Engaging Men in Sexual and Reproductive Health

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Summary

Engaging men in sexual and reproductive health (SRH) across the life span is necessary for meeting men's own SRH needs, including: prevention of STIs, HIV, unintended pregnancy, and reproductive system cancers; prevention and management of infertility and male sexual dysfunction; and promotion of men's sexual health and broader well-being. Engaging men is also important given their relationship to others, particularly their partners and families, enabling men to: equitably support contraceptive use and family planning and to share responsibilities for healthy sexuality and reproduction; improve maternal, newborn, and child health; prevent mother-to-child transmission of HIV; and advocate for sexual and reproductive rights for all. Engaging men is also critical to achieving gender equality and challenging inequitable power dynamics and harmful gender norms that can undermine women's SRH outcomes, rights, and autonomy and that can discourage help- and health-seeking behaviors among men.

Evidence shows that engaging men in SRH can effectively improve health and equality outcomes, particularly for women and children. Approaches to involving men are most effective when they take a gender transformative approach, work at the personal, social, structural, and cultural levels, address specific life stages, and reflect a broad approach to sexuality, masculinities, and gender. While there has been growth in the field of men's engagement since 2010, it has primarily focused on men's role as supportive to their partners' SRH. There remains a gap in evidence and practice around better engaging men as SRH clients and service users in their own right, including providing high-quality and accessible male-friendly services. A greater focus is required within global and national policy, research, programs, and services to scale up, institutionalize, and standardize approaches to engaging men in SRH.

Keywords: adolescent male, adult male, sexual health, reproductive health, family planning, male engagement

Why Focus on Men and Sexual and Reproductive Health?

Sexual and reproductive health (SRH) has traditionally been perceived as solely a women's domain, and women have been the bearer of the greatest amount of responsibility for SRH and its outcomes. While women are disproportionately affected by the global burden of sexual and reproductive health and disease, particularly with respect to family planning and

maternity-related morbidity, unmet SRH needs also have a critical impact on men and boys of all identities worldwide. Sufficiently addressing the SRH rights of everyone, including men, is grounded in the constitution of the World Health Organization (WHO):

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
>
> (WHO, 2006)

Engaging men across the life span in SRH and care is important for several reasons. First, it is important to address men's own SRH and to highlight that SRH is equally important to men and boys. Specifically, for men, goals of SRH include, but are not limited to, preventing sexually transmitted infections (STIs), human immunodeficiency virus (HIV) infection, unintended pregnancy, and reproductive system cancers; promoting sexual health and development, healthy relationships and behaviors, reproductive life planning, and preconception care; and reducing problems with infertility and sexual performance—with the overall goal of increasing quality of life and access to care (Marcell et al., 2015). Second, sexual and reproductive healthcare offers a clinical opportunity for addressing men's other health needs, which is an area of growing focus, given that globally men die younger than women and are overrepresented in nearly every major burden-of-disease category (Ragonese et al., 2019). Third, engaging men in SRH allows men to share responsibilities for healthy sexuality, which is critical for healthy relationships, and to involve men as supportive partners in contraceptive use and family planning, parenting/fathering, and broader SRH outcomes for women and children (Starrs et al., 2018).

Fourth, engaging men in SRH is central to achieving gender equality. While men have often been absent from the focus on SRH, as a result of patriarchal structures, they can often dominate decision-making within relationships, such as around family size and their partner's choice and use of contraceptive methods. Moreover, inequitable power dynamics and harmful male gender norms and attitudes can shape men's behaviors in ways that undermine women's rights, exacerbate gender inequalities, and contribute to perpetuating poor SRH outcomes for women, men, and children (Hook et al., 2018). Inequitable attitudes among men have also been found to be associated with their greater rate of perpetration of intimate partner violence (Levtov et al., 2014). For men, male gender norms can discourage help- and health-seeking behaviors and promote risk-taking, sexual dominance, and an illusion of invulnerability that undermine their SRH. Therefore, successfully meeting the Sustainable Development Goals target for ensuring universal access to sexual and reproductive health and rights (SRHR) will not be possible without engaging men as full, equitable partners who are invested in their own health and are supportive of (and not decision-makers in) women's health and autonomy.

A growing body of evidence confirms that engaging men in SRH can effectively improve health and equality outcomes, in particular those that seek to work with men in gender-transformative ways as supportive partners in SRH (Barker et al., 2007; Greene & Levack, 2010; Interagency Gender Working Group [IGWG], 2006; Kraft et al., 2014). Since 2018, global public health institutions have begun to further engage in addressing this issue, as evidenced by WHO's men's health strategy for Europe, which includes a focus on SRH (WHO, 2018). Researchers, such as the 2018 Guttmacher-Lancet Commission on SRH (Starrs et al.,

2018), have called attention to the gap in work within the SRH field on engaging men and addressing harmful masculine norms. Despite these developments, overall approaches to engage men in SRH remain small-scale and short-term efforts that have not achieved sufficient scale in terms of reach or being institutionalized within public policy and practice or global frameworks. Importantly, there remains a critical gap in evidence and approaches that seek to engage men as stewards of their own SRH—moving beyond a primary focus on men's role as supportive to their partners' SRH—and this gap therefore forms the greater focus of this article.

History of Focus on Male Involvement in SRH

Focusing on men and boys within the context of SRH is not a new phenomenon. Since the mid-1990s, there has been increasing global recognition of the need to engage men in SRHR, particularly around contraceptive use and family planning. In 1994, the UN International Conference on Population and Development (ICPD) Programme of Action highlighted the importance of "male involvement" in SRH and is widely regarded as the seminal development for putting this issue on the map (United Nations, 1994). It was followed by other intergovernmental declarations on the topic, particularly the Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women (United Nations, 1995) and the report of the forty-eighth session of the Commission on the Status of Women (United Nations Commission on the Status of Women, 2004). Together, the declarations provided a clear mandate for work on men's SRH within a human rights framework. This led to the development of novel strategies and evidence for effective engagement of men and boys in advancing SRHR. These developments took place alongside an increasing recognition of reproductive rights (and, latterly, sexual rights) for women and girls, following the work of many activists and organizations that called for women to have greater agency over their bodies and choice over reproductive decisions. It was many of these feminist activists, including male profeminist allies, and women's rights organizations, particularly in the Global South, that called for greater male involvement in SRH.

Despite the international mandate for work on men's SRH, there was initially limited attention given to the issue, except for a focus on the involvement of men as partners for the SRH outcomes of women and children. While this approach is important, it has been criticized because it instrumentalizes the role of men and focuses on men's individual behaviors, rather than on structures and gendered power dynamics. An example of a criticized approach is engaging men solely to increase contraceptive acceptance among women within societies that are rigidly patriarchal without questioning the structures of power. The men-as-partners orientation nevertheless remains the primary focus of much of the efforts to date in this area (as noted in the section "Why Focus on Men and Sexual and Reproductive Health?"). Since 2010, programming efforts have more deliberately expanded the vision for constructive male engagement, reflecting the necessity of addressing men's own SRH as well, and engaging men as SRH advocates, although moderate progress has been made.

The focus on male engagement has often also been primarily a focus on heterosexual men. For men who have sex with men (MSM), policy instruments were broadly silent until the 2011 Political Declaration of Commitment on HIV/AIDS, which was the first to specifically mention MSM. While including MSM was an important step, attention to MSM remains limited in

scope, focusing only on the inclusion of MSM in national prevention strategies. Other entities, such as the Global Commission on HIV and the Law, show how repressive laws and high levels of stigma, discrimination, and marginalization create barriers to accessing SRH and HIV services. For example, same-sex sexual activity remains criminalized in many countries, and in some countries it is subject to the death penalty (Shand et al., 2017). In May 2019, the WHO decided to no longer classify transgender health issues as mental and behavioral disorders in its global manual of diagnoses, a step that will assist in reducing stigma and in increasing access to necessary health services for transgender individuals (WHO, 2019).

