



A Call to Action

# GETTING TO EQUAL

ENGAGING MEN AND BOYS IN SEXUAL AND REPRODUCTIVE  
HEALTH AND RIGHTS AND GENDER EQUALITY





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# I. INTRODUCTION

# Unmet sexual and reproductive health (SRH) needs continue to have **global urgency**.

These unmet needs are a critical threat to the health of individuals of all gender identities worldwide. SRH issues, including sexually transmitted infections (STIs), HIV and AIDS, family planning, menstrual hygiene, and maternity-related morbidity, represent 14 percent of the global burden of disease, a proportion that has remained unchanged since 1990 (United Nations, 2014).

## **Gender inequalities remain a significant barrier to addressing such health issues.**

Harmful gender norms and attitudes have a negative influence on both men's and women's health and well-being, shaping men's behaviors in ways that have a direct impact on the sexual and reproductive health and rights (SRHR) of their partners, their families, and themselves. At the same time, SRH and family planning issues are often treated as women's responsibility. Global frameworks have traditionally failed to adequately address the ways in which inequitable gender dynamics and masculinities play a role in perpetuating poor SRH outcomes, a paradigm that ensures women continue to bear the responsibility of family planning, exacerbates gender inequalities, and leads to suboptimal health outcomes for men, women, and children. The 2018 Guttmacher-*Lancet* Commission report highlights this need for increased attention toward relational approaches to masculine norms and men as agents and partners in SRHR (Starrs et al., 2018).

## **Achieving full equality needs men – not in the form of men in charge of women's reproductive decisions but rather men as full, equitable partners invested in their own health and supportive of women's autonomy.**

Full attainment of SRHR for women is impossible without the engagement of men as users, partners, and advocates in promoting SRHR and newborn and child health. Since the mid-1990s, there has been increasing global recognition of the need to engage men in SRHR and family planning work, with discussions at the 1994 International Conference on Population and Development resulting in a call to involve men more actively in reproductive health (Drennan, 1998). This led to the development of novel strategies and evidence for effective engagement of men and boys in advancing SRHR. However, these efforts have largely been limited to engaging men in their roles as supportive partners, and they have often taken an instrumental approach focused on men's individual behaviors rather than one focused on structures and gendered power dynamics. Recent efforts have expanded the vision for constructive male engagement to include a focus on men's own SRH as well, though moderate progress has been made: While overall modern contraceptive use doubled between 1970 and 2015, men's use of contraception via vasectomy, male condoms, or withdrawal has remained constant since the 1980s, accounting for just one-quarter of all contraceptive use (United Nations, 2015; Ross & Hardee, 2017).

**Evidence confirms that engaging men in SRHR, when done well and thoughtfully, can work.** Interventions engaging men in gender-transformative ways as supportive partners in SRH can lead to improved health outcomes (Boender et al., 2004; Interagency Gender Working Group, 2006; Greene et al., 2010; Kraft, Wilkins, Morales, Widyono, & Middlestadt, 2014). Moving forward, there is also a need for further reflection and action around men's roles as stewards of their own health and as allies in the advancement of SRHR for all.

**This call to action highlights 10 areas and opportunities to move us toward equality.**

This brief on men, SRHR, and gender equality aims to advance the conversation with policymakers, donors, implementers, and activists, and to identify opportunities for further collaboration among advocates. The brief outlines guiding principles, priority areas, and goals for engaging men and boys as clients, partners, and SRHR advocates. This work should support, complement, and build on past and ongoing transformative work by feminist and women's rights organizations and activists.



## II. GUIDING PRINCIPLES

# This brief proposes the following high-level **guiding principles** to inform and support approaches to **engaging men in sexual and reproductive health and rights**.

These principles cut across all 10 identified priority areas in the following section and are crucial to the success of working effectively with men and boys to advance SRHR for all. Engaging men in SRHR has the potential to cause harm if a gender-transformative, rights-based approach is not taken; any discussion must therefore begin with keeping women's rights central.

- **Center women's rights and choice.** All work must unequivocally take a human rights-based approach, incorporating sexual and reproductive rights and upholding women's rights and autonomy – including women's right to choose if and how their partners are included in their SRH decisions and services. This brief aims to affirm and complement approaches that promote equality, prevent gender-based violence, and improve SRHR for women around the world.
- **Use gender-transformative approaches.** Rigid masculine norms around self-sufficiency impede men from positive health-seeking behaviors, with consequences for themselves, their partners, and gender equality more broadly. Interventions and initiatives throughout the life cycle – including with youth – should provide opportunities for reflecting on and challenging narrow gender roles and unequal power relations, and for practicing healthy, caring behaviors. A gender-transformative approach is key to developing effective programs, including the use of gender power analysis and a focus on addressing harmful gender norms, inequities, and violence against women.
- **Take a positive approach to men's engagement.** Support men to be more caring, gender-equitable, and active in their health and the health of their families. Encourage approaches that invite men to be agents of positive change in their lives and relationships, and to be advocates for gender equality and SRHR more broadly.
- **Acknowledge and affirm the diverse contexts and masculinities** around the world and their intersections with SRH service provision. Approaches must be adapted to the local context and needs among men, their partners, and their families – with their meaningful involvement in the design phase – to be relevant, equitable, and effective. Language and approaches should address differential access and stigma so individuals of varying sexual orientations and gender identities are reached. Amplify the voices of men who already support sexual and reproductive rights for women.
- **Take a life-cycle approach,** recognizing that gender norms and SRH behaviors and needs are shifting and varied across age groups and life stages. Objectives and interventions should ensure that programs are age-appropriate and disaggregated with targeted entry points for each group, including active engagement with youth, to promote comprehensive SRHR for all.

- **Use evidence-based approaches and rigorous operational research** to inform optimal design and effectiveness of interventions and maximize the impact of investments. Initiatives and interventions should take a learning approach, informed by and building upon existing research, policy, and good practices. High-quality service delivery data, further research on what works, and a culture of shared learning are necessary to address gaps and advance the evidence base on engaging men in SRHR.
- **Provide high-quality, gender-sensitive services with strategic entry points for men.** SRH services must be safe, effective, accessible, patient-centered, and designed with community involvement. Clients have the right to comprehensive and accurate information, privacy and confidentiality, dignity, and respect. Services should be male-friendly, stigma-free, and incorporating strategic entry points – including for adolescents and couples – while also ensuring access to private services, particularly for women who have experienced gender-based violence, men who have sex with men (MSM), individuals of diverse gender identities, and others who may face stigma.
- **Use an ecological framework<sup>1</sup> and work toward an enabling policy environment** as a necessary condition for meaningful advancement in SRHR. Efforts targeting individual- and community-level change require supportive structural environments, as attitudes, behaviors, and access are shaped and influenced by institutions, policies, and the ways policies are implemented. Investments in scaling up and institutionalizing effective approaches to engaging men in advancing SRHR and gender equality must be part of the strategy to achieve a healthy and sustainable future.

