying me, they had taken urine and blood samples earlier. My husband had given me sh. 10,000/=, transport was sh. 4,000/= and drugs were for sh.10,000 given it was not available at the health facility. Me, I used to attend ANC at government health facility knowing that I will pay around Sh. 50,000/= but when I went in a private clinic, I spent Sh. 130,000/= and I even incurred debts. If health workers were available at night, it would save on such costs. There is need to improve on care by health workers. You may reach in labor pains, like my first born, it happened when I was at the gate and it is my fellow women who helped me to give birth. I even delivered from then floor. There is need to put drugs in health facilities (Female KII youth, Buikwe).*

> *There are no drugs in hospitals. Government should get off and leave us alone to take drugs/marijuana. Where services are free, there are distant. After circumcision, there is no treatment (Male FGD, Buikwe).*

> *There is a cost attached to every service that hospitals provide and on drugs they will say out of stock meaning you buy. Ideally we have health centers that are not distributed to communities*

making accessibility difficult. Now costs with covid19 period is high. In this period, people are encouraged to keep home to avoid covid19 which becomes a barrier with cafew rules …. For women, when they go to health centers, they find the health team tired and not receptive. Teenagers who have just started these services, are pushed away and for adults, they will seek alternatives in TBAs. When we get to health centers at times and people are not there, we give up, there is limited services in health center IIs and staffing. … (Male KII, District Official 3, Wakiso).

… condom contribution but we have fake ones. We receive ngabo and life guard (Male FGD, Buikwe).

Health facility related charges

Some of the study participants reported that female and male clients were constrained by the high costs associated with seeking of medical care. It was reported that even after childbirth, the health facility bill tends to be too high to the extent that some of the participants perceived the high charges as a cost for getting a baby. To some of the study participants, some of the SRH services that require to be paid for like counselling are not a priority given the competitive needs that require to be paid for.

Those who cannot meet the cost because access has a dimension of affordability, availability, this could affect vulnerable groups like refugees, orphaned and other vulnerable children, child mothers and people in human settlements. Even when we say free services, there is indirect cost attached e.g. commodity. Demand is higher than supply which causes insufficient supplies. In the National Essential Drugs, qualification report. What is provided is minimum health care package which is costed and financed (Male KII, MoH).

... These days they sell children to us, everything you take to health facility is costly, even the bill for child birth is high. ... For GBV, it is mama police and LC system that handle them. We have counsellors, though police station is easily accessible by women than other areas. Even if a woman is in wrong, the police will defend her. … (Male FGD, Buikwe).

The high charges especially in private health facilities which a consumer may not wish to pay for e.g. for counselling. How do I pay money for counselling? (Male KII District Official 3, Buikwe).

…. one time an implant disappeared in my wife's body and I spent 100,000/= to find and remove it, yet inserting it was free of charge. There is FP that was given to my wife which affected her, I left her and got another woman (Male FGD, Wakiso).

Absenteeism of health workers

It was also reported that much as the SRH services are being promoted and encouraged, some of the health workers were hardly found in the health facilities. For example, one of the study participants reported that while she was going to deliver a baby, she reached at the health facility by 2pm and never found any health workers at the facility.

ANC was recommended, but when I went to deliver, I did not find health workers at 2pm yet I was walking from home and water had started coming out. I delivered from a private clinic. Delivery, SMMC, FP, immunization of children and sex education is at health facilities but rare. Women benefit a lot. Men get SMMC and treatment for illnesses like STIs (Female KII youth, Buikwe).

Absenteeism of health workers at the facilities especially those that work in labs. …when we go for treatment at the health facilities, many times we are given treatment based on what we tell health workers. They rarely do base treatment on lab tests because the lab technicians are rare to be found (FGD Males, Wakiso).

Distant health facilities

Another key challenge that was reported to be hindering access and utilization of SRH services was in relation to distant health facilities. It was reported that long distance meant required money to cater for transport charges. In addition, participants reported that fear of Covid19 has also negatively affected response to outreaches besides the negative politicking of SRH.

Distant health facilities- a service requires transport to a health facility. Others simply do not know that certain services exist. They think health seeking is for people who are sick. … Current situation of Covid19 has scared away people who health facilities and health workers have Covid19. Even in outreaches, people refuse to attend. Political interference- providing wrong messages on services like saying that government is providing immunization for wrong reasons. … (Female KII, District Official 2, Wakiso).

Distant health facilities yet the youth of these days are not the type that would like to move distances for services like SMMC and counselling. But condoms have been brought near in shops and points like bars in washrooms especially the pink condoms (Male KII District Official 3, Buikwe).

Lack of youth friendly spaces

From the study, it was reported that some of the health facilities in the districts of focus lack youth friendly policies and spaces. In addition, it was also reported that when young people visit health facilities, they are mixed with adults, something that was said to be making the young people feel bad and uncomfortable. Lack of separate spaces for the young people and adults was reported to be limiting dialogue between the youth and the health workers. It was also reported that young girls do not access SRH services for fear of being seen at health facility. More so, it was reported that health workers are not well equipped to provide SRH services to special groups like the young people and persons with disabilities (PWDs) which as well limited utilization

For young people, boys and girls, their framework has never been approved, SRH with girls below 18 years is not there, yet they are sexually active (Male KII, MoH).

There is lack of separate youth friendly corners in some health facilities to allow smooth flow of dialogues. Some health facilities lack youth friendly services. A young woman seated with old women feels bad will not be able to discuss anything. There is limited capacity of health workers in providing services for the young people (Male KII District Official 3, Buikwe).

…The persons with disabilities are disadvantaged by distant health facilities and limited capacity of health workers to serve such special groups. The health workers and police also lack training in sign language. You may find a health worker who may not have skills in handling PWDs. Health workers need to exercise affirmative action to build capacity of PWDs (Male KII District Official 2, Buikwe).

Youth need a lot of privacy and some health facilities are too small to provide it. Have a lot of confusing information for example thinking that if one is started on FP may not deliver. Some unemployed or poorly paid cannot afford services (Female KII, District Official 2, Wakiso).