An important component of the evolution of work on engaging men in SRH has been the focus on conceptualizing work with men within gender-transformative approaches (Barker et al., 2007; Howse et al., 2010; Ruane-McAteer et al., 2019). This builds on the framework of the Interagency Gender Working Group (IGWG, 2017) which provides a continuum of programs, from programs that are "gender blind"—designed without any consideration of gender-related outcomes and factors—to those that are "gender aware"—programs that have deliberately examined and addressed gender-related issues—to "gender transformative"—programs that not only accommodate gender-related issues to, for example, increase men's and boy's access to care, but also provide males with opportunities to reflect on and challenge unequal power relationships and harmful gender norms. Programs for men that deliberately use gender-transformative approaches have been found to be most successful (as compared to gender-blind or gender-aware approaches) in changing men's health-related attitudes and behaviors (Barker et al., 2007). Despite this, gender-transformative approaches with men in SRH can be challenging to implement, and although they may positively shift men's health behaviors, they can have less impact on altering existing unequal power relationships (Stern et al., 2015). A systematic review in 2019 also found that many SRH interventions targeting men are insufficiently intentional in using a gender-transformative approach (Ruane-McAteer et al., 2019).

Guiding Principles for the Work

It is important that work to engage men in SRHR is grounded in key principles. Engaging men in SRHR has the potential to cause harm if not undertaken well and thoughtfully, and in particular should use a gender-transformative, rights-based, and client-centered approach. Adapting principles from International Planned Parenthood Federation (IPPF) and the United Nations Population Fund (UNFPA) (Shand et al., 2017), as well as Promundo (Hook et al., 2018), Table 1 highlights key principles that should inform and support approaches to engaging men in SRHR and that are crucial to the success of advancing SRHR for all.

Table 1. Guiding Principles for Engaging Men in Sexual and Reproductive Health and Rights (SRHR)

- Take a *human rights-based approach*, incorporating sexual and reproductive rights, and amplifying the voices of men who already advocate for SRHR.
- Uphold *women's rights and autonomy*, including women's right to choose if, and how, their partners are involved in their sexual and reproductive health (SRH) decisions and services.

- Use *gender-transformative approaches*, which provide opportunities for reflecting on, and challenging, rigid male gender norms and roles and inequitable power relations, including challenging men's violence against women. This approach should incorporate both the individual and broader social and structural contexts that shape gender inequalities.
- Take a *positive approach to men's engagement* that supports men to be more healthy, caring, and gender-equitable and that acknowledges the positive role they can, and already do, play in their own SRH and that of their families.
- *Take a broad approach to sexuality, masculinities, and gender*, recognizing and celebrating the diversity of sexualities and of masculinities, and that men and women together, or with members of the same sex, shape gender roles and relations.
- *Acknowledge men's own vulnerabilities*, including their specific needs, experiences, and challenges in relation to SRH, which are often not well understood nor taken into account within SRH policies and approaches.
- Promote *nondiscrimination and stigma-free services*, addressing differential access due to sexism, social exclusion, sexual orientation and gender identity, homophobia, racism, or any form of discriminatory behavior.
- Provide *high-quality, male-friendly, and client-centered services using accessible entry points* for men, boys, and couples, including a healthcare model that is not solely biomedical, that incorporates rights and gender equity, and that provides privacy and confidentiality, dignity, and respect.
- Use *an ecological framework (see Conceptual Framework Model section) and work toward an enabling policy environment* (going beyond only individual- and community-level change) as a necessary condition for meaningful advancement in SRHR.
- Take *a life-cycle approach* that recognizes that men's SRH needs and behaviors vary across age groups and life stages (see figure 2).
- Reflect *evidence and learning*, including being informed by, and building upon, research, policy, and evidence-based practice to maximize the impact of investments. Collect high-quality service-delivery data, undertake further research, use adaptive programming approaches, and promote a culture of shared learning.
- Adapt approaches to *local contexts and SRHR needs* among men, their partners, and families, and ensure the *meaningful involvement of communities* in designing responses to their needs.

Conceptual Framework Model

Approaches to engaging men in SRH are often underpinned by a multifaceted approach in which men are engaged at multiple levels to achieve SRH outcomes. Building on the framework of many organizations that are implementing work on engaging men in SRH (Greene & Levack, 2010; Shand et al., 2017) and on the socioecological model (Bronfenbrenner, 1986), we present a conceptual model for this work (figure 1) that sees work on men's roles in SRH as including the following four levels:

- Addressing males' gender role beliefs and norms and promoting cultural change that promotes gender-transformative approaches.
- With men as clients/users of SRH services, increasing their access to, and utilization of, SRH services in their own right.
- With men as partners/fathers, supporting the SRH of partners, children, and families and promoting SRHR.
- With men as SRH advocates/change agents, engaging in advocacy for SRHR, in challenging gender inequalities and harmful masculinities in communities and societies, and in acting as policy decision-makers.

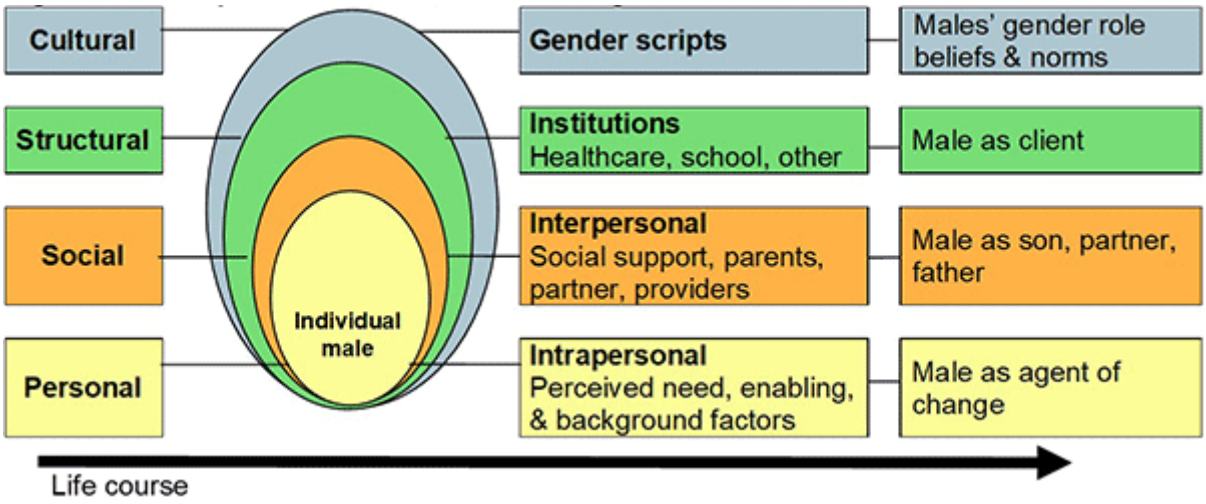

Figure 1. Conceptual framework: Socioecological levels for work on men's sexual and reproductive health (SRH).

At the center of the model is the individual man. The model recognizes that, while globally men face many similar SRH needs, the spread and types of SRH concerns are not even. Men's SRH needs are affected by a range of socioeconomic factors, including place of residence, age, marital status, race, sexuality, and economic status. Approaches to engage men in SRH must understand, and program for, those differences (Shand et al., 2017). Each of these components, while separately important, should not be implemented alone: all four are essential to ensure successful and gender-equitable SRH outcomes with men.

Men as SRH Clients/Users of SRH Services

Globally, SRH services and policies historically targeted women and children. While essential, these efforts have often excluded men across the life span, including male adolescents and young adults. Guidelines released from 2014 onward by the United States Office of Population Affairs (OPA) and Centers for Disease Control and Prevention (CDC)— *Guidance for Providing Quality Family Planning Services* (QFP)—and the International Planned Parenthood Federation (IPPF)—*Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys* —have begun to acknowledge the lack of standards for male SRH care and to inform the delivery of SRH care to men (Gavin et al., 2014; Marcell et al., 2015; Shand et al., 2017).

