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To cite this article: Solomon Mwije (2018): Men and maternal health: The dilemma of short-lived male involvement strategies in Uganda, Health Care for Women International, DOI: [10.1080/07399332.2018.1466887](https://doi.org/10.1080/07399332.2018.1466887)

To link to this article: <https://doi.org/10.1080/07399332.2018.1466887>



Accepted author version posted online: 25 Apr 2018.
Published online: 01 Jun 2018.



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Men and maternal health: The dilemma of short-lived male involvement strategies in Uganda

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ABSTRACT

This article has been written to call for further attention to the importance of involving males in efforts to reduce maternal mortality. Since the 1995 International Conference on Population and Development [ICPD], institutional and community arrangements have been implemented in developing countries to engage males in maternal and child health promotions. The government of Uganda – in partnership with other health promotion institutions such as the United Nations agencies – has in the past decade formulated and implemented national and local strategies for male involvement in Sexual and Reproductive Health and Rights (SRHR). Nevertheless, strategies are such as Male Action Groups (MAGs) have been short-lived because the strategies within cannot by themselves work without ‘genuine’ acceptance at community levels where implementation takes place. Even acceptance alone is also not enough. Majority of males have more interest in economic than social endeavors. They have less interest to engage in maternal health promotion initiatives. Cultural based perceptions and behaviors associated with patriarchal tendencies remain the greatest challenge. Therefore, relevancy, functionality, adaptability, and sustainability in relation to the effectiveness of male involvement initiatives must be assessed before these interventions are initiated in such culturally diverse communities with different informal institutional arrangements. The individual, interpersonal and institutional contexts in which interventions operate matters. The article identifies relevant stakeholders and suggests, though not discussed in detail, strategies for improving stakeholders’ interests to respond to male involvement as a core issue in maternal health.

ARTICLE HISTORY

Received 5 January 2018
Accepted 15 April 2018

Background

This article has been written to call attention to the importance of involving males in efforts to reduce maternal mortality. Key definitions have been provided for clarity.

Maternal health: Health as the health of women during pregnancy, childbirth, and the postpartum period.

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Male involvement: The fulfillment of responsibilities of men in reproductive health through support and care.

Male involvement strategy: Any methodical processes of having males engage in health programs/project/activities related to reproductive health to promote maternal and child health.

Reducing maternal mortality is not for individual or household benefit but an entire nation. According to the World Health Organization (WHO), the maternal mortality ratio (MMR) is the most commonly used measure of maternal mortality, and it is defined as the number of maternal deaths during a given period per 100,000 live births during the same time (WHO, 2005). Per the Sustainable Development Goal (SDG) 3.1, it is stated that by 2030 the global MMR is reduced to less than 70 per 100,000 live births from 216 per 100,000 live births in 2015 (WHO, 2017). Table 1 shows the statistical estimates of Uganda and global representations of MMR from 1990 to 2015.

Uganda's 2015 target for the Millennium Development Goal (MDG) 5 was to reduce the MMR by three quarters between 1990 and 2015 (WHO, 2015). This has hardly been achieved. Although the 2015 estimates by WHO stated that Uganda's MMR was 343 per 100,000 live birth, according to Uganda Bureau of Statistics (UBOS), Uganda's MMR was 438 per 100,000 live birth (UBOS, 2016; WHO, 2015). These statistics merely represent estimates not relatively actual. The MMR cases might be higher or lower than what is presented for a country because the statistical projections depend much on the methodologies used to quantify them and the geographical scopes represented.

Considering the performance of countries on MDGs, there was, but challenged improvement. Reduction in such significant number of maternal deaths requires immense efforts by the community, national and international institutions, and agencies. Most deaths can be prevented by increasing access to quality health care before, during, and after childbirth (WHO, 2017).

Table 1. Trends in estimates of maternal mortality ratio (MMR) (maternal deaths per 100,000 live births) 1990–2015.