Girls fear getting FP being that they fear to be seen at health facility. Fear getting pressure after blood testing and finding they are positive, fear of peers knowing., ... If men know they are sick, they travel and go for checkup in further health facilities is secrecy without informing the partners at home. … (Female KII, Buikwe).

Negative perception of health worker about PWDs

It was also reported that in addition to limited capacity of health workers to provide SRH services to PWDs, some of them including district officials perceived PWDs as asexual. The way they reacted towards PWDs that were pregnant indicate that some health workers did not expect this special category of people to be engaged in SRH services to the extent that some PWDs tend to be provide with certain methods of modern FP without their consent. This was said to be provided to them out of sympathy since PWDs are not expected to be pregnant and later on give birth.

Health worker's perception that PWDs should not get pregnant makes them to pause some questions that are insensitive; like why are you pregnant? and they tend to provide FP methods without consent. Though at times choosing for them FP is necessary. We had a half cast who would produce regularly and health workers inserted in FP to help (Male KII District Official 2, Buikwe).

Health facility delays

Furthermore, study participants reported that there are delays at health facilities which hinder access and utilization of SRH services. Delays at the health facilities were reported to be by the health workers who first engage in conversations before attending to patients. In addition, it was also reported that public health facilities tend to have long queues

At times you find health workers who first converse with each other and delay proving services or attending to clients. Sometimes doctors ask for money that you do not have, even those in public health facilities. Long queues at health facilities. … (Female FGD, Buikwe).

Delays at the health facility and then they say I take drugs at 1pm when there is nothing I have eaten having spent time waiting. …. Some health workers advise discordant couples to separate which makes some couples to fear visiting health facilities (Male FGD, Wakiso).

Rudeness of health workers

Study participants reported that challenges in relation to rude character of some of the health workers. It was reported that patients who visit health facilities are given prescription according to what they explain to the health worker without first examining their health like checking blood to ascertain the right medication. The rudeness of the health workers was attributed to over staying at the health facilities.

Health workers are rude; the way they question us is not polite. When you tell a health worker that I have a headache, they just give us Panadol without carrying out tests. Absenteeism of health workers at the facilities especially those that work in labs. When health workers spend a lot of time in health facilities, they behave as if they own the health facilities, there is need to transfer health workers. We need health workers that are born in our community who know our language and are sympathetic (Male FGD, Wakiso).

Lack of SRH information

It was also reported that there is a barrier in terms of failure to get SRH information to target communities. It was mentioned that even if services are available, unless people get clear information about those services, then accessibility remains a nightmare. In addition, it was also reported that some of the people had wring perceptions about the SRH services and hence passing on wring information about the same. An example was given on HPV vaccination for girls where they reported that the vaccination had effects of failing girls to give birth, and yet correct messages to counteract such wrong messages were not forth coming.

… if services are there and communities are ignorant, won't access them. Distant health facilities within the Sub-county. Moving to health facilities and you find there is no service. Wrong perception of the masses, in villages there is a lot of misperceptions and passing on of wrong messages e.g. HPV will make girls not give birth and such goes on like burning fire. Then also response to correct wrong messages is also not there … (Male KII Sub-County Official, Wakiso).

Lack of male focused SRH services at health Facilities

Study participants reported that at health facilities, there were no SRH services that targeted men. It was reported that even men who try and escort their wives to health facilities, they are asked to leave their wives behind being that health workers dis not have anything to do with men.

Lack of package for men. Primary beneficiary of ANC is a lady but the man is a stake holder. The man comes in to provide nutrition, and learning how to cater for child and mother. Indirect costs at health facility, money, time (Male KII, MoH).

ANC services are provided at Makonge health facility, we escort them but we get challenges, the health workers once told me that for you, your work is finished since you have brought her at the health facility (Male FGD, Buikwe).

Myths about SRH services

From the study participants, the other barriers reported to accessing SRH services were the myths particularly about some of the modern methods of FP. It was reported that some of the myths were on SMMC where it was said that circumcised males have a limited number of children to produce. In addition, there was a myth on HPV and the reason for targeting young girls. This was also said to be intending to reduce the population by reducing the fertility rate. Such myths were reported to have discouraged young people and adults, males and females from accessing and utilizing SRH services.

> *The first to circumcise had no problem but after they said that those worked on have a limited number of children they have to produce people complained about the reason behind and felt bad, which discouraged some of the boys and men. Some men just accept it for health purposes and prevention of infections. Limited drugs available, even if one is badly off, they do not try to find other drugs, they just refer people to get drugs from somewhere else. This discourages people to go back. Some people even get sick but have no money to take them to health facilities (Female KII Community leader, Wakiso).*

> *Myths about service like FP believe is that FP is meant to reduce population, that women who use it become barren forever which also affects immunization that HPV targets young girls with an intention to stop them from ever giving birth and that it they cause cancer. The question they usually ask is why only girls? Knowledge gap – to know that the service is to improve one's health. In urban setting, people are too busy and do not have time. Both men and women are affected. Even women in urban setting are busy looking for money (Female KII, District Official 2, Wakiso).*

Limited partners supported male targeted SRH

More so, some of the study participants reported that access and utilization of SRH services by men and boys was limited by having very few partners are in place supporting their SRH. This was attributed to the fact that even the health system itself assumes that since women and girls are the most vulnerable persons in community, to be the only ones in need of SRH services. In addition, it was reported that men and boys have poor health seeking behaviors with a perception that they are strong enough to manage own health. Besides, it was mentioned that men tend to keep themselves busy, thinking that health issues are for women.

> *We have very few partners supporting men and the boy child. The system has tended to take it that since girls are vulnerable, they are the only ones supported. Partners could have handled boys and girls at family and community levels. Culturally, men tend not to take up services, they tend to have a lower health seeking behavior. They think they are strong to manage all by themselves. Issue of access to health facilities- some places are really remote and access to services is really hard. … there is even lack of security in case of abuse (Male KII District Official 2, Buikwe).*

> *... Some men tend to keep themselves busy and say health issues are for women. Even those who try take them and leave them there. Some men say they do not mind testing for HIV because they test by proxy through their wives. Youth are shy to test because of fear their colleagues to know about the test (Female KII youth, Wakiso).*

Personal behavior

According to some of the study participants, accessibility to SRH services is also hindered by the way a person conducts himself. It was reported that some of the men just fear visiting health facilities especially for HIV test being that they have multiple sexual relationships. It was also reported that some of the men even when they have an STI, they hardly inform their female counterparts to go for treatment, having perceived such illnesses as feminine. More so, participants reported that access to SRH services was also limited by the decline in intimacy relationship between a couple and the level of income. Family with limited love and income was said to be limited as well in accessing SRH services. Furthermore, it was reported that the male clients tend to take themselves as people who are too busy to visit health facilities, though they seek SRH services via none physical means like through using toll free lines.