1 See Laurie Heise's adaptation of the ecological model as a conceptual foundation.

# What is this brief **NOT** about?

**It's NOT about “men's rights” or men versus women.**

**While the brief is focused on engaging men in SRHR, the goal is to outline the benefits of engaging men for the purpose of advancing gender justice and improving SRHR for everyone, including men, women, and people of all gender identities.**

**It's NOT exclusively about heterosexual or cisgender individuals.**

**We affirm the need to respect and support people in their diversity, amplifying the well-being of people of all sexual orientations and gender identities and working to remove discriminatory policies and stigmatization from SRH approaches and services.**

# What **IS** this brief about?

**Equity, gender justice, and reproductive justice within an intersectional framework.**

**Engaging men in SRHR must be embedded within the broader reproductive and social justice movement and must take into account poverty and other inequalities. Promoting gender-equitable norms around men and adolescent boys' SRH gives them the tools to take responsibility for their health, and to respect and support women's, girls', and all individuals' health, rights, and choices.**



### III. THE STATE OF MEN'S ENGAGEMENT IN SRHR

# The State of Men's Engagement in SRHR

## A) CHALLENGES AND PRIORITY AREAS

To advance the conversation with SRHR policymakers, donors, and implementers, this brief identifies 10 key areas in which men's engagement could be further advanced for maximum impact. Based on a review of the literature, each area seeks to outline research, gaps, and promising approaches in the work to engage men as clients, partners, and agents of positive change for the SRHR of all, with an emphasis on gender-transformative approaches and supporting women's rights. The areas of focus represent opportunities for further collaboration among advocates and significant improvement in public health.

### **1. AD HOC COMPREHENSIVE SEXUALITY EDUCATION (CSE) WITH A LACK OF GENDER-TRANSFORMATIVE CONTENT ON MASCULINE NORMS AND RELATIONSHIPS**

Comprehensive sexuality education (CSE) is “an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, non-judgmental information” for youth both in and out of school (UNESCO, 2015). It aims to equip children and young people with developmentally appropriate and accurate information, skills, attitudes, and values that enable them to care for their bodies and protect their health and well-being. In addition, CSE seeks to promote healthy, pleasurable, and respectful relationships, and to increase young people's ability to make responsible, consensual, and autonomous decisions about their sexuality and SRH while fully respecting the rights of others to do the same (UNFPA, 2015; Levtov, Van der Gaag, Greene, Michael, & Barker, 2015). CSE should take a rights-based and gender-focused approach to sexuality education, with an emphasis on the importance of respectful relationships and communication skills.

A focus on gender-transformative CSE for adolescents is critical to building healthy SRH attitudes and behaviors, as many become sexually active during this period and ideas and beliefs around gender roles and SRH form. Attitudes and behaviors – both positive and harmful – formed in adolescence can carry over into adulthood, making CSE around puberty, fertility, and gender norms at this age integral to equipping men with the knowledge and skills to develop healthy SRH patterns, gender-equitable practices, and respect for all sexual orientations and gender identities. CSE should also include critical reflections on pornography and other societal messages about masculinities and femininities.

Relatively few sexuality education curricula address the full and recommended range of competencies, attitudes, and behaviors, instead choosing to “cherry-pick” key elements (UNESCO, 2015). Additionally, there is often a “wide gap between progressive national policies and programme implementation at the local level” (UNFPA, 2015). While CSE programs should always be locally adapted and implemented within the boundaries of national laws and policies, there are certain core topics that are essential to maintaining quality and meeting international standards, such as addressing

critical knowledge gaps and harmful gender norms (UNFPA, 2015). CSE programs emphasizing gender and power are far more likely to reduce rates of STIs and/or unintended pregnancy than “gender-blind” curricula (Barker, Ricardo, & Nascimento, 2007; Haberland, 2015). A review of the limited evidence on CSE programs with these components shows an increase in boys’ awareness of sexuality and pregnancy prevention and improved gender-equitable attitudes (UNESCO, 2017). Because few programs disaggregate CSE program data by gender, we have little evidence on the impact of such programs on boys specifically (Hardee, Croce-Galis, & Gay, 2016).

## **2. INADEQUATE UPTAKE OF EXISTING MALE CONTRACEPTIVE METHODS**

Although contraceptive options include methods for men and those that require their participation, family planning programming has predominantly focused on women. The use of male methods (including male condoms, vasectomy, and withdrawal), together with calendar-based methods, account for just one-quarter of all contraceptive use worldwide, a proportion that has remained steady since the 1980s (Ross & Hardee, 2017). The use of male methods is most common in Northern Europe and least common in sub-Saharan Africa, where only 2.4 percent, 1.3 percent, and 0 percent of the population uses condoms, withdrawal, and vasectomy, respectively (United Nations, 2015). Men’s low levels of use force onto women the burdens of pregnancy prevention, which can be costly, inaccessible, stigmatized, invasive, and involving serious side effects. Many interventions use approaches with the perspective that women are the contraceptive users, with insufficient attention to reaching men as contraceptive users in their own right – perpetuating the outdated paradigm that family planning is a “women’s issue.” More men sharing the burden of pregnancy prevention is both the cause and consequence of greater gender equity, couples’ communication on SRH, and improved health-seeking.

There are significant challenges for improving the uptake of male contraceptive methods. Vasectomy is a highly effective, relatively inexpensive, and low-risk procedure compared to female sterilization (Shih, Turok, & Parker, 2011), yet insufficient awareness among clients and providers and persistent myths related to side effects constitute a significant demand-side problem (Shattuck et al., 2016). World Vasectomy Day (WVD) is an example of a family planning movement increasing awareness of and demand for male methods around the world. Mexico was chosen as the WVD headquarters in 2017, and with technical assistance, media campaigns, and dedicated demand generation efforts, the country ultimately saw a 40% increase in the number of vasectomies over two years (Centro Nacional de Equidad de Género y Salud Reproductiva, 2018). Vasectomy service delivery could be improved by task-shifting services to lower cadres of workers, similar to innovations in voluntary medical male circumcision (Shattuck et al., 2016). Withdrawal can be an effective, appropriate method in certain situations, such as for couples needing a back-up method (Jones et al., 2009) or for those with religious objections to contraception (WHO, 2015). Despite this, little research has been done on how to position withdrawal as an option for couples in the absence of a more effective one (Hardee, Croce-Gallis, & Gay, 2017). Correct use of the Standard Days Method, a male-cooperative, calendar-based method, depends to a great extent on the ability of providers to screen clients effectively and teach them how to use the method

successfully. While providers may at first be reticent to see the Standard Days Method as an effective alternative to other contraceptives, after training experience, they may find it easy to teach and to learn (Gribble et al., 2008), and it may motivate providers to “broaden the female-centered paradigm for [family planning] services” (Croce-Galis, Salazar, & Lundgren, 2014).

Alongside service delivery constraints, men’s contraceptive use is highly correlated with access to social and economic capital, like education and wealth (Ochako et al., 2017; Kabagenyi et al., 2014; John, Babalola, & Chipeta, 2015). Additionally, rooting male contraceptive use in religious and cultural belief systems – for example, by working in partnership with faith leaders – can bring about an increase in positive attitudes and behaviors toward male contraceptive use (Perry et al., 2016).

Gender norms also provide challenges to the uptake of male methods. Addressing inequitable gender norms that limit men’s participation in contraceptive use is key. When men and boys have been exposed to gender equality programming, they are more likely to report increased contraceptive use, including condom use (Hardee et al., 2017). To see an increase in vasectomy, it is important to confront gendered beliefs held by both men and women about the threats to male health and identity posed by the procedure and to provide counseling around fertility loss (Walter & McCoyd, 2009). Studies in low-resource settings, while limited, suggest that both men and women have low acceptance and accurate knowledge around vasectomy and that they fear poor sexual performance. Some women fear the procedure will promote male infidelity or retaliation if the method fails (Shattuck et al., 2016). The promotion of vasectomy programs could be improved by coupling mass media messaging that dispel myths with the provision of practical information on how to access services and outreach that allows individuals to ask questions.<sup>2</sup> Male condom use – offering dual-protection from both STIs and pregnancy and highly effective when used correctly – is associated with more gender-equitable beliefs for both men and women (Vincent et al., 2016) but is often rejected after men enter a committed relationship with a female partner (Ntata, Mvula, & Muula, 2013). Thus, women, once in a union, often continue to bear the brunt of responsibility for preventing unintended pregnancy (Ringheim, 1999; Ntata, Mvula, & Muula, 2013). Further research is needed on how to sustain condom use after long-term coupling (Hardee et al., 2017).