Region	MMR										% change in MRR between 1990 and 2015
	1990	1995	2000	2002	2005	2006	2008	2010	2011	2015	
World	385	369	341	—	288	—	260	246	—	216	44
Developed regions	23	22	17	—	15	—	—	13	—	12	48
Developing regions	430	409	377	—	319	—	—	273	—	239	44
Africa	870	834	770	—	654	—	620	565	—	495	43
Sub-Saharan Africa	987	928	846	—	717	—	—	624	—	546	45
East Africa	995	906	790	—	659	—	—	521	—	424	57
Uganda ¹	687	684	620	—	504	—	—	420	—	343	50.1
Uganda ²	—	527	—	505	—	—	435	—	438	438	—

Source: WHO (2015, 2017); UBOS and ORC Macro (2001); and UBOS (2012, 2016).

¹Only 49.9% change in MRR between 1995 and 2015. Estimates have been computed to ensure comparability across countries, thus they are not necessarily the same as official statistics of the countries, which may use alternative rigorous methods (WHO, 2015, 2017).

²Only 17% change in MRR between 1995 and 2015. Official statistics of the country by Uganda Bureau of Statistics (UBOS) which may have used alternative rigorous methods.

The improvement in access to quality health care in Uganda has been possible because of national health policies and health sector strategic plans guided by international frameworks such as MDG and now SDG objectives (MoH, 2010; WHO, 2017). However, improvement in access does not of itself result in improved utilization, and the result of such situations is high MMR.

Factors influencing high MMR

Per Andersen and Newman Framework of Health Services Utilization, the factors influencing access and uptake of health services are categorized into: (a) *Predisposing factors* (such as demographic, social structural, and attitudinal-belief variables); (b) *Enabling factors* (conditions that make individuals able to secure health service resources available to the them); and (c) *Need factors* (perceived illness include symptoms the individuals experience in a given period and a self-report of general state of health, such as excellent, good, fair, or poor) (Andersen & Newman, 2005). These factors, therefore, enable or limit the accessibility and utilization of maternal health services among women.

The unmet targets for reducing maternal and under-five deaths are associated with both supply and demand factors which determine whether a woman can access and utilize the health care or not. Uganda's health service delivery system consists of private (not-for-profit and for-profit) and public providers and practitioners from national to community level. The services within lower-level health systems are "crippled" by limited facilities, equipment, and inadequate personnel with obvious incompetence. Per Ministry of Health (MoH) (2010), the factors related to high MMR include broken health systems combined with poor health promotion strategies, limited or no human resources, limited medical and equipment supplies including transport and communication equipment for referral, limited or no facilities and inadequate appropriate buildings. All these are on the supply side of the health care service delivery, and they negatively affect access to maternal health care.

On the demand side of health services, the poor health-seeking behaviors catalyzed by negative perceptions and attitudes, illiteracy, and poverty at individual and household levels also limit utilization of maternal health care services (Mwije, 2015). For instance, in 2009, 47% of pregnant women in Uganda made the four recommended antenatal visits, but the percentage reduced to 32% in 2010 and increased again to 47.6% in 2011 (MoH, 2011). Nevertheless, not seeking help has been rated as the most significant factor in such a situation. Most maternal deaths can be prevented using necessary medical interventions, but it is now well known that there are other factors (social determinants) that affect access and use of maternal health care (WHO, 2017). Other household factors such as reliance on the traditional birth

attendants (TBAs), work overload of expecting mothers, and limited support from family members, especially males, have a significant influence on maternal and child health.

Male involvement in maternal and child health care is a significant factor in improving maternal health. The 1995 International Conference on Population and Development (ICPD) report stipulates that “special efforts should be made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior, including family planning, parental, maternal and child health [...]” (United Nations, 1995, p. 27). The need for male engagement in maternal health at all levels of health decision making and service delivery is important in reducing MMR of any nation. If male engagement in maternal health is factored in the Andersen and Newman (2005) health utilization framework, males’ socio-economic and demographic characteristics, their supportive behaviors and perceptions towards maternal health care utilization are essential for women’s health.

