



BUILDING MALE INVOLVEMENT IN SRHR:

A basic model for Male Involvement in Sexual and Reproductive Health and Rights



Sonke Gender Justice Network

HIV/AIDS, Gender Equality, Human Rights

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Table of Contents

1. Why male involvement in SRHR?	5
2. Introduction to the model on male involvement	6
2. I. Who can use this model? For what purpose?	6
2. II. What does this model include?	6
2. III. Adapting the model for local context	6
3. Designing a Programme for Male Involvement in SRHR	8
3. I. Model for male involvement: men as equal partners, clients and agents of change	8
3. II. How is this model useful?	9
3. III. Illustration: Model for male involvement in SRHR	10
3. IV. Men as equal partners, clients, and agents of change: expanded	11
3. V. Clients of SRH services: How preventive is men's service use?	12
3. VI. Operationalizing the model: questions to ask and priority actions	17
4. Ingredients list	20
4. I. Activities	20
4. II. Actors	24
4. III. Skills	24
4. IV. Relationships in the community	24
4. V. Equipment	24
5. Programming guidelines	25
6. Monitoring and Evaluation	26
7. Documentation	27
7. I. Peer Educators who work in the field should...	27
7. II. Collecting stories of change from men and women	27
8. Involving men in SRH: improving the health and well-being of women	29
9. Conclusion	29
Appendix One: Definition of terms	30
Appendix Two: Additional Resources	31

About Sonke Gender Justice Network:

Sonke Gender Justice Network (Sonke) is a non-partisan, non-profit organization, established in 2006. Today, Sonke has a growing presence on the African continent and plays an active role internationally. Sonke works to create the change necessary for men, women, young people and children to enjoy equitable, healthy and happy relationships that contribute to the development of just and democratic societies. Sonke pursues this goal across Southern Africa by using a human rights framework to build the capacity of government, civil society organizations and citizens to achieve gender equality, prevent gender-based violence and reduce the spread of HIV and the impact of AIDS. Sonke is the current co-chair of the MenEngage global alliance, and chair of the MenEngage network in the Africa region.

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Abbreviations

M&E	Monitoring and Evaluation
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections
VCT	Voluntary counseling and testing

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1

Why male involvement in SRHR?

SEXUAL AND REPRODUCTIVE HEALTH (SRH) has historically been most concerned with population control and, consequently, the fertility behaviour of women. In addition, SRH has predominantly been approached in negative ways, using scare tactics and other means that make addressing SRH difficult. In this context, SRH has focused primarily on controlling women's bodies and reproduction, rather than on ensuring women the choice and freedom to make the decisions appropriate for their life and context, or on how to understand one's SRH needs. In the last twenty years, reproductive rights (and far less frequently sexual rights) have also become part of mainstream SRH frameworks as women's rights organizations from around the world have fought for the rights of women to have more agency and choice over their bodies and reproductive decisions. While these efforts have been critical and have advanced sexual and reproductive health and rights (SRHR) for everyone around the world, little attention has been placed on the specific role of men and boys in SRHR, both for improving their own SRHR as well as their partners' SRHR. Where there has been attention placed on men and boys, it has generally been with the assumption that their SRH needs could be addressed by simply adding extra services on to existing ones traditionally tailored to women. A result of placing the burden of SRH on women and inadequate attention on men's SRHR needs has been that women must bear the majority of the responsibility for their own and their families' sexual and reproductive health. This exacerbates gender inequality, leads to poor health outcomes, and detrimentally excludes nearly half of the population. Perhaps most potentially dangerous of all, women-only SRHR does nothing to challenge the mentality that men are not responsible for their own or their partner's sexual and reproductive health and rights. We must continue to support and promote accessible SRH services and freedoms for women; these are critical services that still and always will need a lot of support. But it is not a zero-sum game. By engaging men in SRHR and gender equality, we can be even more effective in building helpful and preventive services for both men and women, as well as promoting healthy and happy relationships in our communities.

One of the most important things to remember about building male involvement in SRHR and gender equality is that men, as well as women, benefit a great deal from it; SRH is not just a women's issue. Research has consistently shown that men are keen to be more involved, and women are generally supportive of their partner's increased participation.¹ Engaging and educating men around their own sexual and reproductive health is imperative in preventing STIs (including HIV), preventing unwanted pregnancies, and reducing the burden of these issues on women. In addition to seeing men as partners and parents, however, it is also important that men are seen as individuals with male-specific sexual and reproductive health needs. These include medical male circumcision (MMC); male-specific STI symptoms; male-specific family planning needs, male infertility; erectile dysfunction; and prostate and testicular cancers. Not only will addressing individual SRH improve men's health outcomes; promoting and encouraging men to address their own sexual and reproductive health is also good for women's health outcomes.

Just as women begin a lifelong journey of ongoing SRH maintenance and care post-pubescence in order to manage their reproductive and sexual health, so too should men embark on a similar trajectory. It is imperative that each individual, regardless of gender or sexuality, assumes the responsibility for one's own SRH maintenance and has access to those necessary services, including but not limited to STI prevention and family planning. Integrated throughout all of these services, however, must also be a commitment to gender equality in both the provision and utilisation of services. For example, we will be far more effective in the long run if, rather than just handing out condoms to men on the street, we integrate handing out condoms into a larger effort of teaching men (and women) communication skills around sexual encounters (including an individual's right to make decisions regarding his/her own body), or show men that it is not only important to be taking responsibility for their own SRH but to be supportive and communicative about their partner's SRH as well. In short, we must envision building male involvement in SRHR and gender equality as a combination of engaging men as clients, partners, and agents of positive change.