Across all methods, it is essential to disaggregate service delivery data by gender and contraceptive method. Otherwise, any efforts to increase contraceptive uptake will be missed (Hardee et al., 2017). Further, no program should boost demand for male SRH services without ensuring they are accessible; conversely, service providers’ trainings or condom procurement alone is insufficient: effective programs pair service delivery with demand-side promotion activities. Biases at the policy level, including views of policymakers and family planning program managers on men’s use of contraception, are important to address as well to ensure promotion of male methods.

2 One such successful program, the *Promocão de Paternidade Responsável* (Promotion of Responsible Fatherhood) campaign, aimed to increase knowledge, awareness, and utilization of vasectomy in three Brazilian cities from 1989 to 1990. A 30-second television spot was developed featuring two animated hearts – one male, one female – to depict the purpose and safety of vasectomy and to illustrate that it does not interfere with sexual pleasure. At the end, viewers were provided with the name of a local clinic and a phone number to contact for more information. The campaign was also shared across radio and billboards. During the 15-month campaign, an estimated 4 million people were reached, and the monthly average of vasectomies performed increased during implementation by 82 percent in Sao Paulo, 108 percent in Fortaleza, and 59 percent in Salvador (Kincaid et al., 1996).

Community-based promotion can be time-consuming and costly: program models including outreach activities should ensure that there is continued attention and resources devoted to social engagement with male networks, community mobilization, and household outreach (Croce-Galis et al., 2014). Any and all outreach to men encouraging greater sharing of the contraceptive burden should take a life-cycle approach, teaching adolescents about male methods of contraception as well as female methods; it should also take a gender-transformative approach, encouraging men to reflect on how their health choices impact their partner and on how gender and power dynamics affect these choices and risky behaviors, as well as building skills for partner communication and negotiation. Programs seeking increased male contraceptive use must not further entrench inequitable gender norms.

### **3. LIMITED RANGE OF CONTRACEPTIVE OPTIONS AVAILABLE TO MEN AND THEIR PARTNERS**

In addition to further research to understand why men are not using existing contraceptive methods at high rates, expanding new methods for men is critical. The absence of a reversible method for men that falls somewhere between condoms and vasectomy is a serious limiting factor to any effort to equalize the gendered burden of contraception, and recent studies have confirmed that there is demand for a novel and reversible male method (Glasier, 2010; Kabagenyi et al., 2014): Across four cities around the world, between 44 and 63 percent of men reported that they would use a contraceptive pill, and over 70 percent of women in a study in Scotland, South Africa, and Shanghai reported willingness to rely on their partner's use of a hormonal male contraceptive, with only 2 percent of the sample saying they would not trust it (Glasier et al., 2000). Research shows that if even 10 percent of men interested in using a new male-controlled method did so, the introduction of a male pill or temporary vas occlusion could have a substantial impact on pregnancy prevention, by 3.5 to 5.2 percent in the United States, 3.2 to 5 percent in South Africa, and as much as 30 to 38 percent in Nigeria (Dorman et al., 2017).

There are two promising male non-hormonal contraceptive methods currently in late-stage development, including Vasalgel, a non-hormonal gel inserted into the vas deferens that blocks sperm passage, and a pill form of the Indonesian herb *Justicia gendarussa* that temporarily interferes with sperm's ability to perforate a female egg. Both innovations are reversible. While no significant clinical human trial of Vasalgel has been conducted outside of India (though animal trials are ongoing in the United States), the gendarussa pill has demonstrated high effectiveness in preventing pregnancy in several human trials, and it is expected to receive approval from the Indonesia National Agency of Drug and Food Control and go to market as early as 2020. Other promising approaches include hormones, which block sperm production; a fast-acting muscle relaxant in the vas deferens; and a device that binds to the sperm's surface and prevents motility (Male Contraception Initiative, n.d.). Importantly, in 2015, the development of a testosterone and androgen male contraceptive pill with funding from the Bill and Melinda Gates Foundation was put on hold – despite showing effectiveness in preventing pregnancy – after clinical human trials revealed significant mood-altering side effects. Some suggested the halting of the trial showed a double standard, with this novel male pill showing similar side effects as current

female hormonal methods. Such double standards should be addressed in an effort to make progress in men sharing the contraceptive burden with women.

It is vital to continue advocating with donors and pharmaceutical companies to hasten the pace of research into and development of novel, effective male contraceptives. To do so, more research should be conducted on the barriers to investment. Despite the finding that a novel male contraceptive could open up a market of an estimated 44 million new users (Dorman & Bishai, 2012), large pharmaceutical companies have so far been reluctant to move forward with novel male contraception to any serious extent, owing to concerns over side effects and liability, and a disbelief that men would use the method (and correctly) (Edwards, 2017).

Concurrently, we need more evidence on the unique barriers to acceptance of such methods, among both men and women. For example, it may be important to consider how to confront misperceptions about hormonal contraception and male infertility, or how female partners may perceive relinquishing contraceptive control to men. Once more methods are available, it is essential to create a market for such services by piloting service delivery and outreach strategies that appeal to the user. Such efforts must include advocacy with practitioners on effective counseling techniques. Importantly, creating a market for novel male contraceptive methods may also bring men into a larger “culture of health,” in which clinic visits for contraceptive counseling are paired with other essential services.

## **DO NO HARM**

Central to any effort to increase men’s role in preventing unintended pregnancy must be respect for women’s preferences on whether to engage their partners and the engagement of men “in equitable ways that protect and encourage women’s autonomy” (High Impact Practices in Family Planning [HIPs], 2018).

## **4. MEN’S INCONSISTENT SUPPORT FOR THEIR PARTNERS’ SEXUAL AND REPRODUCTIVE HEALTH (SRH) AND METHOD USE**

SRH is often considered women’s domain. At the same time, men dominate decision-making in many traditionally patriarchal settings regarding family size and their partner’s use of contraceptive methods. This contradictory role among men of being both key decision-makers regarding fertility desires and remaining detached from reproductive health issues is a central challenge for improving SRH in patriarchal societies (Kabagenyi et al., 2014). To address these power imbalances, SRH-focused programs must be gender-transformative and take a life-cycle approach, understanding that factors influencing boys’ and men’s support for women’s and partners’ SRH vary by life phase.

Available evidence shows that women whose partners disapprove of modern contraceptive practices are unlikely to use them, and vice versa (Odimegwu, 1999;

Ezeanolue et al., 2015). With this in mind, certain programs have targeted male partners in SRH information campaigns and interventions to support female use of SRH services, including contraception. Other programs aimed at male partners have focused on bringing more men to antenatal care services, encouraging supportive parenting, and preventing mother-to-child transmission of HIV (Greene et al., 2006). Program models vary: When couple counseling is not possible, alternative approaches to involving men include male-only educational talks, male health promoters, behavior change communication activities targeting men, and the integration of family planning content into non-health activities (such as agriculture and sanitation projects) (Lundgren, Cachan, & Jennings, 2012). In general, effective interventions targeting couples do not solely focus on the individuals but rather take a socio-ecological approach, understanding and targeting different levels of influence, including family, community, social norms, and structures (Barker et al., 2007).