Relevance of male involvement in maternal health

Researchers across the globe have shown that male involvement in sexual and reproductive health (SRH) can help in improving maternal health. Mullany, Becker, and Hindin (2007) in their randomized control trials in urban Nepal found that male involvement in antenatal care increased the frequency of antenatal visits by women during their pregnancy. This, as established by Story et al. (2012) in their study in Bangladesh, may be attributed to power relation changes at household level as males gain positive perceptions and support towards maternal and child health care. Males can offer social support by helping in household reproductive work, accompanying wives for antenatal care, wanting to know about antenatal care, supporting their wives in contraceptive usage, and supporting their wives after delivery (Mwije, 2015). Adenike, Esther, Adefisoye, Adeleye, and Sunday (2013) in their study in Nigerian found that although male involvement is low, men are aware that they have a responsibility to offer economic and decision making support for skilled health attendance and delivery. Males can as well provide intimate partner emotional care (encouragements) and change behaviors to improving on bonding with mother and child (Davis, Luchters, & Holmes, 2012). Per Greene et al. (2006, p. 16), “improving men’s understanding of their motivations, fears and desires, their ability to approach topics relating to sexuality, and their respect for their partners’ wishes is central to improving reproductive health.” Therefore, institutions and agencies involved in health services delivery and maternal health promotion must design appropriate male involvement strategies to improve maternal health. [Figure 1](#) shows a

conceptual framework on how male involvement may influence in improvement in maternal health and help in reducing MMR.

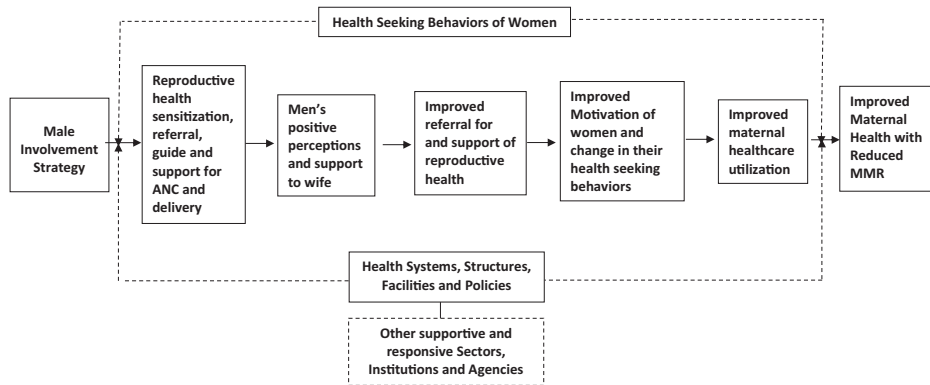


Figure 1. Conceptual framework on how male involvement may improve maternal health.

Source: Author

Strategies for male involvement in maternal health in Uganda

The government of Uganda has for the last three decades formulated and implemented national policies and local interventions to improve maternal health care service delivery and reduce MMRs. These include: the National Health Policies 1 and 2, the 2005 National Family Planning Advocacy Strategy, National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2010–2015, Adolescent Sexual and Reproductive Health Policy 2010–2015, Health Sector Strategic and Investment Plans 1 to 3, District Health Teams (DHTs), and Village Health Teams (VHTs) (MoH, 2010; Republic of Uganda, 2013). However, these present opportunities for both women and men to use the health services but a challenge of limited male involvement in maternal health still hinders improvement in the uptake of the services.

The government of Uganda also has for the last decade formulated and implemented gender equality strategic guidelines and interventions to improve on male involvement in maternal health care. For instance, the 2007 Uganda Gender Policy was designed with a purpose to guide all stakeholders at all levels in planning, resource allocation, implementation, and monitoring and evaluation of programs with a gender perspective (Ministry of Gender, Labour and Social Development, 2007, pp. 14–15). The stakeholders may be at institutional, community, and household level, thus including males. The government has embarked on working with non-for-profit health providers such as WHO and other United Nations agencies to design, fund, and implement male involvement strategies at national and local levels. Since 2011, the MoH, UN Joint Program on Population (UNJPP) and WHO have been working in partnership to support several activities under the following male involvement strategies: (a) The National Strategy for Male

Involvement in Child Health, Sexual and Reproductive Health and Rights including HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) (2011–2016); (b) Male Action Groups (MAGs); (c) Alliance for Parents, Adolescents and Community for Adolescent Health (APADOC); (d) Youth-Friendly Corners (YFCs); (e) Information, Education and Communication (IEC)/Behavioral Change Communication (BCC) for advocacy mainly done by DHTs and VHTs; and (f) health facility based strategies which are used to influence and motivate males to support their wives before, during, and after pregnancy (MoH, 2011, 2013a, 2013b; UNJPP, 2012, 2013). While stipulating responsible actors, these strategies are designed with strategic guidelines on how implementation should be done.