> *They (men) fear to go because they have many multiple sexual relations and they are scared of knowing the health status. He says leave me to die don't take me to hospital. There is a man whom I had sex with and I got an STI. He went to hospital to have treatment and he was asked to call me for the same. He called me and we went together for treatment, we all became well. But there are men who will not tell you when they are infected. There are diseases which have been defined as women diseases like candida, when you get an STI and you tell your husband about it, he will say those are women diseases. And when we get pregnant those diseases affect us badly, they come with itching of private parts. When you tell him about STDs he just abuses you. Instead of going together for treatment, you go alone and because he is also infected, you get re-infected. …* (Female FGD, Wakiso).
>
> *If love is over at home, one may say, I will not add children. If the level of income is less, yet you want to visit a health facility, it cannot be possible.* (Male FGD, Wakiso).
>
> *Men pretend that they are busy and have a lot of work and other excuses. They say if my wife tests and she is found positive, I will share on her medicine. On the fifty clients a day, you find thirty-five are females and only fifteen are males. We have a Toll free (080031122) which is normally accessed by boys. They feel free to be helped on phone and not physically. A few boys come for general medical care like for STI screening and treatment, HIV testing and counselling and circumcision* (Female KII Senior staff IP2, Kampala).
>
> *There is a general problem of men being poor health seekers, being busy with their livelihood work which affects access and utilization of SRH services …* (Male KII, MoH).

There are indeed various structural impediments at the level of the health facility. These impediments, coupled with men's poor health seeking behaviour (as already indicated in the report) exacerbate the already poor men's health indicators, whether as health clients or actors in the sexual reproductive health care system. Men who are already struggling to seek for medical care, will easily be put off by long ques, drug stock outs and the costs involved in seeking health care especially amongst the rural poor men. Further masculine-related constraints relate to least developed men's Sexual reproductive services. Unlike women and girls who, out of modern and specialized medicine, have specialized services such as gynecologists or a wide variety of SRHR products, men hardly access readily available specialized sexual reproductive services and products.

4.0 Validation of the study

The study findings were validated in a workshop organised by CEHURD, on the 24th May 2021. The validation exercise brought together key stakeholders that included some of the study participants in the local governments of Buikwe and Wakiso districts; civil society actors that are in partnership with CEHURD under the JAS Programme. The validation programme included a presentation of findings by the research team, critical reflections from the panel of experts on gender, SRHR, and discussions in the plenary. The validation meeting was aimed at sharing study findings with the stakeholders and getting feedback for further improvement of the report. Below, the report shares lessons learnt from the validations and further areas of study that could be conducted in future to provide a nuanced understanding of masculinities and SRHR in Uganda.

4.1 Lessons Learnt

Participants in the validation meeting commended the research team for exploring in-depth a key question of masculinities and SRHR. They acknowledged the relevance of interrogating men and masculinities at a time when the global gender equality agenda is focused on forging ways of challenging deep-seated social and gender norms that slow down achievement of gender equality. In particular, participants drew the following learnings from the study

- Harmful masculinities are part of the social norms that slow progress on gender transformation.
- That some of the civil society organisation at the national and community levels commonly ignoring the focus on men and boys.
- That there is need for intentional and context-specific focus on men in gender equality programming. They noted that while there are programmes on male involvement in the country, these tend to be broad, focusing on all communities in an-all-size-fits-all way.
- That the issue of male involvement should be intentional and their role clearly defined. Why do we involve men? Which men are we involving and how are we involving them? What do we want to achieve?
- That there is need to challenge traditional gender norms and definitions of who a man is. That we need to embrace the notion of Ubuntu and use it to examine constructions and changes in masculinities. That both theory and practitioners in masculinities and SRHR need to embrace emancipatory aspects of culture.
- Participants called for a deliberate programming for male involvement by focusing the campaign on lower levels such as family socialisation and early childhood education where boys and girls are trained in gender equal ways.

- That inequalities between and amongst women and men cannot be solely attributed to gender differences. That men and women are equally victims of globalization and its related neo-liberal policies, and poverty as a class issue.

- That men are not a homogeneous category. Not all men are oppressive, abusive and villains. That it is important that while we explore masculinities, we look at the contexts in which masculinities are constructed and the changes being experienced from time to time.

4.2 Areas for further research

The validation exercise suggested critical areas that could be explored further to enrich the understanding of masculinities and realisation of SRHR in Uganda. Suggested areas of study include the following.

1. Explore and compare the influence of masculinities on the uptake of SRHR among educated and less educated men.

2. Use the concept of Ubuntu in understanding men, masculinities and SRHR. How were masculinities constructed in the past (pre-colonial times)? Deconstruct the global and neoliberal perceptions of development, gender, masculinity, especially the individualist way of understanding women and men. explore collective, unity and respect among women and men in pre-colonial cultures and how this was articulated through the concept of Ubuntu. What can we learn from these nuanced conceptualizations?

3. Interrogate male involvement initiatives in health care systems especially on the men accompanying their wives for antenatal care. We need to study which men these are, what their motivation is and the impact of these

4. Study the changing patterns of male behaviour – why is there increased talk on men abandoning their responsibility in the family or that men are no longer men?

5. What has enabled progressive forms of masculinities and how can we tap into these lessons to nurture more men into progressive male behavioral lifestyles?

5.0 Recommendations: Towards progressive masculinities that promote SRHR

This study has noted complex ways through which men and masculinities are nurtured in language, culture, religion and the economy. The study further demonstrated ways through which normalized behaviours, practices and expectations compromise men's health seeking behaviours particularly their access and utilization (or the lack) of SRHR services. At the policy level, the study highlighted close association of SRHR programmes and services to women and the implications of feminizing reproductive health on men's resistance. Feminization of SRH not only contributes to inadequate SRH information to men but also exacerbates men's resistance because they largely view SRHR as a women's affair. These dilemmas are further worsened by men's poor health seeking behaviour as well as cultural conceptualisation of sexuality conversations as private and personal matters.