SRH Care Guidance

The QFP makes recommendations for core family planning and SRH services to deliver to reproduction-age persons, and, for the first time, delineates preventive SRH care services to deliver specifically to men. The QFP makes comprehensive recommendations that reproductive-age men receive family planning services (i.e., contraception and counseling; information on achieving pregnancy; basic infertility care; preconception healthcare; and STI diagnosis and treatment), family planning-related preventive services (e.g., genital examination to assess progress of healthy sexual development), and other preventive services (e.g., lipid screening), and that quality family planning delivery be monitored for women as well as for men (Table 2).

Table 2. Checklist of Family Planning and Related Preventive Health Services for Men

	Screening Components and Source of Recommendation	Family Planning Services (Provide Services in Accordance with the Appropriate Clinical Recommendation)				Related Preventive Health Services
		Contraceptive Services[a]	Basic Infertility Services	Preconception Health Services[b]	STI Services[c]	
History	Reproductive life plan[d]	Screen	Screen	Screen	Screen	
	Medical history[d,e]	Screen	Screen	Screen	Screen	
	Sexual health assessment[d,e]	Screen	Screen	Screen	Screen	
	Alcohol & other drug use[d,e,f]			Screen		
	Tobacco use[d,f]			Screen		
	Immunizations[d]			Screen	Screen for HPV & HBV[g]	
	Depression[d,f]			Screen		
Physical Exam	Height, weight, and BMI[d,f]			Screen		
	Blood pressure[d,e]			Screen[g]		
	Genital exam[e]		Screen (if clinically indicated)		Screen (if clinically indicated)	Screen[g]
Lab Testing	Chlamydia[d]				Screen[g]	
	Gonorrhea[d]				Screen[g]	
	Syphilis[d,f]				Screen[g]	

HIV/AIDS[d,f]		Screen[g]
Hepatitis C[d,f]		Screen[g]
Diabetes[d,f]	Screen[g]	

Abbreviations: AIDS, acquired immunodeficiency syndrome; BMI, body mass index; HBV, hepatitis B virus; HIV, human immunodeficiency virus; HPV, human papillomavirus; STI, sexually transmitted infection; QFP, *Guidance for Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*.

a No special evaluation needs to be done prior to making condoms available to males. However, when a male client requests advice on pregnancy prevention, he should be provided contraceptive services as described in the section "Provide Contraceptive Services" in the QFP.

b The services listed here represent a subset of recommended preconception health services for men that were recommended and for which there was a direct link to fertility or infant health outcomes (Frey et al., 2008).

c STI services also promote preconception health but are listed separately here to highlight their importance in the context of all types of family planning visits. The services listed in this column are for men without symptoms suggestive of an STI.

d CDC recommendation.

e U.S. Preventive Services Task Force recommendation.

f Professional medical association recommendation.

g Indicates that screening is suggested only for those persons at highest risk or for a specific subpopulation with high prevalence of infection or other condition.

Source: Gavin et al. (2014).

In the context of serving a global audience, the IPPF's global service package discusses how, in promoting health equity and reducing disparities in SRH morbidity and mortality, the care of males follows evidence-based guidelines and takes into consideration available resources. It outlines an essential SRH service clinical care package that includes the elements described in Table 3. To build an effective global workforce of highly skilled healthcare providers for males, however, SRH care cannot be the sole responsibility of certain specialties and needs to be incorporated into all levels of healthcare systems (Society for Adolescent Health and Medicine, 2018).

Table 3. Sexual and Reproductive Health (SRH) Clinical Services and Associated Components for Men and Adolescent Boys

SRH Clinical Services for Men and Adolescent Boys	Components[a]
1. Assessment Questions on Client History	a. Take a standard medical history b. Take a detailed sexual health assessment (including sexual function and satisfaction) c. Assess for fertility intentions d. Take a cancer evaluation (as appropriate) e. Assess for experience of sexual and gender-based violence, including intimate partner violence (initial assessment questions) f. Assess for alcohol, tobacco, and other substance use g. Assess for mental health, including depression h. Assess for nutrition, food availability, diet, and exercise i. Assess for immunizations/vaccinations
2. Physical Exam	a. Measure height and weight, and calculate body mass index (BMI) b. Measure blood pressure c. Conduct external genital and perianal exam d. Conduct other physical exam(s) relevant from history using clinical judgment
3. Contraception	a. Counsel client (if not undertaking couple counseling) and provide information on all available contraceptive options, his role in contraception, and how to be supportive and communicate with his partner in choosing the contraceptive option that works for them both b.

SRH Clinical Services for Men and Adolescent Boys	Components[a]
	Counsel the couple (if partner agrees) and provide information on all available methods of contraception, including promotion of dual protection c. Provide condoms and condom-compatible lubricant, as well as other contraceptive methods, including emergency contraception d. Provide vasectomy services (or referral)
4. Sexually Transmitted Infections (STIs)	a. Counsel client and provide information on STIs, including couple counseling (if partner agrees) b. Conduct external genital and perianal exam (as part of syndromic management) c. Provide etiological diagnosis of STIs (diagnostic testing; i.e., laboratory and microscopy) d. Treat STIs following syndromic management or etiological diagnosis e. Counsel client and provide support for partner notification about STIs and facilitated treatment (where applicable) f. Provide condoms and condom-compatible lubricant g. Provide HPV and hepatitis B vaccinations h. Provide viral hepatitis services, including prevention, screening, and treatment
5. HIV and AIDS	a. Provide HIV testing services (including information and counseling) b. Provide condoms and condom-compatible lubricant c. Provide antiretroviral treatment for HIV (or referral), including initiation, monitoring, and adherence support d. Provide preexposure prophylaxis (PrEP) for HIV e. Provide postexposure prophylaxis (PEP) for HIV f. Provide voluntary medical male circumcision (VMMC) g. Counsel client on how to support partner in preventing mother-to-child transmission of HIV (if partner wants) h. Diagnose, manage, and prevent HIV-related co-infections and comorbidities i. Provide care and support for men and adolescent boys living with HIV

SRH Clinical Services for Men and Adolescent Boys	Components[a]
6. Disorders of the Male Reproductive System, Including Sexual Dysfunction	a. Diagnose sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation), counsel client, and provide referral b. Treat (or refer) for sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation) c. Treat (or refer) for other disorders of the male reproductive system (warts, varicoceles, urological disease, etc.) d. Screen and treat for urinary tract infections (or refer)
7. Male Cancers	a. Counsel client on sexual and reproduction-related male cancers (prostate, testicular, penile, anal, breast) b. Take a history for sexual and reproduction-related male cancers c. Refer for further investigation and management as necessary
8. Fertility and Infertility	a. Counsel client on basic fertility awareness, including preconception health b. Counsel couples for conception (if the partner agrees) c. Counsel client on infertility d. Provide basic infertility care for men, including semen analysis e. Provide vasectomy reversal (recanalization) services (or refer) f. Treat for infertility/provide assisted reproduction (or refer) g. Counsel client (and partner) on adoption (or refer)
9. Prenatal and Postnatal Care, Including Safe Motherhood	a. Counsel client on preconception, support during pre- and postnatal period, and caregiving b. Provide links to a support group for expectant and new fathers/classes on parenting/fatherhood skills
10. Safe Abortion Care[b]	a. Counsel clients who are partners on the role they can play as a source of support in safe abortion care b. Support client to be a supportive partner and to participate in pre- and postabortion care counseling sessions (if the partner wants)