The Uganda national strategy for male involvement (2011–2016)

A national strategy on male involvement (2011–2016) was launched in 2011 with the aim of improving male participation in child and maternal health including SRH and HIV/AIDS through providing strategic directions to all stakeholders in Uganda (MoH, 2011). The strategy stipulates that without male involvement it is challenging to realize healthy families because male participation increases children's survival and the ability of women to enjoy their sexual and reproductive health and rights. Males are, therefore, recognized as significant decision makers in households.

This strategy aims at “providing viable and comprehensive framework to address male involvement in child and maternal health including sexual and reproductive health and rights issues,” with a mission “to facilitate the attainment of a harmonious and productive society where males and females realize their full sexual and reproductive health and rights as well as responsibilities” (MoH, 2011, p. 9). Its objectives include: (a) guiding development/review/ updating of policies and laws that support male involvement in child and maternal health; (b) promoting the participation of all stakeholders, communities, and other sectors to engage men and boys in achieving gender equality and health equity; (c) ensuring provision of quality male-friendly Sexual Reproductive Health and Rights (SRHR) services including HIV/AIDS; and (d) enhancing evidence-based interventions for male involvement (MoH, 2011, p. 10).

The implementation of this strategy was targeted to be within the National Health System structures which are made up of public and private sectors. The strategy comprehensively focuses on strategic directions including: mobilizing stakeholders on the importance of male involvement, building capacity for delivery of quality male-friendly health services, integrating male-friendly services in programmes, strengthening coordination and networking and partnerships, lobbying and advocating for resources, carrying our BCC programmes, and supporting research, documentation and monitoring and evaluation of male-friendly health

services (MoH, 2011, p. 13). Nevertheless, a comprehensive evaluation of the impact of this strategy has not been done.

Uganda's Male Action Groups (MAGs) approach

One of the specific community-based implemented male involvement strategies in Uganda is the MAGs. MAGs were initiated in 2012 in 15 districts with a role of increasing referral to health services and uptake of family planning and women's access to maternal health. A functional MAG is defined as a formal or informal organized group of males, formed for a specific cause, registered with the district, and is reported by the district officials to be active. For a MAG to qualify as advocating for SRH and rights, the group must have the following activities as a minimum: peer promotion activities, community outreach activities, reproductive health and rights activities, in their action plans that are implemented (UNJPP, 2012). There are formal and informal MAGs. The former is registered with and known by the DHTs and VHTs. In Uganda, there are currently two types of MAGs. Those under the Ministry of Gender, Labour and Social Development are formed with a purpose of integrating men into gender mainstreamed and sensitive programmes and others under the MoH are established with the aim of promoting SRH under which maternal health promotion lies. Figure 2 shows the concept of a Male Action Group stipulating the group's activities aimed at promoting maternal health.

A mid-term evaluation report by UNJPP carried out in 2013 showed that MAG initiatives have acted as catalysts for reproductive health promotion. MAGs have increased referral to health services, uptake of family planning, and women's access to maternal health. They are helping in changing male perceptions and attitudes towards maternal health, improving male support through referrals, reducing stigma among males through peer education on maternal health, improving referrals and support for antenatal care, and mobilizing men for health promotion through community outreaches and advocacy (UNJPP, 2013). The same mid-term evaluation carried out one year after MAG formulation and implementation indicated that due to MAGs an improvement of about 28.4% of pregnant women being accompanied by their husband for antenatal care was realized.