A significant barrier for couples is difficulty in communicating about sexual and reproductive health-related topics. Gaps in couples' family-planning expectations can be addressed through improving men's and women's ability to have effective conversations on the topic (Lasee & Becker, 1997; Shattuck et al., 2011). For example, increasing male knowledge of the fertility cycle and reproductive systems can improve support for partners' family planning use (Croce-Galis et al., 2014). These approaches can promote greater marital harmony and gender equity and protect against further entrenchment of male-dominated decision-making (Greene & Levack, 2010). A recent randomized control trial of a gender-transformative intervention for young parents in Rwanda, with a focus on fathers, found that both men and women reported higher rates of modern contraceptive use in the intervention group compared to the control group nearly two years after the intervention started (Doyle et al., 2018). Save the Children's Malawi Male Motivator Project found that an intervention led by male community health educators that paired couple communication with gender-transformative education targeting husbands at the household level could facilitate female contraceptive use. Male-to-male interventions have the benefit of normalizing male discussion and competence in what is traditionally a woman's domain (Shattuck et al., 2011). However, only a handful of programs have proven conclusive links between such men-as-partners interventions and female contraceptive use. In particular, there is a gap in research on men's involvement in emergency contraceptives.

The rigor of the evaluations on engaging men as partners varies, and such multi-level and multi-component programs are complicated to measure. For example, when male engagement is an ancillary component, it can be difficult to distinguish between the effects of male involvement and the effects of the family planning intervention itself (Lundgren et al., 2012). Therefore, it may be important to develop or deploy evaluative methods that help capture the impact of male engagement with greater precision. Furthermore, few of the effective approaches to engaging men in improving their female partners' access to SRH services have been taken to scale. Eventual scale-up requires the identification of and adherence to a set of practices and principles identified as central to men-as-partners interventions, such as a gender-transformative approach, and documentation and dissemination of challenges and successes of scale-up efforts.

## DO NO HARM

There are challenges to couple-centered programs in which the male partner may play a dominant role in the exchange with the health provider or in the decision-making process. Providers are at risk of exhibiting a bias toward men's decision-making power in heterosexual relationships and discriminatory attitudes toward same-sex couples. Providers should ensure that:

- Both partners are willing to participate in a joint counseling session;
- Both members of the couple have an equal opportunity to express their concerns and ask questions; and
- Individuals have an opportunity to speak with the provider in private.

Source: *Greene & Levack, 2010*

## 5. UNCERTAINTIES AROUND MEN'S ROLES AS SUPPORTIVE PARTNERS AND ADVOCATES FOR WOMEN'S ACCESS TO SAFE ABORTION SERVICES

The Guttmacher-*Lancet* Commission on Sexual and Reproductive Health defines SRH as a “state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction,” which includes the right to “decide whether, when, and by what means to have a child or children, and how many children to have” (Starrs et al., 2018). Within this, access to safe and effective abortion services and care cannot be separated from any other core component of SRH. Yet in most countries, abortion services are unsafe, illegal, and/or hard to access. Globally, 56 million abortions occur each year, and nearly half – 25 million – are considered unsafe (Ganatra et al., 2017). Unsafe abortion – concentrated almost exclusively (97 percent) in low-income countries – contributes to 8 to 11 percent of maternal mortality worldwide, claiming the lives of 22,800 to 31,000 women annually (cited in Barot, 2018).

Men's role in abortion functionally operates on two levels: at the structural level, in controlling the exercise of social, political, and economic power and the institutions, laws, and norms that govern abortion access and quality, and at the individual level, in relationships with women seeking abortion (Freeman, Coast, & Murray, 2017). Since male involvement in abortion decision-making is too often negative, it is critical to ensure that when men are involved, it is in ways that are respectful and supportive of women's decisions about their bodies (Barker & Sippel, 2017) and that more men are encouraged to advocate and speak out in support of women's access to legal, safe abortion.

Available evidence suggests that men around the world are heavily involved in abortion decisions, access, and service provision. The International Men and Gender Equality Survey (IMAGES) in Brazil, Chile, Croatia, India, and Mexico found that between 11 and 27 percent of women had ever terminated a pregnancy and that male partners in all countries except Mexico were significantly involved in the decision to seek an abortion

(Barker et al., 2011). A recent study in Zambia showed men influenced whether women sought safe or unsafe abortion: The desire to avoid disclosing pregnancy to men out of fear of their reactions, interference, or abandonment were important influences on some women's decisions to seek abortion, on the secrecy and urgency of the procedure, and on the level of risk assumed. In this context, the men who played positive roles used their position to support safe abortions by accessing information and providing economic resources (Freeman et al., 2017). In contexts of scarce information related to the legality and availability of abortion, many women are forced to consult with male authorities to find this information and ultimately access safe abortion services (Freeman et al., 2017; Rossier, 2007; Centre for Research on Environment Health and Population, 2007).

There is evidence that men's support during post-abortion care has important impacts on facilitating a more rapid physical and emotional recovery for women (Abdel-Tawab, Huntington, Hassan, Youssef, & Nawar, 1999), but in general, few programmatic approaches have tried to engage men to increase women's safe abortion access (Ipas, 2009). Focusing programs solely on women runs the risk of affirming men's ability to distance themselves from abortion and thus escape the social, economic, or penal consequences, leaving women to carry this burden (Nyanzi, Nyanzi, & Bessie, 2005); at the same time, programs must tread carefully to support women's full autonomy in making such decisions. Further research on male involvement in abortion decision-making and services is necessary.

Additionally, deeply held religious and cultural beliefs can be significant barriers to changing the abortion access landscape. Successful campaigns engaging men as change agents in support of women's SRHR (see area 10) point to the importance of working with key influencers – such as religious and cultural leaders – who can then share these messages with their communities in contextually relevant ways.

Research in the United States shows that men are as likely as women to support keeping abortion legal (Smith & Son, 2013). The recent success in Ireland in passing a law by referendum legalizing abortion points to the importance of engaging men as allies in support of women's rights, particularly critical given the current global backlash against women's reproductive rights and autonomy.

## DO NO HARM

Efforts to promote an expanded role for men as supportive partners and advocates for access to safe abortion services must prioritize women's autonomy in decision-making and must carefully guard against unintended consequences of expanding men's role in this area, such as the encroachment of harmful norms that limit women's agency.

## 6. LACK OF MEN'S ACCESS TO AND USE OF HIV PREVENTION, TREATMENT, CARE, AND SUPPORT

Despite their many social and economic advantages, men are less likely than women to seek out healthcare, to take an HIV test, or to initiate and adhere to HIV treatment (Cornell, McIntyre, & Myer, 2011). Across sub-Saharan Africa, men and boys living with HIV are 20 percent less likely than women and girls living with HIV to know their HIV status, and they are 27 percent less likely to be accessing treatment. Globally, antiretroviral therapy coverage among men and boys aged 15 and older was 47 percent in 2016, compared to 60 percent of women and girls. Male reluctance to access testing and treatment services early leads to poor outcomes for HIV-positive men: They tend to have a lower CD4 count at treatment initiation and additional complications compared to women, lower rates of viral suppression, and a greater likelihood of death while on antiretroviral therapy (Naidoo et al., 2017). As a result, men are more likely than women to die of AIDS-related causes: globally, they accounted for about 58 percent of the estimated 1.0 million AIDS-related deaths in 2016 (Ettiègne-Traoré et al., 2013; Druyts et al., 2013).