SRH Clinical Services for Men and Adolescent Boys	Components[a]
c. Sexual and Gender-Based Violence (SGBV) Support)	a. Screen for experience of SGBV, including intimate partner violence b. Counsel and support clients affected by violence and refer for clinical, psychosocial, and protection services c. Refer clients who have a history of perpetrating violence against women to a relevant program/support group
Information and Counseling[c]	a. Provide information and counsel client on sex, sexuality, and sexual health, including pleasure (for man and partner) b. Provide information and counsel client on self-confidence and self-esteem c. Provide information and counsel client on relationships and nonviolent communication and negotiation d. Provide information on comprehensive sexuality education (CSE), values, and gender equality, with specific focus on role of men, to reach both in and out of school youth e. Provide information on genital/anal health and hygiene f. Counsel client and provide information on stigma reduction, particularly in the context of HIV and other STIs

a Not all components need to be provided for each client. The components provided depend on the specific needs of each client.

b UNFPA does not promote abortion as a method of family planning. Rather, it accords the highest priority to voluntary family planning in order to prevent unintended pregnancies and to eliminate recourse to abortion. UNFPA helps governments strengthen their national health systems to deal effectively with complications of unsafe abortions, thereby saving women's lives. Some maternal deaths are due to unsafe abortion. Therefore, its impact on women's health, lives, and well-being should be addressed, as nations agreed in the International Conference on Population and Development Programme of Action (ICPD PoA). Postabortion care should be provided. Where abortion is legal, national health systems should make it safe and accessible.

c Specific information and counseling are also included in other sections. Within clinic settings, if the counseling is not directly provided by the healthcare provider, it can be provided by a member of the healthcare team.

Source: Shand et al. (2017).

In 2018, the Guttmacher–Lancet Commission on Sexual and Reproductive Health and Rights proposed a comprehensive and integrated definition of SRHR and recommended for the first time an essential package of SRHR services and information for all persons, not specifically for males, that should be universally available and that is consistent with, but broader than, the SRH targets of the 2030 Agenda for Sustainable Development (Starrs et al., 2018). Table 4 summarizes the recommended package components, which include the commonly recognized components of SRH (i.e., contraceptive services, maternal and newborn care, and prevention and treatment of HIV/AIDS), but also less commonly provided components: care for STIs other

than HIV; comprehensive sexuality education; safe abortion care; prevention, detection, and counseling for gender-based violence; prevention, detection, and treatment of infertility and cervical cancer; and counseling and care for sexual health and well-being. This article recognizes that many countries may not be prepared to provide the full spectrum of services but recommends that governments commit to achieving universal access to SRHR and to making continual and steady progress, regardless of where they are starting.

Table 4. Integrated Definition of Sexual and Reproductive Health and Rights (SRHR)

Sexual and reproductive health is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when, and whom to marry
- decide whether, when, and by what means to have a child or children, and how many children to have
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence

Essential sexual and reproductive health services must meet public health and human rights standards, including the “Availability, Accessibility, Acceptability, and Quality” framework of the right to health. The services should include:

- accurate information and counseling on sexual and reproductive health, including evidence-based, comprehensive sexuality education
- information, counseling, and care related to sexual function and satisfaction
- prevention, detection, and management of sexual and gender-based violence and coercion
- a choice of safe and effective contraceptive methods
- safe and effective antenatal, childbirth, and postnatal care
- safe and effective abortion services and care
- prevention, management, and treatment of infertility

- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections
- prevention, detection, and treatment of reproductive cancers

Source: Starrs et al. (2018).

Components of Male-Friendly SRH Care

Healthcare settings are often not set up to treat male patients (van den Berg et al., 2015), which can negatively affect men's perceptions of the quality of the SRH services they receive. Even where attention has been given to the service-delivery needs of men and boys, this is often done in a cursory manner that simply adds to existing services tailored to women, rather than sufficiently addressing gaps in SRH care for men (Hook et al., 2018). The Society of Adolescent Health and Medicine's 2018 Position Statement, "Advocating for Adolescent and Young Adult Male Sexual and Reproductive Health," states that increasing men's global access to supportive and comprehensive SRH care will require multilevel strategies and investments to explicitly incorporate men's health needs (Society for Adolescent Health and Medicine, 2018). Such approaches will need to include clinical, structural, educational, and policy changes required to address the specific preparations needed for healthcare and nonclinical service providers who work with men. The approaches need to ensure that necessary supports are in place for males to access and receive confidential, quality SRH care. This will also require service-delivery models and healthcare provider competencies that reflect male-friendly, nonjudgmental, developmentally appropriate approaches that are sensitive to males' needs, regardless of sexual orientation, gender identity, and culture; guidelines for establishing supportive, youth-friendly environments and care provision to improve access to, and utilization of, SRH care by males; and measures that aim to reduce persistent social and structural barriers, including, but not limited to, addressing stigma, strengthening social supports, disseminating information about available services, improving healthcare coverage, and addressing issues related to socioeconomics, education, experiences of racism, traditional masculinity beliefs, and geographical access barriers.

The Health Communication Capacity Collaborative (HC3) at Johns Hopkins University provides additional components for high-quality male-friendly SRH care for men, outlined in Table 5 (HC3, 2017).

Table 5. Characteristics of Positive Clinical Experience and Setting for Men

- Men receive counseling and service delivery in a separate clinical setting from women and children, including specific waiting area and room.
- Client flow for services moves men from the waiting area, to counseling, to the procedure, to recovery, and to postoperative counseling without overlapping.
- Recovery space that accommodates more men than the clinical/operating space where the procedures are performed.
- Providers dedicate adequate time for pre- and postprocedural counseling.
- Services are available to men in places and at times that are convenient for them, including evening and weekend clinics and mobile service delivery.

- Clinic staff who provide SRH services to adolescent men (e.g., STI testing/treatment) are trained in youth-friendly services.

Source: Health Communication Capacity Collaborative (HC3) (2017).

Male SRH Life-Cycle Approach

In providing quality male-friendly SRH services, it is important to recognize that men's SRH behaviors and needs vary across age groups and life stages, as do the factors influencing boys' and men's support for women's and partners' SRH. Programming should ensure that approaches with men are age-appropriate and provide targeted entry points for each stage of the life course, including opportunities for men's active engagement in comprehensive SRHR for all, as suggested by general life-course theory (Elder et al., 2003). At the time of publication, a male life-cycle approach for SRH broadly (rather than solely male reproductive health) does not exist. Building on a male life-cycle approach developed by the first author (Shand, 2017), and further refined by Shattuck (2018), the authors provide a life-course approach (figure 2) to guide programming on for engaging men in comprehensive SRH throughout their lives (Shattuck, 2018). The approach considers males in the following stages:

- Early adolescents (10–14 years old)
- Older adolescents (15–21 years old)
- Single adults (who may have casual sexual partners or only male partners)
- Newly married/cohabiting men and couples (of all sexual orientations) with no children
- Pregnancy and postpartum for men and couples (of all sexual orientations) with children
- Parenting stage for couples with children
- Older stage for men and couples who no longer desire to have children and in older age