The study has also revealed the subtle and hidden masculine norms and values that hinder the uptake of sexual reproductive health rights. In effect, these findings contribute greatly to the on-going global conversation on how to negotiate social norms that slow down the achievement of gender equality. In particular, findings on who a man is, construction and representation of ideal masculine identities in diverse Uganda communities, and the implications masculinities have for SRHR enable us to understand why progress towards realisation of SRHR is getting slower and more difficult. On the one hand, findings such as these alert us to the nature of resistance towards SRHR services, i.e. the invisible power of masculine norms which is often taken for granted in gender equity programmes, in effect, missing a deeper understanding of social change. On the other hand, they (findings) offer us pointers to possibilities of transforming harmful masculinities and femininities towards gender equality.

While there are promising innovations around engaging men to participate in SRH, the focus is largely on working with men at an individual level as champions and change agents and 'using' these categories of men, not in understanding men's SRHR experiences but rather to advance maternal health goal. In effect, such an individual approach misses the opportunity to understand masculinities as deeply rooted social structures that have wider implications on SRHR. The approach also limits the focus on men as gendered beings, as intelligible sexual and reproductive health care beneficiaries.
In view of the complex constructions and representation of masculinities and femininities in everyday life, the impact certain forms of masculinities have on the realisation of SRHR and the shortcomings of some of the innovations on engaging men, the study came up with multi-pronged recommendations.

These include:

- Recommendations to raise consciousness about prevalent social (gender norms) that are normalized and legitimised yet they hinder access and usage of SRHR services
- Recommended set of innovations to rise consciousness about the link between SRHR and masculinities and address masculine obstructions to SRHR for women, men, youth and other social categories of the population.
- Recommendations that highlight the role of different stakeholders in promoting effective realisation of sexual and reproductive health
- Recommendations related too policy reforms/implementation towards intentional focus on men, masculinities and health.

There is need for a deliberate focus on men and boys' needs and interests in SRHR. This involves moving beyond individual approaches to men as champions who promote maternal health. Rather, as indicated in GWED-G model indicates, adopting a comprehensive model of focusing on masculinities as socially structured i.e. men as peer educators to fellow men, change agents and role model of men as well as a focus on masculine vulnerability. Re-center issues of masculinities in SRHR policy and programs.

A comprehensive and deliberate focus on men and masculinities includes:

- A specific rather than and implicit or incidental, focus on the topic of men and masculinities. [not a by-the-way or mistaken focus, or an appendage on gender but rather as an intentional focus to investigate men's and boy's everyday ways of doing and being men].
- A focus that acknowledges and takes account of feminist, gay and other critical gender scholarship.
- By recognizing men and masculinities as explicitly gendered rather than nongendered
- By understanding men and masculinities as socially constructed, produced and reproduced rather than as somehow, just "naturally" one way or another [when we construct men as universal, homogeneous and generally privileged, and women as subordinates and the other of men, we essentialise them in problematic ways as natural and superior beings.
- By seeing men and masculinities as variable and changing across time (history) and space (culture), within societies, and through life courses and biographies.
- By spanning both the material and discursive in analysis – physical relations amongst men but also concerns sets of discourses/sets of expectations that influence/constrain the way men behave and act.
- By interrogating the intersecting of gender with other social divisions in the construction of men and masculinities e.g. how religion intersects with culture to define who a man is. (See reflections from Kimmel, Hearn & Connell, (2005:3-4)
  m time to time.

There is need for rights activists to promote alternative forms of masculinities. The study has pointed out ways in which traditional forms of being a man (household headship, decision making, domination) constrain men's seeking behavior in particular men's access to SRHR services. The study also noted progressive forms of male behaviour that promote access and utilization of SRHR even when these categories of men are ridiculed and stigmatized. These findings point to the fact that there is no universal way of being a man but rather diverse forms of masculinities. In effect, there is need for deliberate sensitization to enable men understand that there are different ways of being a man and that accessing health facilities does not make them less of men.

Promote health education and information focusing on men and young boys. This could include conversation on how normalize ways of being men compromise men's health and the health of those around them. Health education and information could be one of the ways through which to deconstruct harmful masculine practices.

Normalize conversations on sex, sexuality and SRHR services especial amongst the youth. In a conversation with a female youth, it was noted: *"There is need to normalize conversations on SRHR. At the moment, whatever that is discussed remains seen as private, meant for adult married people. Youth engagement in SRHR is seen as 'abnormal'".* The study noted multiple experiences through which conversations on sex and SRHR are enshrouded in silence stigma, myths and misconceptions. Silences about sexual reproduction services were noted in religious circles and at the household level. For example, some of the religious leaders noted that they cannot speak about things such as condom use, family planning or sexual relations to their audiences. They argued that their audiences have multiple age groups and sharing such information may not be appropriate to all. Others conceived condom use as a sin while others felt conservations on sexuality would promote promiscuity. In effect, conversations on SRHR remain constrained, deeply silenced and largely viewed as abnormal. Yet religions not only have wider audiences and command following, there are actors of influence who progressively support contraception (Okiror, 2020). Tapping into these progressive religious voices to normalize conversations on SRHR would contribute towards confronting deep-rooted resistance, increase consciousness and ultimately uptake of SRHR services.