These poor HIV outcomes can be driven by harmful male gender norms, which promote risk-taking, sexual dominance, and invulnerability – discouraging help-seeking behaviors. Men and adolescent boys who adhere to such masculine norms tend to have negative attitudes towards condom use, more sexual partners, and a higher likelihood of contracting STIs (Barker et al., 2010). Masculine norms that direct men to seek help only when they are very ill have been found to result in men's lower rates of HIV testing, and men who don't know their HIV status are more likely to engage in risky sexual behaviors (Lynch, Brouard, & Visser 2010; Napper, Fisher, & Reynolds, 2012). These harmful masculine norms drive HIV transmission for both men and their partners.

Overall, women constitute more than half of adults living with HIV (amfAR, 2016), and unequal gender norms and gender-based violence increase women's risk of HIV infection in heterosexual relationships. Women in violent relationships may have decreased autonomy to negotiate the timing of sexual intercourse and condom use. As a result, those women who report intimate partner violence are more likely to be infected by partners with HIV (Jewkes, Dunkle, Nduna, & Shai, 2010; Diaz-Olavarrieta et al., 2009; Weiss et al., 2007). HIV prevention efforts that focus on encouraging women to negotiate safer sex assume a level of autonomy and empowerment that many women, especially sex workers and young women in intergenerational relationships, do not have (Dunkle et al., 2006). This inequality contributes to the burden of testing being placed primarily on women and can lead to a stigmatization of women as ultimately responsible for HIV transmission. In this context, women's fears of rejection or violence from their partners can form a barrier to testing and treatment, leading to worse health outcomes for women (Maman, Groves, King, Pierce, & Wyckoff, 2008). Research studies from India, Kenya, Rwanda, South Africa, Tanzania, the United Kingdom, the United States, and Vietnam show that women who are HIV-positive are more at risk of violence than women who are HIV-negative, and that violence is a driving factor for HIV (Program on International Health and Human Rights and Harvard School of Public Health, 2009). Programs working to address HIV should integrate a focus on violence prevention and transforming violence-supportive attitudes among adolescent boys.

In an environment where SRH issues are perceived as a woman's domain, healthcare settings are not always set up to treat male patients (Davis, Luchters, & Holmes, 2012; Rutgers WPF & Promundo, 2014; Van den Berg et al., 2015). In addition to men's sexual risk-taking and poor health-seeking behaviors, these health systems infrastructure issues – such as suboptimal policies, services, hours, and a lack of gender-sensitive training for clinic staff – prevent men from accessing the care they need to maintain health, which, in turn, contributes to the burden on women and health systems (IPPF & UNFPA, 2017). Where attention has been given to the service delivery needs of men and boys, it has often been done in a cursory manner by simply adding to existing services traditionally tailored to women, failing to sufficiently address gaps in service coverage.

Additionally, evidence shows that many men have poor access to HIV services owing to intersecting forms of discrimination based on race, class, sexuality, gender identity, and disability (Dworkin et al., 2011; Peacock et al., 2009). Men who have sex with men (MSM) are globally 24 times more likely to have HIV than the general population (UNAIDS, 2017), and transgender women are 49 times more likely (WHO 2015), yet MSM and transgender communities often have less access to HIV services and treatment, and can face increased consequences for seeking them out. In settings where men having sex with men is criminalized, testing, treatment and access to care must be carefully considered and addressed, and services must not involve criminal justice authorities (WHO, 2016). Self-testing provides one possible entry point by allowing individuals to conduct a preliminary test to rule out HIV/AIDS acquisition in the privacy of their own homes. These approaches may be particularly appropriate for people with high ongoing risk of HIV, such as key populations and serodiscordant couples, who could benefit from more frequent testing. Further, voluntary assisted partner notification services can be offered in such cases where a partner is afraid to disclose their status to another person(s). In cases where violence is a possibility, services can be paired with intimate partner violence screenings. Sensitization and anti-stigmatization trainings should be conducted with health services staff to combat homophobia and transphobia and the impact of discrimination on health outcomes for lesbian, gay, bisexual, and transgender (LGBT) communities.

Men can play a positive and important role in HIV prevention and treatment. For example, voluntary medical male circumcision is a proven biomedical approach which can significantly reduce HIV and STI incidence for both men and women (WHO, 2007). Voluntary medical male circumcision can also provide a platform for engaging men in discussions around unhealthy masculine norms. Well-designed voluntary medical male circumcision programs that take a gender-transformative approach to address masculine norms discouraging health-seeking behavior can improve men's SRH and that of their partners on multiple levels (IPPF & UNFPA 2017).<sup>3</sup>

3 Modeling based on data from the Bophelo Pele Male Circumcision Centre in Orange Farm, South Africa, found a decrease in HIV prevalence, from 36.6 to 22.4 percent, and estimated a decrease in incidence of up to 20 percent in women aged 15 to 29 having sex with circumcised men (Jean et al., 2014). This program model has also shown that voluntary medical male circumcision can be a useful access point for providing men with education on SRH, as well as voluntary counseling and testing and medical exams (Stern, Peacock & Alexander, 2009).

In addition, male engagement can play a critical role in the prevention of mother-to-child transmission of HIV. When an expectant father is counseled and tested for HIV, the mother is more likely to return for follow-up, successfully take antiretrovirals, and adhere to recommendations around breastfeeding (Peltzer, Mlambo, Phaswana-Mafuya, & Ladzani, 2010; Farquhar et al., 2004). Fathers' involvement in the prevention of mother-to-child transmission has been shown to decrease the risk of infant HIV infection and of mortality of HIV-uninfected infants (Aluisio et al., 2011). Overall, a gender-transformative approach encourages men to challenge inequitable gender norms and increase their uptake of HIV testing and treatment, thereby reducing the disproportionate burden on women. Interventions can take community-based approaches to address harmful male norms along the HIV prevention-treatment cascade, including working with traditional, religious, or community leaders.

The global HIV response has achieved remarkable success in prevention and treatment, so much so that global leaders have reoriented around the goal of ending AIDS completely by 2030. Yet, the cycle perpetuated by harmful masculine norms – risky sexual behavior, avoidance of HIV testing, continued risky behavior when HIV status is unknown – drives HIV transmission for both men and their partners. Breaking this cycle by better engaging men in HIV prevention efforts and services can improve the health of both men and women and is fundamental to achieving the current Joint United Nations Programme on HIV/AIDS (UNAIDS) “90-90-90” targets.<sup>4</sup>

## **7. LACK OF MEN'S UPTAKE OF SEXUALLY TRANSMITTED INFECTION (STI) DIAGNOSIS AND TREATMENT**

The estimated annual incidence of non-HIV STIs increased by nearly 50 percent between 1995 and 2008 (Ortayli, Ringheim, Collins, & Sladden, 2014). According to World Health Organization estimates, the global prevalence and incidence of four curable STIs – chlamydia, gonorrhea, trichomoniasis, and syphilis – remain high in adult men and women, with nearly 1 million new cases acquired each day (Newman et al., 2015). It is estimated that young people carry the largest global burden of STIs, with more than one-fifth to greater than one-half of some STIs appearing in young people aged 10 to 24 (Bearinger et al., 2007).