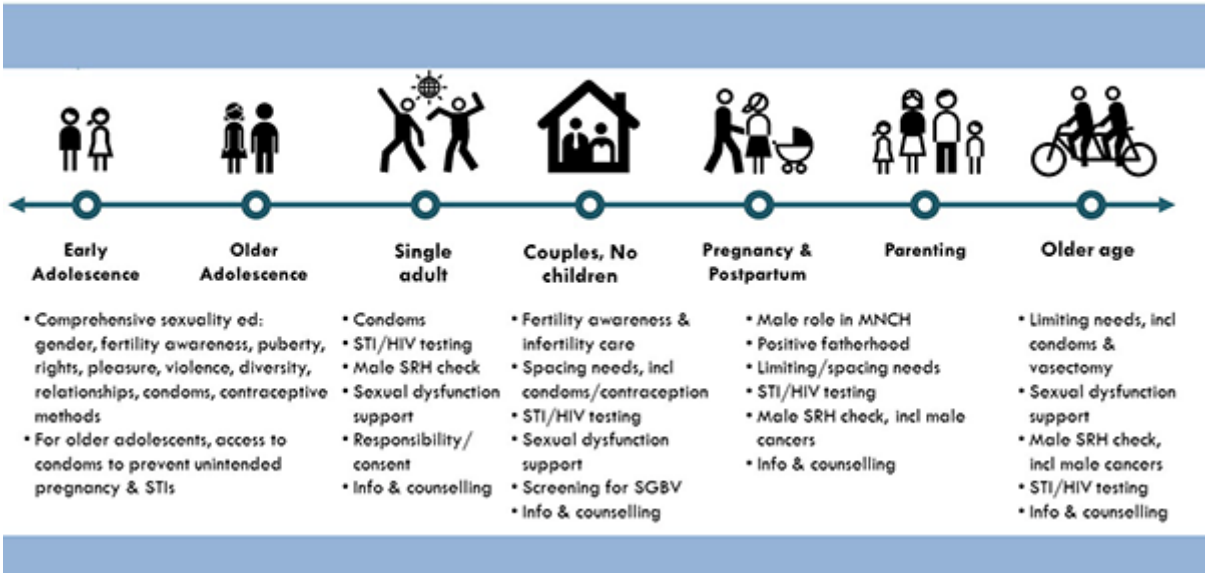

Figure 2. Areas of intervention along the male sexual and reproductive health (SRH) life course.

Engaging Men as Clients

Studies that examine engaging men as clients have received little attention or mixed results and have been mainly conducted in the United States. Strategies that have been shown to be successful in engaging young men in care have focused on family planning services through established female patients (Fine et al., 2017; Raine et al., 2003). Other successful approaches have focused on increasing STI or HIV screening practices through direct education via standard curriculum-based approaches (Marcell et al., 2013; Philliber et al., 2002; Vandevanter et al., 2005), approaches that are peer-led (Boyer et al., 2007; Johnson et al., 2010) or media-based (Dowshen et al., 2015; Friedman et al., 2014; McFarlane et al., 2015), or approaches that engage youth-serving professionals (Dittus et al., 2014, 2018; Loosier et al., 2016; Perin et al., 2019). However, non-sex-specific strategies (Philliber et al., 2002; Vandevanter et al., 2005) have not always been as successful in engaging males as much as they engage females, in contrast to strategies that specifically target males (Johnson et al., 2010; Marcell et al., 2013; Perin et al., 2019). It is possible that non-sex-specific strategies do not necessarily take into account ways in which young men are lacking in their socialization around healthcare and do not provide clear messages to males about the importance of SRH care promotion.

In the global setting, men have very limited occasions to enter the clinical system, unlike women, who experience maternity care and other related gynecological care or accompany infants and children on occasions that might also result in increases in mothers' connection to care. Given this, as an example, men in Malawi have been found to perceive the formal health system as unable to address their SRH needs, particularly around their sexual concerns, including physiological challenges (Shand, 2021). Culturally sensitive approaches, including those that understand the role of traditional medicine, have shown success in India in enhancing clinically based care to better reach men and to improve their uptake of sexual health and dysfunction services (Schensul et al., 2004, 2006). One specific procedure where men are the sole targets as clients, especially in sub-Saharan Africa, is voluntary medical male circumcision (VMMC). Male circumcision has been shown scientifically to be partially (at least 60%) effective at preventing HIV acquisition in males who are exposed through heterosexual (vaginal) intercourse with female partners. Since 2007, sub-Saharan African countries with the highest prevalence of HIV have been mobilizing resources to make VMMC available. While initially demand generation targeted adult men, demand has been highest among boys under age 18. However, a 2016 systematic review of the literature revealed a general absence of health services addressing the specific needs of male adolescents, resulting in knowledge gaps that could diminish the benefits of VMMC programming for this population (Kaufman et al., 2016). No standard promotion of an SRH service package exists outside of the minimum VMMC services package that is promoted by the WHO. However, quality of care may be lacking even within the context of the minimum VMMC service package. One study that examined whether the WHO-defined minimum package of VMMC services was received among male adolescents, including HIV testing, HIV prevention counseling, screening/treatment for STIs, condom promotion, and the VMMC procedure, found that although counseling included VMMC benefits, little attention was paid to risks, including how to identify complications, what to do if they arise, and why avoiding sex and masturbation could prevent complications, especially among young adolescents age 10 to 14 (Kaufman et al., 2018). Another study that explored the approaches used during adolescent VMMC counseling and whether these strategies maximize broader HIV prevention opportunities found that HIV

prevention and care messages were inconsistent and sometimes totally absent from VMMC counseling sessions (Kaufman et al., 2017). A further study that assessed the perceptions of VMMC facility managers and providers about training content and their perspectives on age-appropriate adolescent counseling found that lack of training for working with adolescents influenced the type of information that was communicated (Tobian et al., 2018). Specifically, providers expressed hesitation in communicating complete sexual health information—including HIV testing, HIV prevention, proper condom usage, the importance of knowing a partner's HIV status, and abstinence from sex or masturbation during wound healing—with younger males (age < 15 years) and/or those assumed to be sexually inexperienced (Tobian et al., 2018). Finally, to our knowledge, no standardized approaches have been developed to use VMMC as a platform to address unhealthy male gender norms, including those that discourage men's health-seeking behavior, despite the opportunity that VMMC can provide to take such a gender-transformative approach.

Men and HIV

Beyond VMMC, research has asserted that there is a "blind spot" when it comes to HIV service responses to men (Shand et al., 2014): men are less likely than women to be tested for HIV or to initiate and adhere to HIV treatment (Cornell et al., 2011). Men's reluctance to access testing and treatment leads to poor health outcomes: upon initiating antiretroviral therapy (ART), they have higher CD4 counts and more complications than women, and they are more likely to die while on ART (Naidoo et al., 2017). Globally, men accounted for 58% of the estimated 1.0 million AIDS-related deaths in 2016 (Druyts et al., 2013), often as a result of seeking help only when they are very ill. When men do not know their HIV status, they are more likely to engage in risky sexual behaviors (Lynch et al., 2010). Intersecting forms of discrimination based on race, class, sexuality, gender identity, and disability further impede men's access to HIV services (Dworkin et al., 2011; Peacock et al., 2009), despite the fact that MSM, for example, are 24 times more likely to have HIV than the general population (UNAIDS, 2017). A further innovation in HIV prevention, preexposure prophylaxis (PrEP), is highly effective at reducing HIV infections among people at high risk of HIV infection when taken regularly, and it has been a successful prevention technology among gay men and other MSM. However, the global scale of PrEP remains limited (UNAIDS, 2017), and studies in certain countries find that additional information and support are required to boost PrEP uptake and adherence among men (Garnett et al., 2017; Liu et al., 2017; Rolle et al., 2017). Given this context, UNAIDS produced a report in 2017 specifically focused on reaching out to men and boys to address the blind spot in the response to HIV (UNAIDS, 2017).

Men and STIs

The global prevalence of four curable STIs—chlamydia, gonorrhea, trichomoniasis, and syphilis—remains unacceptably high in adult men, as well as women, with around one million new cases acquired each day (Newman et al., 2015). Male gender norms around risk-taking can lead some men and boys not to use condoms, and therefore to contract an STI and to be less likely to access STI care, treatment, and support (Peacock et al., 2009). A lack of sensitization among some providers, limited confidentiality, insufficiently targeted materials, and STI services not being integrated into standard protocols for male wellness checks can create additional barriers to men's diagnosis and treatment. As with HIV, specific vulnerable

groups of men, such as MSM, migrants, sex workers, those identifying as nonbinary, and members of transgender communities, may face particular stigma and discrimination in seeking STI care (Collumbien et al., 2008; Hook et al., 2018).