Action Matrix: Strategic objectives, Key areas of concern, proposed interventions and Actors

#	Strategic objective	Key issues	Proposed Actions	Actors
1	Promote a *deliberate* Policy and programmatic focus on men and boys' needs and interests in SRHR	There are gender equity policy reforms within the health sector that remain silent on the place of men in reproductive health Rights Most of the international and regional legal framework are silent on the role of men in realising sustainable sexual and reproductive health There are national strategies on male involvement in health (in Particular SRHR) that remain unimplemented	▪ Create awareness about the existing international, regional and national legal framework and their respective action plans, which promote male needs and interests in Sexual and reproductive health and rights e.g. ○ The ICPD+5 plan of action ○ The Beijing+25 Declaration and plan for Action ▪ Advocate for the implementation of the national strategies that seek to promote male involvement in health ○ National Implementation guidelines for Male involvement in Sexual and Reproductive health and rights, Child Health including HIV/AIDS in the Health Sector (2013) ○ Services standards for sexual and reproductive health and rights (2012) ○ The 2017 National Male Involvement Strategy for the Prevention and Response to Gender Based Violence, by Ministry of Gender, Labour and Social Development.	CEHURD MoH MoGLSD
2	Gender responsive sensitisation and awareness creation on the construction and legitimisation of harmful forms of masculinities To promote transformation of harmful social (gender) norms and practices that perpetuate constrain uptake of SRHR services	• Access and use of SRHR services is intricately linked with social and gender norms • Most women who 'sneak out' and access SRHR services without their spouses' approval often experience violence	• Conduct gender awareness-raising campaigns that aim at making patriarchal values, attitudes, practices and socialization processes as underlying causes of GBV visible to men. • Promote the formation of male action groups to engage men in confronting and transforming their own male privilege, questioning their own contributions to sustaining GBV • Work with CSOs, CBOs and Faith-based organisations and other existing structures that reach out to households to encourage gender equitable parenting e.g. ○ Engage fathers in the nurturing of their children reduce the burden on women and promotes shared responsibility. ○ Encourage women who are custodians of culture to promote gender equitable socialisations especially amongst boy	Reproductive health Uganda MGLSD Media EOC MoH CSOs

			children. • Conduct community sensitization through citizen platforms (barazas) on gender based violence to offer space to communities to reflect on cases of GBV and possible ways of curbing them. • Carry out training to build capacities of staff in government and private health institutions on the importance and the role of men and boys in promoting the use of sexual and reproductive health services • Build a critical mass of male executives and managers in private and public sector employment with different levels of knowledge and skills in analyzing and advocating for the role of men in SRHR. • Promote media campaign with messages that promote boys and youth participation in SRHR. This is aimed at normalizing sexual reproductive health services for the youth. • Promote national school debates on the role of men and Boys in promoting family planning.	Academic Institutions UNFPA UN Women
3	Equip men with knowledge, skills to cope with public ridicule that comes with exhibiting progressive male behaviours	Men who choose to use SRH services or accompany their wives for SRHR services are ridiculed as 'not-men-enough', and sometimes labelled 'women'.	▪ Acknowledging and scale up progressive forms of men's behaviours, and practices that promote uptake of SRHR services ▪ Establish male peer educators and mentors to support fellow men in promoting the uptake of SRHR services ▪ Ensure quality of care in clinical settings (non-discriminative) targeting men and women. ▪ Create male-friendly environments that can encourage men seek reproductive health care These can be done through; ▪ Sensitization workshops ▪ Male-friendly activities e.g. soccer matches, street theatre performances and sports competitions themed around 'the role of men in promoting SRHR. ▪ Forming male groups and facilitating conversations on SRHR amongst them ▪ Sharing and documenting personal stories of changing men, men supportive decisions on use of family planning, violence-free families. ▪ Broadcast visual messages on male involvement in public spaces such as hospital waiting rooms. ▪ Promote wider social alternatives of being a man – men supporting each other, as well as women and children.	CSOs MOH Development partners

4	To raise awareness among SRHR duty bearers to provide gender sensitive SRHR services	Some duty bearers are consciously or unconsciously guided by assumptions of SRHR as an exclusively female domain in their service provision.	• Collaborate with duty bearers in health sector to give correct information to adolescents and other men and women on family planning (FP), safe motherhood and child care and dispel the rumours about Family planning methods. • Conduct gender awareness campaigns amongst SRHR service providers (such as medical professionals, security agents, legal officers, teachers, etc.) to promote the role of men in promotion of sexual and reproductive health • Train staff (medical/counsellors, legal, media officials) in understanding and responding to complexities of experiencing GBV. • Service providers to share information through the media on SRHR services available to men	MGLSD Health Sector Education Sector Media
5	Promote strategic partnerships in engaging men and boys in promoting SRHR services	There are different organisations promoting male involvement strategies in isolation to each other thus missing the opportunity of collectively questioning patriarchal norms and practices that hinder access and utilization of SRHR services Some of the initiatives promoting male involvement are ad hoc in nature, focusing on men as individuals rather than the social structures that nurture male norms and values	• Strengthen the existing SRHR coordination mechanisms at different levels and integrate male involvement activities therein. • Build new or join existing local, national and regional networks on male involvement (e.g. *MenEngage Africa)* to promote partnerships amongst civil society, public organisations and decision-makers, development partners on the progressive and proactive engagement of men and boys in realisation of SRHR • CEHURD to collaborate with development partners to mobilise resources for promoting gender aware male involvement strategies in the health sector, Sexual and reproductive sector, in particular. • Promote Public private partnership • Strengthen partnership with cultural/traditional institutions, faith-based organisations and CSOs to promote Sexual and reproductive health education and services amongst their constituents. • CEHURD should collaborate with UN Entity on Gender Equality and Women's Empowerment, UNFPA and other sister UN Agencies to promote international, regional and national agenda on male involvement SRHR programming. • Advocate for integration of men, masculinities and health care concerns in the teaching and research within academic institutions.	CEHURD MGLSD CSOs Development partners, e.g. UNFPA, UN Women, Faith-based organisations Academic Institutions