Men and boys who equate masculinity with risk-taking and sexual dominance are more likely to shun condom use and to contract an STI and less likely to access STI care and treatment (Peacock, Stemple, Sawires, Sharif, & Coates, 2009). Additionally, partners experiencing physical or psychological abuse by an intimate partner have an increased risk of developing an STI (ibid). Program designers should use a gender-transformative lens to address these norms and prevent violence, encouraging men to act as responsible stewards of their own health, supporters of the health of their partners, and advocates for STI prevention. Additional, key strategies for expanding men's engagement in STI prevention and care include involving positive male role models to encourage other men and boys to use condoms and seek testing for HIV and STIs, and involving men in strategies to reduce STI-related stigma (IPPF & UNFPA, 2017).

<sup>4</sup> The Joint United Nations Programme on HIV/AIDS (UNAIDS) target is that by 2020, 90 percent of all people living with HIV will know their HIV status, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90 percent of all people receiving antiretroviral therapy will have viral suppression.

Further, there is a distinct lack of targeted educational materials, spaces, and sensitized providers, creating additional barriers to men’s diagnosis and treatment. STI services may not be integrated with other services for men, which means they are not normally captured in yearly wellness checks or physicals (see area 9). Particular groups of vulnerable men, such as MSM, migrants, or sex workers, may face particular stigma or discrimination for seeking STI care (UNFPA et al., 2015), particularly in areas where homosexuality and sex work are criminalized or marginalized. Such communities therefore may not be reflected in STI surveillance systems (Newman et al., 2015). Accessibility challenges among different groups of men should be a focus of formative research for community interventions.

Going forward, it is important that STI services are horizontally integrated across other health programs, particularly SRH programs, in order to more efficiently use health system resources and at the same time better meet client needs (UNAIDS, 2010a). For example, one obvious linkage with HIV programming is gender-transformative voluntary medical male circumcision services, which have been shown to be effective in preventing both STIs and HIV (Grund et al., 2017).

## **DO NO HARM**

While it may be clear from a health system and resource perspective that integration is preferable, there may be good reasons that certain health services are “siloes” – for example, to accommodate vulnerable populations such as women seeking care after intimate partner violence. Integrated services should be instituted only if it is possible to ensure the privacy, safety, and dignity of all patients. Service providers and staff should be trained on patient needs and risks and take appropriate precautions on behalf of patient safety when needed.

## **8. MEN’S MARGINAL ROLE IN MATERNAL, NEWBORN, AND CHILD HEALTH (MNCH)**

Research has shown engaging men as supportive partners in MNCH has lasting benefits for families, communities, and gender equality, serving as an effective entry point to address a wide range of gendered health and development outcomes (Doyle et al., 2018). The involvement of fathers before, during, and after the birth of a child can support women’s health outcomes by increasing their use of maternal health services, influencing their health behaviors positively, and providing emotional support (Levtov et al., 2015). Men’s presence as supportive partners can also be used to broaden men’s own engagement with health services and encourage stewardship of their own health throughout their lives (Davis et al., 2012; Yargawa & Leonardi-Bee, 2015; Mullany, Becker, & Hindin, 2006; Mangeni, Mwangi, Mbugua, & Mukthar, 2013; Ri-Hua et al., 2010). For example, men’s involvement in antenatal care visits can provide an important opportunity to connect men with the health system, screen for and treat STIs and other health problems, and provide education about healthy behaviors.

Male engagement in MNCH, when done using gender-transformative approaches encouraging men to critically reflect on gendered attitudes, behaviors, and power inequalities, can support the advancement of gender equality more broadly as well. For example, studies have shown that training expectant fathers on healthy pregnancy can increase the likelihood of men participating in domestic work and taking their wives to doctor appointments (Sinha, 2008; Midhet & Becker, 2010). Programs involving men in MNCH have shown improvements in health outcomes for women, newborns, and children through increased uptake of MNCH services, increased couple communication and improved relationships, increased value of girls, greater sharing of unpaid care work, and reduced intimate partner violence (Comrie-Thomson et al., 2015; Doyle et al., 2018).

However, in most parts of the world, men are still unlikely to attend the birth (Gadsden, Fagan, Ray, & Davis, 2001; Levto et al., 2015). The presence of a male partner during birth, if desired by the mother, can be beneficial to the well-being of both mother and baby and can be a meaningful shared experience for couples (Sapkota, Kobayashi, Kakehashi, Baral, & Yoshida, 2012; Rutgers WPF & Promundo 2014). Health systems and policies should ensure a woman's right to have her male partner present (or not) during delivery, and simultaneous efforts to change norms around childbirth are critical. When a new child is born, fathers – with the mother's permission – should attend postnatal care visits with the mother and child, encourage exclusive breastfeeding when possible, and endorse communication around family planning. Giving men and women the opportunity to discuss family planning during maternity care can provide both the necessary information and space for shared decision-making (HIPs, 2017). While evidence from programs dating back to the 1960s have shown that postpartum family planning can significantly increase women's uptake of contraceptives (Castadot et al., 1975; Achyut et al., 2015; Bolam et al., 1998; Speizer, Calhoun, Hoke, & Sengupta, 2013), men's involvement has not historically been a focus of these programs. Recent efforts to make postpartum family planning an access point for couples have yielded positive results (HIPs, 2017).

Research from multiple countries has linked low levels of men's involvement in MNCH with the perception that pregnancy and childrearing are the woman's domain (Rutgers WPF & Promundo 2014). In addition to impacting men's health-seeking behavior, these gender norms are often reflected in the attitudes and actions of healthcare providers, making them less likely to invite male involvement in MNCH care (Aguayo, Correa, & Kimelman, 2012; Fägerskiöld, 2006) or to target men with the information they need (Burgess, 2006; Davis et al., 2012). When providers and staff lack training to welcome and support men in their role as parents and partners, men may feel uncomfortable or excluded (Davis et al., 2012; Natoli, Holmes, Chanlivong, Chan, & Toole, 2012). However, when providers are trained and sensitized to encourage men to play a more active role in MNCH, they can improve outcomes for families as well as challenge harmful gender norms around health and caregiving. Gender-sensitive training initiatives for service providers are needed to raise awareness about the positive role men can play in MNCH and to identify opportunities and methods for better engaging men whose female partners desire their involvement (Ergo, Eichler, Koblinsky, & Shah, 2011). Barriers to men's engagement in MNCH can also include the physical design of health facilities and materials, such as the sharing of rooms by multiple women in labor and the lack of waiting areas, restrooms, and educational materials for men. To address this, some municipalities in Brazil have

incorporated criteria for recognizing facilities as “father-friendly” (Stern & Shand, 2015).

Studies from programs in a variety of contexts have identified effective and promising approaches to engaging men in MNCH, as the evidence base on the positive impact of men’s engagement on women’s, children’s, and men’s own health continues to grow. Health systems, communities, and civil society organizations should work together to develop and scale up interventions to educate and support the involvement of men in MNCH while ensuring the autonomy and rights of women. Programs incorporating peer education, community meetings, distribution of educational materials, one-on-one counseling sessions, workplace-based initiatives, group education, and mass media campaigns have yielded positive results such as improving men’s knowledge and increasing couple communication (Sinha, 2008; Davis et al., 2012). The many existing successful program models provide a foundation for future work – but there is also a recognized need to expand and tailor these programs to include men who are not well reached, such as adolescents, minority groups, and immigrants.