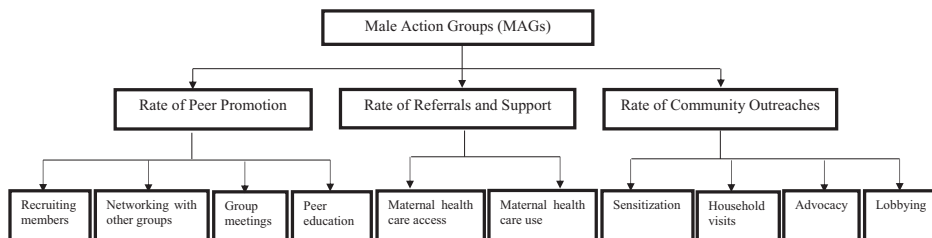


Figure 2. The male action group (MAG) concept.

Challenges associated with male involvement in maternal health promotion

Per Comrie-Thomson et al. (2015), there is a persistent dichotomy between traditional and modern perspectives on gender equality and human rights. It becomes difficult to implement a policy which relatively diverges from cultural and traditional settings. This could be attributed to cultural relativity and diversity. For instance, among the 52 MAGs that were formed in 2012, 8 had already ceased to operate after one year of implementation (UNJPP, 2013). The implementation of male involvement strategies is therefore significantly affected by limited community acceptance to have their beliefs and values changed. Additionally, men, influenced by household poverty, prefer programs with economic value compared to those with social value. Escorting a wife for antenatal care is perceived as a waste of time (Mwije, 2015).

Van den Berg et al. (2015) suggest that health workers have a role in encouraging community leaders to expand male involvement in supporting their wives for reproductive health uptake including HIV/AIDS testing. However, it is never easy to get men change their perceptions and attitudes towards SRH especially in a society where there is cultural diversity (Sileo, Wanyenze, Lule, & Kiene, 2017). Following the 2006 WHO policy guidelines, the MoH in Uganda introduced a policy on mandatory couple testing for HIV infections to prevent mother-to-child transmission (PMTCT) but this has interfaced enormous challenges (Larsson et al., 2010). In some registered cases, men and women, because of fear, resort to hiring “fake” husbands (especially boda-boda cyclists) to enable pregnant women to access and utilize maternal health services at health centers (Watala, 2013).

Other noncultural challenges associated with male involvement in maternal health include: unwillingness of responsible stakeholders to embrace initiation and implementation of male involvement strategies, limited stakeholder awareness and willingness to have these initiatives as priority areas, limited implementation resources and skills, limited or lack of monitoring and evaluation of male involvement strategies, limited evidence-based research and information on strategic implementation, and limited coverage of the initiatives partly due to insufficient funds for outreach to distant village (Sileo et al., 2017). In the case of MAGs, they face community mistrust, identify dilemmas, and limited commitment of members and other stakeholders. For instance, each formal MAG must have a maximum of 25 active members; but on average, only 12 members out of 25 attend the monthly meetings (UNJPP, 2013). Development interventions do not work in a vacuum, and therefore stakeholders must refocus their collective efforts on having communities accept and adapt male involvement strategies.

Possibilities for sustainable male involvement strategies

Harmonization and integration of male involvement strategies into the local development structures is a significant need for maternal health promotion. Male involvement strategies must be adapted to local gender systems to improve on acceptance levels in culturally diverse societies. The incentives, systems barriers,

and health-seeking behaviors differ between men and women (Comrie-Thomson et al., 2015; Larsson et al., 2010). There is need to adopt and use bottom-up mechanisms for male involvement. The DHTs need to shift their decision making processes from the health center, district and sub-county levels to village levels where all men and women work together to identify and work on their problems (Jennings, Cherewick, Hindin, Mullany, & Ahmed, 2014). Such kind of ownership of interventions may create possibilities for sustainability. The MAGs under MoH and Ministry of Gender Labour and Social Development should be harmonized because these seem to work on the same cause of the general problems to maternal health (MoH, 2013b). In addition to peer education carried out by MAG members, male agents with rigorous training in sexual and reproductive health and rights are needed. Trained males should be integrated in DHTs, sub-county health teams, and VHTs (Sileo et al., 2017). It becomes easier to have males sensitize and convince their fellow men to join the initiatives based on personal experiences.