Men and Infertility

Infertility estimates among men have been conducted mainly in developed countries. For example, one household-based study in the United Kingdom found that approximately 10% of men had tried to get their partner pregnant for 12 months or longer but did not (Datta et al., 2016). However, only half of these men had ever sought infertility services, with far fewer young adult men seeking care (Datta et al., 2016). A 2018 systematic review found that, despite reproduction-age male and female adults desire for children, the majority lacked information about infertility risk factors and had low-to-moderate fertility awareness, with greater awareness seen among women, more educated persons, people reporting difficulty conceiving, and those who planned their pregnancies (Pedro et al., 2018). Qualitative research with men in Malawi has found that cultural norms around the importance of male fertility render male infertility shameful and emasculating, and that men use traditional health services for infertility concerns due to limited fertility services in the formal health system (Shand, 2021).

Men as Contraceptive Users

The disproportionate SRH burden on women is often clearly encapsulated by the focus on research into, and service provision for, contraception. At the level of research, national demographic health surveys (DHS), which typically cover the 15- to 59-year-old age range, ask women much more comprehensive and specific information about contraceptive use than men. While DHS include male surveys, the continued growth of which is to be encouraged, the male surveys contain fewer questions on contraception (than the female surveys), typically only ask men about ever-use of male methods (not all methods) if at all, and, within the surveys' sexual activity section, ask about men's current contraceptive use only in the context of which method was used during last sex. By contrast, questions in DHS female surveys on current, and ever-use, of contraception cover all methods and are within the family planning section of the survey. As a result, broader national assertions on unmet need and ever-use can only be made from DHS female data sets. Similarly, the largest collection of cross-country data on contraceptive prevalence, the UN Population's World Contraceptive Use database (UNDESA, 2019), provides up-to-date family indicators solely for women of reproductive age. While comparable data are limited, shared responsibilities for SRH can be explored through examining contraceptive prevalence and method choice. An analysis of UN Population Division data and DHS series data by Ross and Hardee (2017), outlined in figure 3, found that, globally, the prevalence of male methods (vasectomy, male condom, withdrawal, and rhythm) was 15.7% among married/in-union women in 2015. Men's contraceptive use, therefore, represents just one quarter of all contraceptive use worldwide. In the 48 least developed countries of the world, where unmet need for contraception is often highest, Ross and Hardee found the percentage be to even smaller, 6.8%, with male methods representing a very small part of overall contraceptive use.

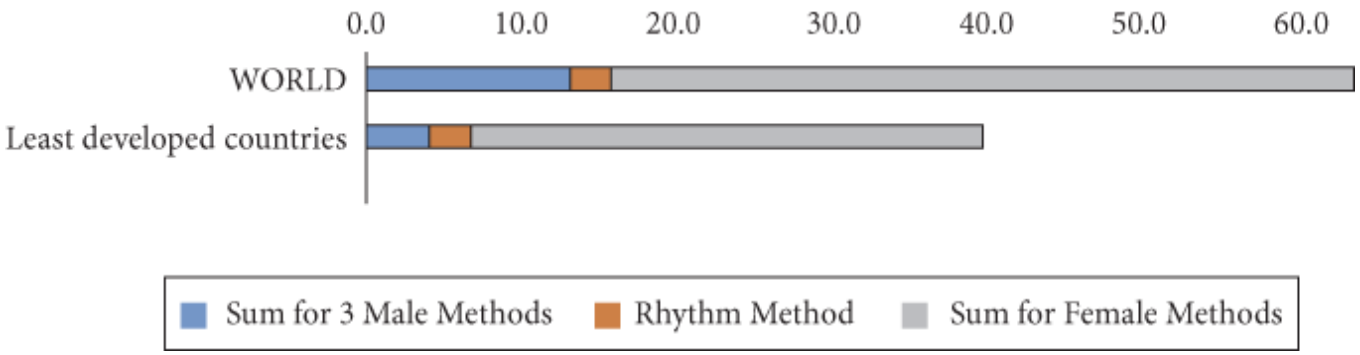

Figure 3. Prevalence of male versus female contraceptive methods. Note that the rhythm method is separated from the other three male methods in order to reflect its more collaborative character (versus vasectomy, male condom, withdrawal).

Source: Ross and Hardee (2017). Green Open Access License.

An analysis of shifts over time is also instructive, demonstrating the extent to which women's method use, particularly within relationships, dominates. While overall modern contraceptive use doubled between 1970 and 2015, men's use of contraception has remained relatively constant. Looking at the 21 years following the aforementioned 1994 ICPD conference, Ross and Hardee found total use of male methods rose by only 2.9 points (from 10.7% to 13.6%) within 106 developing countries, as shown in figure 4. Much of the increase was reflected in the increased use of male condoms during the period—a trend widely associated with extramarital sex, particularly in context of HIV and STIs (Ankomah et al., 2013)—while use of the rhythm and withdrawal methods remained steady, and rates of vasectomy (the only permanent contraceptive method for men) fell during this period. This highlights that there has been insufficient attention to reaching men as contraceptive users in their own right, a factor compounded by the fact that there has been no expansion of the contraceptive methods available for men since the 1960s, as explored below.

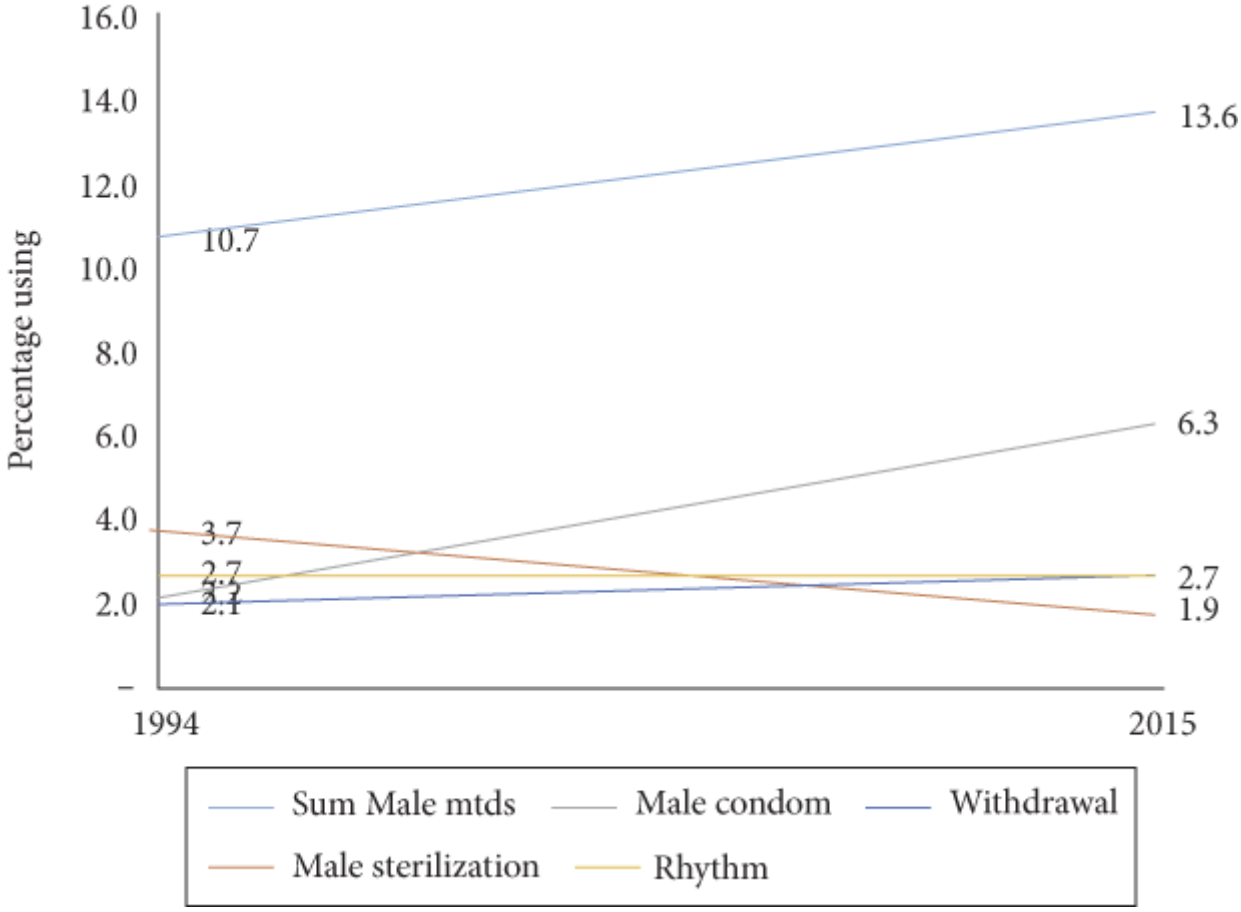

Figure 4. Prevalence of male contraceptive methods from 1994 to 2015.