6.	Strengthen Research and Documentation to enable evidence-based intervention on male involvement in promoting SRHR	Currently, there is a lack of research on masculinities and its impact on health outcomes, in particular SRHR in Uganda, and Africa at large	• Undertake research on men's sexuality, their masculinity and their reproductive behaviour • Generate evidence using both primary and secondary data to demonstrate the importance of involving men and boys in access and utilisation of SRHR. • Regular assessment of performances in male involvement initiatives. • Document trends, success stories, emerging challenges and generate innovations to inspire sustainable change. • Disseminate evidence through existing structures e.g. community forums, dialogues, parliamentary forum that advocate for GBV • Utilize the information in the National Gender Based Violence Database to analyse the role of men in reporting, referral and follow-up on GBV cases • Conduct research to explore duty bearers' own experiences and feelings about gender norms and roles and their implications on services delivery.	CEHURD Academic Institutions CSOs implementing male involvement strategies
7	Strategic engagement with institutional resistance to SRHR programmes	There are social institutions and individuals (religion, cultural leaders) who openly resist uptake of Sexual reproductive health services. There are widespread myth and misconceptions that are deliberately spread to resist SRHR There are gender equality approaches that are uncomfortable with intentional focus on men in promoting gender equality	• Provide health education to cultural and religious leaders to enable them appreciate the role of SRHR in promoting the health of women and men they serve • Challenge the cultural and religious perceptions on the value of many children even when individual men and women cannot look after them. • Challenge the myth and misconceptions about family planning through public health education and campaigns in the media.	Media CEHURD

8	Deliberate promotion of men's health seeking behaviour	High prevalence of what the research established as "paracetamol masculinities" – massive men thriving on painkillers and self-medication in order to perform strength and vehemently deny weakness and sickness	• CSOs should create awareness on the cost of men's self-medication and its implications for men and women's health outcomes e.g. drug resistances, premature death of men, and perpetual men's poor health. • Men need to know that it is in their best interest to seek medical help • Deconstruct public attitudes perceptions about men powerful, strong physically and as non-vulnerable. There is need to reveal health vulnerabilities amongst men • Equip Village Health Team members with knowledge and skills to encourage men seek for health services	CSOs Health care institutions Cultural and religious institutions Family
9	Shape a national conversation on what men stand to gain from gender equality – in particular effective involvement in promoting SRHR	There is inadequate conversation on men and masculinities in national gender discourse	• Facilitate national and local gender equality networks to share the narrative on what men stand to gain from gender equality programmes. • Promote existing men action groups (by CSO e.g. GWED-G) as avenues for fostering conversations on men's experiences. • Facilitate a continuous research agenda (locally & nationally) on the construction of masculinities, masculine diversities, and possibilities for change • Promote the examination of men's experiences as part of gender equality discourse	Academia CSOs Media Actors Government e.g. MoGLSD UNWomen

6.0 Appendices

6.1 Appendix 1: List of Participants

	Mbarara District
1.	Mustafa Birondwa- Male, LC1 Chairperson Kaberebere Town Council
2.	Agripina Tumusiime, Female, Public Health Worker at MUST- GRANTS
3.	Ninsiima Daphine, Female, House wife
4.	Kagogwa Paul, male, local businessman, Vends Matooke, Kaberebere town council
5.	Esther Ahimbisa, widow, Kaberebere Town Council
6.	Kajumba Patrick, Male, LC3 Chairperson Kaberebere Town Council
7.	Lukwago Abel, Elder and VHT, Kaberebere
8.	Arihihi Spacious, female, Midwife Kikoko Health centre III, Kaberebere
9.	Rev. Alfred Tumushabe, Archdeacon – Kaberebere Archdeaconry
10.	Sheik Mutaasa Ismail, Religious leader- Taqua Mosque, Kaberebere, Town council
11.	Hamza Kizito, Imam- Masijidi Safadi, Kaberebere, Town council
12.	Edson Tumusherure, District Health Officer- Isingiro district
13.	Yiga Martin Paul, Deputy Chief Administrative Officer (CAO) Isingiro District
14.	Focus Group discussion (8 men) Kaberebere II
15.	Focus Group Discussion(8 women)Kaberebere
16.	Arihaihi Spacious, Midwife- Kikookwa Health Centre III
17.	Rev. Alfred Tumushabe, Clergy- All Saints Kaberebere
19.	Mutaasa Ismail, Sheikh- Masijidi Taqwa
20.	Tukahirwa John Bosco-Male, LC I Rwenturagara cell
21.	Kempehe Yorokamu- Male, Elder- 68 year old Rwenturagara cell
22.	Kefurika Fulgensia- Female, Elder- 76 year old Rwenturagara Cell
23.	Jovia Mirembe, Elder-52 Rwenturagara cell
24.	Daphine Kibetenga- Female- 24 years
25.	Namara Enid, VHT- Rwenturagara
26.	Itima Stephen, Lay reader- St. John Mukora Church of Uganda
27.	FGD women only, Millet Harvesting Rwenturagara
28.	FGD men only, Omukacwampare
29.	Byaruhanga Arthur, District Community Development officer (DCDO) Mbarara District
30.	Dr. Frank Akatuhurira, In charge- Marie Stopes, Mbarara
31.	Atyang Sharon, 24-year-old, female youth, former Makerere University Student; Lira East, Ayago Parish, Railways Division
32.	Mrs. Ruth Apili Anywar, 56 years old, retired agricultural officer, resident of central park, Lira city
33.	Mr. Trobiach Lworomo, Deputy Resident District Commissioner, Lira District
34.	Omoding Enock, Clinical Officer, outreach coordinator, Reproductive health Uganda (RHU) Lira (Lango Sub-Region)
35.	Ms. Achom Dorothy, Administrator/ Accountant, RHU-Lira (Lango sub-region)
36.	Ms. Acen Sharon, Age 32, Community Development Officer (CDO), Agali Sub-County/Youth Livelihood Program Coordinator, Head Office Lira
37.	Mr. Edmond Acheka, Assistant District Health Officer, (A/DHO) Lira District
38.	Ms. Mildred Omara, 75 years-old retired Nurse, midwife, Ayago parish, Railways Division
39.	Mr. Mabala Douglas, Registration Desk/Cashier, RHU-Lira