Male involvement initiatives should be attached to other economically oriented initiatives to cater for different economic interests of a male who wish to join the male involvement strategies for maternal and child health promotion. In the 2013 mid-term report by UNJPP indicated that one of the main reasons why males were losing interests in the male involvement initiative was limited economic incentives. Men stated that these initiatives did not benefit them economically and therefore creating and attaching income generating projects to male engagement strategies is essential (UNJPP, 2013) if male must remain active and motivated. Men, in Mwije's study (2015), indicated that health center strategies for male involvement were not friendly. For instance, men recommended that health centers need to improve on male-friendly services such as change of antenatal care visit schedules to fit men's interests. From a participatory point of view, there is need to have active males and groups recognized for their relentless and effective performance. Provision of identity materials (such as identity cards and T-shirts) to male agents, celebrations and recognition of active members motivate male agents to sustain their active engagement (UNJPP, 2013).

Table 2. Actor categories with their levels of interest and agency for male involvement.

Level of Agency	Level of Interest	
	Low	High
Low	<p>Actors A</p> <p>Males who are non- members of Male Involvement Initiatives, Women in communities with Male Involvement Initiatives, ...</p> <p>Strategies Community outreaches for awareness (Public Information Campaigns) promotion, improve peer promotion among men, Develop LG and HC by-laws for male involvement, attach income generation projects to interest non-members (men) Male Involvement Initiatives, ...</p>	<p>Actors C</p> <p>Legislators, Private Health Administrators, ...</p> <p>Strategies Dialogue and negotiate for gender sensitive policies and reforms. E.g. dialogue and negotiate with parliamentary committee(s) on health, have think tanks on health reforms, do public information campaigns, ...</p>

(continued on next page)

Table 2. (Continued)

	Level of Interest	
<i>High</i>	<p>Actors B</p> <p>Health service providers, District Health Teams (DHTs), Village Health Teams (VHTs), Media, ...</p> <p>Strategies</p> <p>Think tanks, use media platforms, inspect health facility operations, integrate committees into district and community level structures to strengthen monitoring and supervision and ensure sustainability, training and use of male agents such as within VHTs, ...</p>	<p>Actors D</p> <p>Members (men) of functional Male Involvement Initiatives, Women Action Groups, Ministry of Health (MoH), Donors (such as WHO and UN JPP), ...</p> <p>Strategies</p> <p>Form new and maintain old partnerships, use health promotion stakeholder networks, think tanks, recruit and train more male agents, incentivize Male Involvement Initiatives (T-shirts and identity cards), need to harmonize the Male Involvement Initiatives across different ministries, ...</p>

Source: Author.

Table 2 shows the levels of actor agency and interests in male involvement initiatives such as MAG. The outlined strategies are provided as a basis for improving actor agency and interests from low levels to converge at high levels. To have effective and sustainable male involvement strategies, the agency and interest levels for Actors A, B and C must be shifted shift from low to join Actors D where both levels agency and interests are high. Mendizabal's (2010) Alignment – Interest and Influence Matrix (AIIM) as a stakeholder analysis tool gives a more nuanced explanation of such strategic actor shifts. Therefore, stakeholder-friendly and acceptable strategies (as listed in their positions in Table 2) must be adopted and implemented to improve on stakeholders' interests and agency for male involvement in maternal health. Position D is thus the best to have all actors working in sustained partnerships to promote male involvement in maternal health.

Other possible mechanisms to create sustainable male involvement may include the use of health promotion stakeholder networks that coordinate such interventions, carry out monitoring and evaluation of implemented male involvement strategies, carry out consistent evidence-based research to effectively use research results for the betterment of these interventions. Women can also be integrated into the male involvement initiatives so that men can learn from women. Jennings et al. (2014) assert that women empowerment can negatively or positively influence male involvement in antenatal accompaniment because male involvement efforts may benefit from women groups that have been established to improve women's socioeconomic status.

Conclusion

For male involvement strategies to effectively work sustainably, male agents who are gender sensitive, aware of maternal health needs, and are willing to engage in peer education and community outreaches are needed. It becomes easier to acquire and

disseminate information on the importance of male involvement in SRHR when both males and females are working in partnerships. In most communities in Uganda, there are Women Action Groups (WAGs) that have been formed to address women's social and economic needs. Male agents should work in partnership with such WAGs to understand one another's interests and influences. Male agents in maternal health promotion may not succeed without learning from and with WAGs.