## DO NO HARM

Programs targeting couples may discourage or prevent single or unaccompanied women, or women who would prefer not to involve their partner, from accessing the services and information they need; additionally, poorly designed efforts to involve men could potentially compromise women’s decision-making autonomy and safety (Davis et al., 2012). Policies and programs must pay special attention to their potential gendered consequences, as well as take measures to ensure women’s rights, autonomy, and choice – as to if and how their partners are included in SRH decisions – are unequivocal, central, and upheld.

## 9. NEGLECT OF MEN’S SPECIFIC SEXUAL AND REPRODUCTIVE CONCERNS, INCLUDING DYSFUNCTION AND INFERTILITY, IN THE STRUCTURE OF HEALTH SERVICES

Men and adolescent boys have a variety of SRH needs beyond more traditional SRH services, such as sexual dysfunction, infertility, and male cancers. According to the World Health Organization (2012), nearly 6 million disability-adjusted life years (DALYs) are lost to prostate cancers, and 1 million to infertility. However, too few health systems offer a full array of services to address these, and too few men globally are accessing these. As noted in previous priority areas, lack of treatment is related to a complex array of factors, including rigid gender norm prescriptions about what it means to be a man that reduce men’s likelihood of seeking advice and services; service environments that are not gender-sensitive; and structural-level factors like discriminatory policies or a lack of oversight.

Quality male-friendly care encompasses a range of accommodations that service environments can make to ensure that men and boys find the environment accessible, affordable, and patient-centered. Such accommodations ideally include men receiving

counseling and services in a room separate from women and children; service flow that moves men without overlapping from the waiting area to counseling to the procedure to recovery and to post-operative counseling; recovery space that accommodates more men than the clinical/operating space where the procedures are performed; providers dedicating adequate time for pre- and post-procedural counseling; services available to men in places and at times that are convenient for them, including evening and weekend clinics and mobile service delivery; and training on youth-friendly services for clinic staff that provide SRH services to adolescents (Health Communication Capacity Collaborative, 2017). Important to note, and more widely addressed, is the need for similarly comprehensive, integrated, gender-sensitive services specifically targeting women's SRH as well.

Providing male-friendly SRH care also means addressing less commonly discussed SRH issues such as sexual dysfunction<sup>5</sup> and infertility, which may be stigmatized due to rigid male gender norms that value sexual dominance. Self-reported and interview data from 27,500 men and women in 29 countries found that 28 percent of men aged 40 to 80 report having at least one sexual dysfunction (Nicolosi et al., 2004); notably, a study among much younger men aged 15 to 24 in France found only slightly lower rates (23 percent) of reported sexual dysfunction (Moreau, Kågesten, & Blum, 2016). Infertility<sup>6</sup> is less common: Globally, 1.9 percent of couples are in "primary infertility," or failing to achieve their first birth, and 10.5 percent are in "secondary infertility," or failing to achieve a second birth (Mascarenhas, Flaxman, Boerma, Vanderpoel, & Stevens, 2012). Of these, 20 to 70 percent of infertilities are related to male factors (Agarwal, Mulgund, Hamada, & Chyatte, 2015).<sup>7</sup> Infertility information, ideally provided from an early age, should address and counter any prevailing notions that infertility is only experienced by women to prevent stigma toward the woman when a couple tries and fails to become pregnant.

Poor sexual performance and an inability to have children run counter to normative ideas of what a "real" man should be in many contexts. As a result, if men holding these beliefs suspect they are infertile or experience sexual dysfunction, they may experience psychological distress and may not seek out the support of other male friends, preferring to speak only to their wives (Nachtigall, Becker, & Wozny, 1992; Miall, 1994; Jordan & Revenson, 1999). In some cases of infertility, the perceived threat to men's traditional masculinity can lead to intimate partner violence and ostracism of women as a means of re-establishing masculine hegemony (Mumtaz, Shahid, & Levay, 2013). Any intervention to comprehensively address men's specific SRH concerns must be informed by gender-transformative approaches to deconstruct rigid ideas of manhood, education around destigmatization, and mental health support.

5 "Sexual dysfunction" refers to the various ways in which an individual is unable to participate in a sexual relationship as they wish. Male sexual dysfunctions include excessive sexual drive, dyspareunia (pain during sexual intercourse), premature ejaculation, orgasmic dysfunction (delay or absence of orgasm), male erectile disorder, sexual aversion or lack of sexual enjoyment, and lack or loss of sexual desire (World Health Organization [WHO], 2016).

6 Infertility is defined as failure to achieve clinical pregnancy after 12 months or more of regular unprotected sexual intercourse (Zegers-Hochschild et al., 2009).

7 There is evidence of an overall decrease in sperm quality globally, with studies consistently showing marked decreases in sperm concentration, motility, and normal morphology. The etiology of these trends is unknown but may be related to environmental, nutritional, or socioeconomic factors (Kumar & Singh, 2015). Aging is also a significant factor for sperm decline, though the cause is not quite clear (Dodge, Sakkas, Hacker, Feuerstein, & Domar, 2017).

Ideally, men would be able to have these specific SRH concerns addressed as part of a comprehensive wellness check-up. While not applicable to every visit by every client at every facility, comprehensive wellness visits should consist of the following components: client history; physical exam; contraceptive counseling; STI and HIV and AIDS risks, testing, and management; disorders of the male reproductive system, including sexual dysfunction, male cancers, including family history and screening, fertility and infertility issues; supporting prenatal and postnatal care (if applicable); supporting safe abortion care (if applicable); and experience or perpetration of sexual and gender-based violence (IPPF & UNFPA, 2017). National health plans should incorporate routine wellness visits – tailored to both men’s and women’s specific needs – into the organization of health services and give special attention to addressing any gender or cultural biases through training among providers.

## **10. UNDERDEVELOPED CAPACITY AMONG MEN AS ADVOCATES AND CHANGE AGENTS FOR SRHR**

Patriarchal norms that promote male decision-making and invulnerability and limit women’s agency hinder both women’s and men’s abilities to access SRH. Given this, men are also uniquely positioned to challenge these inequitable norms for the betterment of themselves and women’s health and equality (Adams, Salazar, & Lundgren, 2013; Greene, Gay, Morgan, Benevides, & Fikree, 2014; Singh, Darroch, & Ashford, 2014). When rooted in women’s rights and gender justice approaches, male change agents can increase gender equity around SRHR issues and contribute to a broader social conversation on how learned norms impact both men’s and women’s abilities to access much-needed SRH services.

Some programs have tried to institutionalize this approach with local male activists. Interventions across three countries, mainly focused on family planning and HIV outcomes, show mixed results. The GREAT project, implemented in northern Uganda between 2012 and 2014, promoted gender-equitable attitudes and behaviors among adolescents aged 10 to 19 by identifying, training, and deploying male and female change agents already well-positioned in their communities to have critical conversations about the importance of gender equality with adolescents and the key individuals around them. Endline results demonstrated moderate but positive shifts in the key gender-equality measures (Institute for Reproductive Health, 2015). Similarly, the Malawi Male Motivator Program recruited, trained, and deployed 40 male champions currently using modern contraception with their partners. Over eight months, the champions visited 197 men an average of five times each, with each visit building on the last. Conversations revolved around the benefits of birth spacing and different contraceptive methods, equitable gender norms, and couple communication. Results indicated small increases in condom use between intervention and control but no increases in the use of pills or injectables; more significantly, the intervention made conversation easier between male and female partners over time and promoted more frequent discussions. Programs engaging men as change agents have also demonstrated impact on HIV programming. The One Man Can intervention in South Africa aimed to engage men to support gender equality and reduce the spread of HIV and violence against women through workshops, door-to-door awareness campaigns, street theater, soccer tournaments, mural painting and other methods.