40.	Ms. Achan Hellen, Nursing officer/midwife at Ayago Health Center 3, Ayago Sub-County Lira City
41.	Abuka Nyachon Opio- Assistant Awitong, Ayago Sub-County Lira City
42.	Mr. Okwir Peter, age 39, Local Council 1 (LC 1) Agali B. Village Ayago Parish, Lira District
43.	Focus Group Discussion 1 -composed of 8 men, (Ngetta Sub-county)
44.	FGD 2, composed of 8 Women (Ngetta Sub-County)
45.	Mr. Otim James, Officer in Charge (OC) Ngetta Sub-County Police Station
46.	Mr. Ogola Patrick, In-charge CID, Ngetta Sub-County Police Station
	Interviews on Tuesday 5th January 2021 – Gulu City
47.	Assistant Chief administrative Officer, Gulu City
48.	Ms. Jessica Annena, Senior Probation officer, Gulu District Local government
49.	Ms. Amono Grace, 24-years-old, female youth, former Makerere University Student, Gulu City
50.	Mr. Walter Okot, Lecturer, department of public administration, Gulu University. Walter's first degree is in Law.
51.	Mr. Kidega Jimmy Clayton, retired civil servant, businessman, Iriaga Parish, Senior quarters, Laro Division.
52.	Ms. Pamela Angwech Judith, Executive Director, Gulu Women Economic Development and Globalization – (GWED-G)
53.	Mr. Okoya Richard, Role model man, GWED-G, Bungatira Sub-County
54.	Mr. Okoya Richard, Role model man, GWED-G, Bungatira Sub-County
55.	Mr. Oyaka Charles, Role model man with GWED-G Bungatira Sub-County
56.	Mr. Vincent Onung, Lay Reader, St. Peters Church of Uganda, Bungatira Sub-County.
57.	Mr. Thomas Orach, Chairperson Local Council I (LC I) Owak Village, Agonga Parish, Bungatira Sub-County
58.	Dr. Nathan Okiror, Center Manager Marie Stopes, Gulu City
59.	Ms. Filda Anitia, coordinator Acholi sub-region, Reproductive Health Uganda – Gulu Office
60.	Ms. Anena Grace, Assistant Distriict Health Officer, (DHO) Gulu District
61.	Ms. Goreti Akech, CDO, Gulu District and Andrew Onen Andrew Probation Officer Gulu District
62.	Male-only FGD in Bungatira sub-county, Gulu District
63.	Female-only FGD in Bungatira sub-county, Gulu District
	Interviews Arua District - 7th January 2021
64.	Ms. Teddy Nakubulwa, Monitoring and Evaluation officer, Care International – coordinator male engagement strategy
65.	Ms. Sandra Ewachabo, Deputy Chief Administrative Officer, Arua District
66.	Mr. Stephen Eguma, Probation and welfare officer, Arua District
67.	Ms. Carolyn Omale Barbara, former Makerere University student, from Terego sub-county
68.	Anderu Joyce, Female Academician/Researcher/Business woman. Okwaribu Village, Oluka Sub-County, Arua
69.	Mr. Paul Bishop, District Health Officer (DHO), Arua District
70.	Mr. Richard Aleti, LC 1 chairperson, Adrave East, Azuku Parish, Vurra Sub-County
71.	Mr. Stephen Amandura, Cultural leader, Vurra Sub-County
72.	Dr. Philip Rooney Atidra, In-charge Reproductive Health Uganda – Arua branch.
73.	Mr Andiku Joshua, Male age 52, Married, Health Inspector; Health Inspector, Vurra Sub-County, Adravu Village.
74.	Mr. Adraku Nixion Lita, Male , LC III, Adravu East Village , Vurra Sub –County, Arua District
75.	Rtd Rev. Peter Patrovas Okwonzi, leader of the elders, 85 years old, Vurra Subcounty Arua
	Wakiso and Buikwe Districts

76.	Ms. Kyomugisha Sadiyati, House wife, Kitungwa, Gombe Division.
77.	Ms. Nakimbugwe Teo, Chairperson LCI, Kitungwa, Kitungwa, Gombe Division, Nansana Municipality.
78.	Pastor Kiiwe Charles, Religious Leader, Double Happiness Pentecostal church
79.	Mr. Matia Lwanga, Local Council Chairperson V, Wakiso District
80.	Sr. Betty Nabuganda, District Health Officer, Wakiso District
81.	John Kyejjusa, DCDO Wakiso
82.	Nandawula Sylivia, In charge- Gombe Health centre II, Gombe Division, Nansana Municipality
83.	Batuwa Geofrey, Secretary to the Mayor Gombe Division, Nansana Municipality
84.	Male-only FGD, Kitungwa LC I, Gombe Division
85.	Female-only FGD, Kitungwa LC I, Gombe Division
86.	Nasser Kajambiya, local Business man, Kitungwa
87.	Jjingo Ismail, Primary School Teacher, Global Parents Scgool, Kitanda
88.	Ssewanyo Kigganda Sam, DCDO Buikwe District
89.	Dr. Rchard Boosa, District Health Officer, Buikwe District
90.	Kigongo Mathias, Local Council V chairpersons, Buikwe District
91.	Galabuzi Haruna, Health Inspector Kiyindi Town Council, Buikwe District
92.	Konde Moses; Town Clerk Kiyindi Town Council, Buikwe District
93.	Namukisa Esther, Kiyindi Landing site
94.	KI- Nambuya Mwajuma Kiyindi Town council
95.	Mwanje Juma Muzamiru, Chairperson of the fishermen, Kiyindi landing site
96.	Kizito John Kiwanuka, local business man dealing in mukene
97.	Men –only Focus Group Discussion, Kiyindi Town council
98.	Women-only FGD, Kiyindi Town council
99.	Ssekatawa Messach, Lay reader- St James Church of Uganda (COU), Kiyindi, Town
	Interviews in Kampala
100.	Ms. Mary Kirunda, Makerere University student, a Change-Champion and volunteer with Uganda Youth and Adolescent Health Forum (UYAHF), Kampala
101.	Ms. Demeter Namuyobwa, Medical Cordinator, Reproductive Health Uganda – Kampala
102.	Ms. Allen Asiimwe, Researcher at Medical Research Council/ Uganda Virus Research Institute and London School of Hygiene and Tropical Medicine- Uganda Research Unit
	Interviews in Kamuli
103.	Mr. Conerius Karema, Principal Assistant Secretary, Office of Assistant Chief Administrative Officer, Kamuli District
104.	Dr. Fred Duku, District Health Officer, Kamuli District
105.	Mr. Wafire Brian, District Coordinator, HEPS Uganda
106.	Ms. Annet Kafuko, Community Health Mobiliser, Coordinator Village Health Teams, OPD
107.	Mr. Isabirye Daudi, Chairperson Bugulumbya male action group
108.	Reagan Baganzi, male teenager, (16 years old) Bright College Nawanendi, Kamuli District
109.	Female Focus group discussion, Bugulumbya Sub-county
110.	Male focus group discussion, Bugulumbya Sub-county
111.	Rev. Moses Binyera, Vicor Buguhumbya Parish, Church of Uganda
112.	Cultural leader
	Interviews in Mbale District
113.	Mutonyi Melisi, Acting District Development Officer
114.	Mr. Wanzara Anthony, Principal Assistant Secretary, Chief Administrative Officer
115.	Dr. Ayeko Jackson, In-charge, Reproductive Health Uganda – Mbale Office
116.	Ms. Irene Kugonza, Outreach Programme coordinator, RHU Mbale Office
117.	Nekesa Harriet, Senior probation-Mbale.