On the other hand, policies and strategies may not work without acceptance within communities and institutions. Therefore, bottom-up approaches in formulating, implementing, and evaluation of male involvement interventions are needed (Nyandieka, Njeru, Ng'ang'a, Echoka, & Kombe, 2016). All responsible stakeholders need to work collaboratively on their interests and capacities (agency) to effectively promote the sustainable implementation of male involvement strategies in maternal health promotion. There is a significant challenge of cultural diversity which immensely affect SRHR by prohibiting male support to females, and this requires a collective action approach to institutional change. Therefore, relevancy, functionality, adaptability, and sustainability about the effectiveness of male involvement initiatives must be assessed before such interventions are initiated in such culturally diverse communities. Context matters.

Acknowledgments

I extend general appreciation to Partnership for African Social & Governance Research (PASGR) with special thanks to Dr. Daniel Doh, for initial training on concept formation and typological theories. I would like to thank the University Riverside (California), School of Management where the initial draft of this paper was presented. Special thanks to the editors Eleanor Krassen Covan (PhD), and Elizabeth Fugate-Whitlock (PhD) for their relentless efforts that resulted in this final publication.

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References

- Adenike, O.-B. I., Esther, A.-O. O., Adefisoye, A. O., Adeleye, A. A., & Sunday, O. O. (2013). Perception, attitude and involvement of men in maternal healthcare in a Nigerian community. *Journal of Public Health and Epidemiology*, 5(6), 262–270.
- Andersen, R., & Newman, F. J. (2005). Societal and individual determinants of medical care utilization in the United States. Blackwell Publishers. *Milbank Quarterly*, 83(4), 1–28. doi:10.1111/j.1468-0009.2005.00428.x
- Comrie-Thomson, L., Tokhi, M., Ampt, F., Portela, A., Chersich, M., Khanna, R., & Luchters, S. (2015). Challenging gender inequity through male involvement in maternal and newborn health: Critical assessment of an emerging evidence base. *Culture, Health & Sexuality*, 17 (sup2), 177–189. doi:10.1080/13691058.2015.1053412