Source: Ross and Hardee (2017). Green Open Access License.

Despite the fact that vasectomy has many advantages over female sterilization, including being a highly effective, relatively inexpensive, and low-risk procedure (Shih et al., 2011), limited awareness among providers and clients, and persistent myths related to its side effects, such as fears of poor sexual performance, significantly affect vasectomy demand (Shattuck et al., 2016). Despite the potential of withdrawal as an effective and appropriate method in certain situations (Jones et al., 2009), very little research has been done on this method among men and their partners (Hardee et al., 2017). Research also shows that socioeconomic status (Kabagenyi et al., 2014), religious and cultural beliefs (Perry et al., 2016), and gender norms (Hardee et al., 2017) can directly impact men's contraceptive use. Despite the dual protection benefits offered by the male condom, it is often not seen as an appropriate contraceptive method within an established partnership (Ntata et al., 2013), thus further reinforcing the responsibility of women to prevent unintended pregnancy.

In addition to increasing uptake of existing male contraceptive methods, it is also necessary to expand the current limited range of methods for men beyond condoms, withdrawal, and vasectomy; such an expansion could have a significant impact on pregnancy prevention (Dorman & Bishai, 2012) as well as bring men into contact with other essential health services (Hook et al., 2018). The 2018 Guttmacher-Lancet Commission on SRH (Starrs et al., 2018) highlighted the need to increase the range of male methods. In particular, there is a gap in the provision of a reversible method for men that falls between a short-acting and a permanent method (Hardee et al., 2017), for which studies in the 21st century have confirmed that there

is demand (Glasier et al., 2000; Kabagenyi et al., 2014). While research and development of novel male methods continue, such as work on the male pill, greater global investment and prioritization are required to successfully bring new male methods to market.

Male Sexual Dysfunction Concerns

Sexual dysfunction refers to the various ways in which an individual is unable to participate in a sexual relationship as they would wish. Male sexual dysfunctions include excessive sexual drive, male dyspareunia (pain during ejaculation), premature ejaculation, orgasmic dysfunction (delay or absence of orgasm), male erectile disorder, sexual aversion or lack of sexual enjoyment, and lack of, or loss of, sexual desire (WHO, 2016). Health systems often do not offer specific services for men around sexual dysfunction, which are often less commonly discussed and are stigmatized. This is despite the fact that research across 29 countries found that 28% of men 40 to 80 years old reported having at least one sexual dysfunction (Nicolosi et al., 2004). Poor sexual performance can run counter to normative and cultural ideas of what a “real” man should be (Hook et al., 2018; Shand, 2021) and has been linked to psychological distress among men (Nachtigall et al., 1992). Community-based studies have also demonstrated that there are culture-specific explanations for various sexual health issues in men and for men’s related treatment-seeking, particularly around sexual problems and dysfunction. The studies’ findings suggest that interventions to engage men should be culturally tailored (Verma et al., 2001, 2003).

Men as SRH Partners

As noted, in relation to SRH, men often play the contradictory roles of being both key decision-makers regarding women’s health while remaining detached from SRH issues (Kabagenyi et al., 2014). Therefore, engaging men as partners in contraceptive use, in safe abortion access, in maternal, newborn, and child health, and in prevention of mother-to-child transmission of HIV is critical for advancing SRH outcomes for women and families.

Men as Supportive Partners in Contraception and Family Planning

Past work shows that women whose partners disapprove of modern contraception methods are unlikely to use them (Ezeanolue et al., 2015). Significant barriers also remain due to couples’ difficulties in communicating about contraception, which further impact on use. Approaches that engage men as SRH partners have successfully improved the environment for, and the use of, female contraceptive methods. For example, increasing men’s knowledge of the fertility cycle and reproductive systems can improve men’s support for their partners’ contraceptive use (Croce-Galis et al., 2014). Couples’ communication can be addressed by improving men’s and women’s ability to have effective conversations about their family-planning expectations (Lasee & Becker, 1997; Shattuck et al., 2011). Gender-transformative interventions that work with husbands (Shattuck et al., 2011) and fathers (Doyle et al., 2018) at the household level can improve couples’ communication and increase contraceptive use within relationships. The interventions use a male-to-male education approach, which has the benefit of normalizing male discussion and competence in what is traditionally a woman’s domain (Shattuck et al., 2011). They also have the advantage of promoting greater gender

equity and improving shared decision-making around SRH (Greene & Levack, 2010). Other promising approaches to engaging male partners have included male-only educational talks, male-targeted behavior change campaigns and communication activities, and the integration of family planning content into nonhealth activities, such as agriculture and sanitation projects (Lundgren et al., 2012). In general, interventions that have been found to be effective not only have targeted individuals and couples but also have taken a wider socioecological approach that has aimed to understand and target different levels of influence, including family, community, social norms, and structures (Barker et al., 2007). Overall, the rigor of the evaluations of engaging men as partners in contraception and family planning varies, and few of the effective approaches have been taken to scale.

Men's Support for Women's Access to Safe Abortion

Multicountry research, using the International Men and Gender Equality Survey (IMAGES), has found that, among women who had ever terminated a pregnancy, male partners in all countries (except one) were significantly involved in the decision to seek an abortion (Barker et al., 2011). Available evidence also suggests that women's desire to avoid disclosing pregnancy to men out of fear of their reaction and the implications, as well as men's own views on accessing abortion services, influenced whether some women sought safe or unsafe abortion services and the urgency of them doing so, if at all (Hook et al., 2018). Men can play a positive role in women's access to safe abortion services, by supporting access to information and by providing economic resources (Freeman et al., 2019), and evidence also shows that men's support during postabortion care can facilitate a more rapid physical and emotional recovery for women (Abdel-Tawab et al., 1999). A study of men's engagement in premarital abortion in India found that men played an instrumental role, significantly aiding women's access to safe and quality abortion care, by accompanying their partners to the clinic and by supporting women in secretly navigating the related challenges due to the social stigma of unwed pregnancy (Kedia et al., 2018). In general, the evidence base in this area is extremely limited, and few programmatic approaches have sought to engage men to increase women's safe abortion access (Coyle & Rue, 2009). Overall, men's involvement in abortion decision-making remains too often negative, and it is therefore critical to ensure that where men are involved, it is in a manner that is respectful and supportive of women's decisions about their bodies (Barker & Sippel, 2017), and that, given men often control decisions about the institutions and laws that govern abortion access and quality, men are encouraged to advocate in support of greater access for women to safe and legal abortion services (Hook et al., 2018).