118.	Nabifo Immaculate, CDO,Bungokho Sub-County.
119.	Harono Irene, Mabango village, LC1.
120.	Muboki Nathan, Mabanga Village, Bushikori parish, Bungokho sub-county.
121.	Women-only FGD, Mabanga Village, Bushikori parish, Bungokho sub-county.
122.	Men-only FGD, Mabanga Village, Bushikori parish, Bungokho sub-county

6.2 Appendix 2 on the interview Guide

Men, Masculinities and the Sexual Reproductive Health and Rights (SRHR) Realisation in Uganda

Key informant interview Guide

Introduction

The School of Women and Gender Studies, Makerere University in collaboration with the Center for Health, Human Rights and Development (CEHURD) Kampala, are implementing a project entitled Men, Masculinities and the Sexual Reproductive Health and Rights (SRHR) Realization in Uganda. The project is intended to explore ways in which men's social practices; norms and behaviour enable and/or constrain realization of sexual and reproductive health rights in Uganda. The study will particularly seek to engage with community members and SRHR specialists/activists, on what it means to be a man or a woman in their society, and how these social roles and expectations influence access and utilization of sexual and reproductive health services.

This is therefore to request you to be part of this study. Experiences shared in this interview will be used only on this study, to inform activism on SRHR.

1. Biographical data about the respondent (age, marital status, education level)
2. What is your role in provision of SRH services? Position in community?

Being a man/ forms of masculinities

1. What does it mean to be a man in this community? (variations in descriptions of man/ 'real man'/ perceptions, expectations/ roles and responsibilities)
2. Where do these perceptions about manhood come from? (probe for culture, religion, modernity, etc)
3. How have perceptions about being a man changed over time?
4. Tell us about proverbs and sayings about men in your culture. (probe for meanings of each proverb)
5. How do men relate with women in this community? (roles, decision making)
6. What are the pleasures and privilege of being a man?
7. What are the pressures of being a man?

About SRHR/ Services

8. Are you aware of any sexual and reproductive health services in this community? (Probe for examples of SRH services e.g. HIV testing and treatment, safe male circumcision, family planning, antenatal care, sex education, gender-based violence).
9. Whom do these programmes/ services target? (Who uses which SRH service?/ Who is excluded & why?)
10. How are SRHR perceived in the community? (women perception/ men perceptions)
11. Do men discuss with their spouses/partners about SRH (Probe for discussions on HIV testing and treatment, safe male circumcision, family planning, antenatal care, sex education, gender-based violence)
    a. If yes, how - What do they discuss about?
    b. If no, why do some men never talk about SRH with their partners?

Masculinities and the obstacles to accessing SRH services

12. What are the barriers to accessing SRH services? (individual, institutional related, cultural related)
    a. What hinders men and boys from accessing and using SRH services?
    b. What hinders women and girls from accessing and using SRH services?
    c. Any other category that faces challenges of access and usage of SRH services (PWDs, youth, etc)
13. How do people navigate these barriers?
14. How do men's behaviour, practices, actions in this community enable access and utilisation of SRHR in this community?
15. What should be done to improve access and utilise SRH services by all members of community (probe for suggestions for each of the services: HIV testing and treatment, safe male circumcision, family planning, antenatal care, sex education, gender-based violence)?

6.3 Appendix 3 on FGD guide

Men, Masculinities and the Sexual Reproductive Health and Rights (SRHR) Realisation in Uganda

Focus Group Discussion Guide

Introduction

Name of interviewer (s): ……Date for the interview: …….
Informant characteristics: District/ Sub-county/Parish/Village/Community ……

Group composition (male, female)

Being a man/ forms of masculinities

1. What does it mean to be a man in this community? (variations in descriptions of man/ 'real man'/ perceptions, expectations/ roles and responsibilities)
2. Where do these perceptions about manhood come from? (probe for culture, religion, modernity, etc)
3. How have perceptions about being a man changed over time?
4. Tell us about proverbs and sayings about men in your culture. (probe for meanings of each proverb)
5. How do men relate with women in this community? (roles, decision making)
6. What are the pleasures and privilege of being a man?
7. What are the pressures of being a man?

About SRHR/ Services

8. Are you aware of any sexual and reproductive health services in this community? (Probe for examples of SRH services e.g. HIV testing and treatment, safe male circumcision, family planning, antenatal care, sex education, gender-based violence).
9. Do men discuss with their spouses/partners about SRH (Probe for discussions on HIV testing and treatment, safe male circumcision, family planning, antenatal care, sex education, gender-based violence)?
    a. If yes, what do they discuss about?
    b. If no, why do some men never talk about SRH with their partners?

Masculinities and SRHR

10. Are there men who support usage of SRHR? (Which services do men support, why?)
11. Are there men who use SRH services? (Probe for which services men use?)
12. Are there ways in which men's behaviour hinders women, girls and men's access and utilisation of SRHR? (Probe for men's behaviour and how it affects access and utilization of SRHR).

a. What hinders men & boys from accessing and using SRH services?
b. What hinders women and girls from accessing and using SRH services?
c. Any other category that faces challenges of access and usage of SRH services?

13. What should be done to improve access and utilisation of SRH services by all members of community (probe for suggestions for each of the services: HIV testing and treatment, safe male circumcision, family planning, antenatal care, sex education, gender-based violence)?

Thank you very much for your time and sharing with us and happiest new-year.

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