The program had measurable short-term impacts on individual behavior: after one implementation, 27 percent of men who participated in the workshops subsequently accessed voluntary HIV counseling and 67 percent reported increased condom use (Sonke Gender Justice, 2009).

While these programs mostly focused on family planning and HIV outcomes, such efforts can be linked to supporting SRH issues more broadly, including those identified as priority areas in this brief. The successes of certain programs point to the importance of understanding explicitly how to develop and support cadres of male change agents to advance women's health and rights and gender equality. What are the messages and mechanisms that call in men to this important social transformation work? Methods include creating spaces for critical personal reflection and discussion, working with celebrities or leaders who model positive behaviors and challenge harmful norms, promoting mentorship between potential change agents and experienced activists, and organizing community celebration and recognition. Further, it is important to delineate the roles certain individuals can play as activists for women's rights and gender equality. For example, what are the specific actions male service providers, policymakers, or police can take? Using a socio-ecological approach and understanding how each institution works within society can provide avenues for effective targeted advocacy.

Important gaps remain in this area. Programs have so far been unable to provide persuasive evidence that engaging men as change agents leads to the uptake of more effective methods of contraception than male condoms. Moreover, few of these programs have been taken to scale. In addition, measurement challenges remain in delineating the impact of male engagement versus the service programs alone. Importantly, the motivation and retention of community agents on donor-funded projects has proven to be a challenge. On one hand, motivating champions with more than intrinsic rewards risks sustainability if funding support is lost. On the other hand, asking that people, particularly in poorer communities, volunteer their time for transformative activism – sometimes at risk to them – is difficult. Finally, it is important to avoid reinforcing unequal gender power dynamics by using a “men as champions” framework, which can reward men as “champions” or “heroes” for minimal levels of support for women's rights, thus perpetuating low standards and replicating men's dominance.

## DO NO HARM

Raising Voices, an NGO in Uganda that developed the community-based SASA! program created guidelines, excerpted below, for the ethical implementation of gender-transformative community mobilization programs, including through male change agents:

- **Real change is slow:** When efforts to engage communities in the process of social change are rushed, activities are skipped, or community outreach is not sustained. This can be disruptive to communities and potentially dangerous, due to potential backlash faced by community agents.
- **Center women:** When there is not sufficient training or oversight, this can allow male change agents to dominate, thereby replicating the same power dynamics between women and men that these programs seek to uproot and as a result may actually reinforce community stereotypes, leading to ineffective and dangerous implementation that puts women and community relationships at risk.
- **Foster strong relationships** between change agents and community members, including facilitating ongoing dialogue where grievances are addressed, and strengthening referrals to health services (Raising Voices, 2017).

## B) GLOBAL OPPORTUNITIES FOR THE SRHR COMMUNITY

1. **Shift the international paradigm to include stronger commitments on men and boys, SRHR, and gender equality:** Deepen the focus within current international commitments, goals, and indicators on men as family planning clients and partners to increase men's share of the contraceptive burden (including the Sustainable Development Goals, Family Planning 2020, Performance Monitoring and Accountability 2020, Track20, and United Nations strategies). Many international commitments do not mention or target men, or frame men exclusively as obstacles.
2. **Build the research base on men and SRHR:** Strengthen our understanding on men's SRH-related needs, motivations, barriers, and challenges within a gender power analysis, including exploring ways to broaden the Demographic and Health Survey and other global data collection efforts, and committing as researchers and practitioners to engage the voices of diverse groups of individuals of all genders in our work.
3. **Expand and scale up what works to engage men in SRHR:** Further invest in rigorous interventions to build the evidence base on effective gender-transformative approaches to engage men in SRHR, in particular addressing gender and SRHR norms – especially from an early age – and institutionalizing the many strategies that have been proven to be successful.

4. **Adopt national priorities on men and SRHR:** Include specific commitments to engaging men in SRHR within national and provincial policies, strategies, and guidelines (such as national reproductive health and HIV strategies), addressing the priority areas in this brief.
5. **Include gender equality in how we measure and define SRHR success:** Shift our outcomes of success beyond only family planning to focus on the gender-equality dividends of engaging men in SRHR, particularly the potential for improving couple communication and shared decision-making, preventing gender-based violence, and increasing men's participation in prenatal visits and involvement in caregiving and maternal, newborn, and child health (MNCH).
6. **Invest in men's contraceptive methods:** Given the limited shifts in male contraceptive use over the last 20 years, invest in increasing demand and availability of existing male and male-supported methods, and in the development of novel methods for men.
7. **Position SRHR within a broader men's health agenda:** Address the broader risk factors associated with rigid masculine norms impacting men's mental, physical, lifestyle, and occupational health. Given men's low levels of engagement with the health system, integrate family planning, MNCH, STIs, HIV, and men's broader well-being as appropriate.
8. **Engage men as advocates by encouraging them to stand up for women's SRHR every day:** Given the global backlash against SRHR, and the potential for men as SRHR advocates, encourage all men to speak out to advance this agenda, and find ways to ensure men who speak out also reflect these beliefs in their own behavior.



IV. CONCLUSION

## There is much work to be done to **improve SRHR worldwide**. Men must be part of the solution.

There is much work to be done to advance SRHR worldwide and to transform the harmful gender norms that negatively affect men's and women's health and well-being, influencing men's attitudes and behaviors in ways that directly impact the SRHR of their partners, their families, and themselves.

Moving forward, changing the paradigm that advancing SRHR is solely a women's issue through well-developed, gender-transformative interventions engaging men and boys – in ways that respect women's autonomy – is critical to improve SRHR for all. Despite evidence of the impact of such programs, interventions encouraging men to challenge inequitable norms are small-scale and short-term (Barker et al., 2007). Integration and scale-up are required to accelerate progress toward international SRHR commitments. Indeed, national policies and international commitments – including Family Planning 2020 – often don't cite gender-transformative male engagement as a strategy, reflecting the state of the field and the dominant paradigm, and highlighting a key opportunity for action.

The Sustainable Development Goals provide one highly visible mechanism in which the need to involve men and boys in SRHR work is inextricably linked to the broader global health and development agenda. Working with men and boys in advancing SRHR is a necessary component and strategy to achieve Sustainable Development Goal 3 to “ensure healthy lives and promote well-being for all at all ages.” It is also clear that holding true to a rights-focused, gender-transformative approach to involve men in SRHR and challenge harmful gender norms is essential to meeting Sustainable Development Goal 5's mandate to achieve gender equality. Such linkages provide opportunities for the SRHR community to advance awareness of the priority areas identified in this brief, and to shape policies, systems, research, and practices in the coming years. In highlighting guiding principles, key action areas, and opportunities for impact, this brief aims to provide a more nuanced framing, outline effective strategies, and facilitate the development of a cohesive approach to achieving goals around engaging men in the advancement of SRHR and gender equality. Building on the principles and priority areas of this *Getting to Equal* brief, Promundo is producing a complementary report, *Global Evidence and Action on Men, Gender Equality, and Sexual and Reproductive Health and Rights*, which takes a deeper dive into new data analysis and provides targeted recommendations for further advancement.

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