Men as Supportive and Equal Partners in Maternal, Newborn, and Child Health (MNCH)

Research has found that engaging men as supportive partners in MNCH can positively affect the health outcomes of women, newborns, and children (Doyle et al., 2018) and challenge the perception that pregnancy and childrearing are the woman's domain. The involvement of fathers pre- and postpartum can increase women's use of maternal health services, positively influencing their behaviors and providing emotional support (Levtov et al., 2015). It can further provide an opportunity for men and women to discuss contraceptive use and family

planning, support shared decision-making (Shand, 2018), and provide a meaningful shared experience for couples. Men's engagement in MNCH, when undertaken using gender-transformative approaches, can also advance gender equality, including increasing men's participation in domestic work and taking their wives to doctor appointments (Hook et al., 2018), improving couple communication, increasing the value of girls, and reducing intimate partner violence (Doyle et al., 2018). Men's involvement in antenatal care visits can also provide an important entry point to broaden men's own engagement with the health system, to provide education to men regarding health behaviors, and to screen and treat for male-specific health problems (Hook et al., 2018). As a result, city governments, such as some municipalities in Brazil, have incorporated criteria for recognizing facilities as "father-friendly" (Stern et al., 2015), and the evidence base on positive impact of men's engagement in MNCH continues to grow (Hook et al., 2018). Despite this, too few MNCH programs have sought to specifically target men. In most parts of the world, men are still unlikely to attend the birth of their children (Levtov et al., 2015), with culturally constructed gendered roles for men in many contexts remaining a significant barrier to their doing so and to being engaged in broader MNCH programs (Levtov et al., 2015). In addition, the health system, including the attitudes, actions, and limited skills of healthcare providers, can provide significant barriers to male involvement in MNCH (Aguayo et al., 2012).

Men's Support for the Prevention of Mother-to-Child Transmission of HIV (PMTCT)

Men can also play a critical role in successful PMTCT programs, with fathers' involvement in such approaches being found to decrease the risks of infant HIV infection and of infant mortality (Aluisio et al., 2011). Where an expectant father is tested for HIV and counseled on PMTCT, an HIV-positive mother is more likely to return for follow-up, successfully take ART, and adhere to breastfeeding recommendations, which are important to prevent perinatal HIV (Farquhar et al., 2004). Engaging men in PMTCT also provides an entry point for working with men to challenge inequitable gender norms and to increase their own uptake of HIV testing and treatment, addressing the aforementioned challenges. Despite this, there is a significant gap in engaging men in PMTCT within programming, as reflected by WHO's specifically commissioned report on the topic (WHO, 2012).

Men as SRH Advocates/Change Agents

Given that men are often in positions of power that limit women's and their own access to SRH, men are uniquely positioned to challenge such inequalities, for the betterment of themselves, women's health, and equality (Hook et al., 2018). At the community level, only a limited number of programs have sought to engage men as local advocates or agents of change to increase gender equity around SRHR and to highlight the impact of rigid gender norms, and those approaches that have sought to do so have shown mixed results. For example, the GREAT project in northern Uganda (Institute for Reproductive Health, 2016), which worked with trained male agents of change to promote gender-equitable attitudes and behaviors as well as SRH, found moderate but positive shifts in key gender-equality measures. The Malawi Male Motivator Program (Shattuck et al., 2011) worked with male contraceptive champions to reach other men to promote the benefits of birth spacing and different

contraceptive methods, equitable gender norms, and couple communication, resulting in increased condom use and facilitation of contraceptive conversations between target men and their partners. Programs engaging men as change agents have also demonstrated impact on HIV programming. The One Man Can intervention in South Africa used male and female change agents to engage men to support gender equality and to reduce the spread of HIV and violence against women through group education, awareness campaigns, and community mobilization; the results included increased HIV testing and condom use among one cohort of those targeted (Colvin & Peacock, 2009). These approaches also worked with key male influencers—such as religious and cultural leaders—who can then share messages with their communities in contextually relevant ways and challenge significant barriers to SRH. To date, the programs have been unable to provide rigorous evidence that engaging men as advocates leads to longer-term outcomes and changes in SRH behaviors beyond condom use, and the approaches have not been taken to scale. Indeed, a Young Men as Equal Partners approach, which worked with men as clients, parents, and change agents in Tanzania, had a significant effect at the client and partner level, but limited effect on men's impact on other men (Stern et al., 2015). This program also highlighted potential unintended consequences of rewarding men as "champions" for a minimal level of support for women's rights, while inadvertently reinforcing unequal gender power dynamics between men and women (Stern et al., 2015). Finally, few, if any, approaches address the context of men working in positions of power, such as governments or institutions, an area that is particularly critical given global backlash against women's reproductive rights and autonomy in the 21st century.

Conclusion and Future Considerations

Significant opportunities exist to strengthen the engagement of men in SRH, which would benefit men themselves, their partners, families, and societies. Insufficient funding, reluctance among some donors and health and women's rights activists, and the view that investing in men's SRH needs diverts funding from women's needs have contributed to the limited scale up of approaches or successful pilots (Starrs et al., 2018). Equally, approaches to engaging men in SRH have received valuable criticisms, such as future programming needs to more explicitly promote gender-transformative approaches and to use more robust experimental designs and measures as well as qualitative research (Ruane-McAteer et al., 2019). Feminists and scholars have questioned the extent to which promising approaches with men in SRH ultimately challenge men's overall position of power in society and relationships and promote women's autonomy (Rasmussen, 2008). Interventions to engage men that address only individual attitudes and do not address norms and power dynamics, or that are poorly implemented, can have unintended consequences, such as reinforcing gender stereotypes and decision-making structures that preference men (Shand, 2021). Finally, clinical structurally based and healthcare system-based approaches that aim to improve male SRH care delivery are limited (Marcell et al., 2018). Strengthening men's future engagement in SRHR requires a number of considerations, which can be separated into programs, services, research, and policy.

For programs and interventions, a greater focus is needed on approaches that engage men as clients of services, including those that increase men's uptake of contraception (including and beyond condoms) and their uptake of HIV and STI services, and that take a life-cycle approach in doing so. In addition, more attention should be given to inequitable gender norms that limit

men’s participation in contraceptive use and SRH; this can be done by using approaches that are gender-transformative and address power imbalances and that engage men as change agents in support of women’s SRHR. Particular attention is also required to expanding and tailoring existing programs to include men who are not well reached, such as MSM, adolescents, minority groups, and immigrants.

For services, greater attention should be paid to the physical design of health facilities and materials, which can discourage men from accessing the services, and counseling and service provision should be strengthened around vasectomy, HIV/STI and family planning linkages, infertility, sexual dysfunction, and male reproductive system cancers, as well as for the provision of comprehensive male wellness check-ups. In addition, service-delivery data should be disaggregated by gender and SRH services. Training initiatives are required for service providers to better address men’s SRH needs and to raise awareness about the positive role men can play as partners in SRH (such as in MNCH).

For research, a greater focus is required on how to strengthen men’s uptake of existing SRH services, including contraceptive services, and how such approaches provide an entry point to addressing men’s broader health needs. More research with couples would be advantageous, including ways to sustain condom use after long-term coupling. Greater research into, and development of, novel male contraceptives remains an important priority, along with understanding barriers to acceptance of new male methods among men and women. While men’s involvement as supportive partners in SRH has the strongest evidence base, a deeper understand is needed of the impact of men as partners on men’s and women’s SRH outcomes (in addition to the impact on gender norms) and of appropriate opportunities for male involvement in abortion decision-making and services. Finally, the evidence base around how to develop and support male change agents and advocates to advance sexual rights and gender equality remains inadequate.

At the policy level, few local and national policies have rigorous and financed commitments to increasing men’s uptake of SRH services, including promoting men’s greater use of male contraceptive methods. Policymakers at all levels often have biases in relation to engaging men, and these are important to address. Given the opportunity that MNCH provides, policies should uphold women’s right to have their male partner present during delivery (should a woman want that). And policies should ensure that health plans and approaches at all levels address men’s SRH needs comprehensively, including infertility and sexual dysfunctions, and provide sufficient training to providers. At the international level, broader global commitments by the UN and WHO to engaging men in SRH would be beneficial to encouraging greater action on this agenda among multilateral agencies, governments, donors, researchers, and practitioners.

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