- Davis, J., Luchters, S., & Holmes, W. (2012). *Men and maternal and newborn health: Benefits, harms, challenges and potential strategies for engaging men*. Melbourne, Victoria Australia: Women's and Children's Health Knowledge Hub., University of Melbourne.
- Greene, M. E., Mehta, M., Pulerwitz, J., Wulf, D., Bankole, A., & Singh, S. (2006). *Involving men in reproductive health: Contributions to development*. New York: United Nations: UN Millennium Project.
- Jennings, L. Na. M., Cherewick, M., Hindin, M., Mullany, B., & Ahmed, S. (2014). Women's empowerment and male involvement in antenatal care: Analyses of demographic and health surveys (DHS) in selected African countries. *BMC Pregnancy and Childbirth*, 14(297), 1–11.
- Larsson, E. C., Thorson, A., Nsabagasani, X., Namusoko, S., Popenoe, R., & Ekström, A. M. (2010). Mistrust in marriage-Reasons why men do not accept couple HIV testing during antenatal care- a qualitative study in eastern Uganda. *Bmc Public Health [Electronic Resource]*, 10, 769. doi:10.1186/1471-2458-10-769
- Ministry of Gender, Labour and Social Development. (2007). *Uganda gender Policy 2007*. Kampala: Ministry of Gender, Labour and Social Development (MGLSD).
- Ministry of Health (MoH). (2010). *Health sector Strategic and Investment Plan 2010/11-2014/15: Promoting people's health to enhance socio-economic development*. Kampala, Uganda: Ministry of Health.
- Ministry of Health (MoH). (2011). *The National strategy for male involvement in child health, sexual and reproductive health and rights including HIV/AIDS [2011-2016]*. Kampala, Uganda: Ministry of Health.
- Ministry of Health (MoH). (2013a). *National implementation guidelines for male involvement in sexual and reproductive health and rights, child health including HIV/AIDS in the Health sectors*. Kampala, Uganda: Ministry of Health.
- Ministry of Health (MoH). (2013b). *Training manual for male action groups on male involvement in sexual and reproductive health and rights*. Kampala, Uganda: Child Health, Ministry of Health.
- Mullany, C. B., Becker, S., & Hindin, M. J. (2007). The Impact of including husbands in antenatal health education services on maternal health practices in Urban Nepal: Results from a randomized controlled trial. *Oxford University Press*, 22(2), 166–176.
- Mwije, S. (2015). *Men's perceptions and support in maternal healthcare (MHC) utilization: An exploratory study of men's influence on utilization of maternal healthcare services. A Case of Sheema District Uganda*. Saarbrücken, Germany: LAP LAMBERT Academic Publishing.
- Nyandieka, L. N., Njeru, M. K., Ng'ang'a, Z., Echoka, E., & Kombe, Y. (2016). Male involvement in maternal health planning key to utilization of skilled birth services in Malindi Subcounty, Kenya. *Advances in Public Health*, 2016, 1–8. doi:10.1155/2016/5608198.
- Republic of Uganda. (2013). *Catalogue of Government policies: Strengthening citizen participation and engagement in the public policy process; 29th August 2011 – 28th February 2013*. Kampala, Uganda: Office of the Prime Minister, Department of Policy Implementation and Coordination (PIC).
- Sileo, M. K., Wanyenze, K. R., Lule, H., & Kiene, S. (2017). "That would be good but most men are afraid of coming to the clinic": Men and women's perspectives on strategies to increase male involvement in women's reproductive health services in rural Uganda. *Journal of Health Psychology*, 22(12), 1552–1562.
- Story, W. T., Burgard, S. A., Lori, J. R., Taleb, F., Ali, N. A., & Hoque, D. M. E. (2012). Husbands' involvement in delivery care utilization in rural Bangladesh: A qualitative study. *BMC Pregnancy and Childbirth*, 12(28), 1–12.
- Uganda Bureau of Statistics (UBOS) and ORC Macro. (2001). *Uganda Demographic and health Survey 2000–2001*. Calverton, Maryland: UBOS and ORC Macro.

- Uganda Bureau of Statistics (UBOS). (2016). *The National population and housing census 2014 – Main Report*. Kampala, Uganda: UBOS.
- Uganda Bureau of Statistics (UBOS). (2012). *2012 Statistical abstract*. Kampala, Uganda: UBOS
- United Nations Joint Programme on Population (UNJPP). (2013). *Government of Uganda/ United Nations Joint Programme on Population (JPP) Mid-term Evaluation (MTE)*. Kampala, Uganda: UNJPP.
- United Nations Joint Programme on Population (UNJPP). (2012). *Baseline survey of the UN Joint programme on population*. Kampala, Uganda: UNJPP.
- United Nations. (1995). *Report of the international conference on population and development*. New York: United Nations.
- Van den Berg, W., Brittain, K., Mercer, G., Peacock, D., Stinson, K., Janson, H., & Dubula, V. (2015). Improving men's participation in preventing mother-to-child transmission of HIV as a maternal, neonatal, and child health priority in South Africa. *Plos Medicine*, 12(4), 1–8. doi:10.1371/journal.pmed.1001811.
- Watala, P. (2013). *Husbands hiring boda-boda men to escort their wives for antenatal services*. Kampala, Uganda: New Vision. Accessed http://www.newvision.co.ug/new_vision/news/1326096/husbands-hiring-boda-bodaescort-wives-antenatal-services.
- World Health Organization (WHO). (2005). *World Health Report 2005, Make every mother and child count*. Geneva, Switzerland: World Health Organization.
- World Health Organization (WHO). (2015). *Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population division*. Geneva, Switzerland: World Health Organization.
- World Health Organization (WHO). (2017). *World health statistics 2017: Monitoring health for the SDGs, sustainable development goals*. Geneva, Switzerland: World Health Organization.
- Yende, N., Van Rie, A., West, N., Bassett, J., & Schwartz, S. R. (2017). Acceptability and preferences among men and women for male involvement in antenatal care. *Journal of Pregnancy*, 2017, 1–8. doi:10.1155/2017/4758017.