2

Introduction to the model on male involvement

2. I. Who can use this model? For what purpose?

This model is intended for organizations that are interested in building male involvement in SRH beyond just clinical services.ⁱⁱ Those who are interested in this model see male involvement in SRH as an issue needing an integrated approach that takes into account the many roles and identities each person plays in their life. For the purpose of building male involvement in SRH, this includes thinking about men not only as clients, but also as partners, parents, and potential agents of positive change in their own relationships as well as among their peers and broader community. It is a model that requires its users to view gender equality as a critical and non-negotiable element of improving sexual and reproductive health for both men and women. Further, organizations seeking to utilise this model acknowledge that seeing men only as ‘part of the problem’ is insufficient. Instead, organizations using this model understand the importance of holding men accountable, but are interested in doing so in a way that productively engages men as allies and advocates for gender equality and improving SRH for all.

The model can be used for programming purposes and it carries clear implications for monitoring and evaluation (by for example, tracking changes in behaviours and SRH service utilisation). For example, those working in SRH clinics may find this model useful in developing a framework and strategic plan for developing a programme seeking to increase male involvement in SRH. Programme managers may find this model useful for assessing their target group in a project focusing on SRHR. Policy makers may find this model a useful reference for determining policy priorities to enhance male involvement in SRH.

2. II. What does this model include?

A model for male involvement in SRHR:

- a. Step-by-step assistance in assessing your organization’s specific location and situation in order to maximize benefits from this model (Section 2.III.);
- b. Detailed scenarios expanding the 3 essential components of male involvement (men as equal

partners, men as clients, and men as agents of change) (Section 3.IV.);

- c. Questions to ask and priority actions to take that help to operationalize the model provided (Section 3.VI.);
- d. A detailed “ingredients” list that will help you and your organization think through who to involve, what to involve them in, what skills will be needed to get the work done, and what resources you will need in order to build a strong male involvement programme around gender equality and SRH (Section 4.);
- e. Programme guidelines that will assist you and your organization in developing a programme that addresses the needs of your specific location (Section 5.);
- f. Guidance and tips on monitoring and evaluation (Section 6.); and
- g. Guidance and tips on documenting your organization’s work (activities, workshops, community radio, etc.) as well as success stories and lessons learned from men at your location (Section 7.).

2. III. Adapting the model for local context

In order to use this model to its utmost potential, it is imperative that you know who your target group is and what their needs are; you are knowledgeable about how and where to best reach them; and you understand the components of this model and how to apply them to best suit your setting. The following provides step-by-step assistance in assessing your organization’s specific location and situation in order to maximize benefits from this model:

- Decide where you and your organization plan to work. Make a map and draw boundaries. A geographical boundary is a useful starting point (it can always be changed later).
- Start by analyzing the current situation in your location. In your analysis you need to have a way of understanding and estimating men in their roles as change agents, clients, and equal partners (explained in more detail in the following chapters):

"In order to use this model to its utmost potential, it is imperative that you know who your target group is and what their needs are; you are knowledgeable about how and where to best reach them"

- Change agents - To what extent men are active in the community in terms of promoting gender equality and/or SRHR promotion. This can be done through surveys of community members, interviews with key stakeholders, or participatory methods with groups of community members and stakeholders.
 - Clients - To what extent men are using existing SRH services. Quantitative health utilisation data can be gathered from specific clinics or district health officials. Interviews with service providers and with district health managers, as well as qualitative data gathered from individual men (users or non-users of services) will also be very useful.
 - Equal partners - To what extent are men aware of gender inequality and changing towards more gender equal attitudes and behaviour/ roles. This can be done through surveys of community members, discussions with local groups/organizations working on gender issues, or participatory methods with groups of community members and stakeholders. It is important to include women as informants to determine to what extent men are equal partners.
- This analysis should help you to determine which place on the model (see the illustration 3.III.) best describes the situation in your location.
 - Spend time discussing the different imbalances to see which part best describes your situation. In section 3.VI. there are illustrations of the questions you should be asking for each situation, plus some basic ideas for the priority actions you should consider.
 - Spend time discussing what proportion of men are where in the model (explained below). For example, what proportion of men is in situation H as opposed to situations A - G. This gives you an idea of the scale of the task ahead (which may be useful for prioritising).
 - Your analysis should help you to know how to balance 'men as clients activities', 'men as equal partners activities' and 'men as change agents activities'.
 - Identify stakeholders, both individuals and organizations, who might be interested/valuable in getting involved and developing partnerships with. Pay attention to stakeholders who could ease the burden of your work, such as through developing a referral system for elements of the model you and your organization alone might not be able to provide.

Good practice from Choma, Zambia

The Planned Parenthood Association of Zambia (PPAZ) has worked on involving men and boys as a strategy to enhance the sexual and reproductive health of the population in the town and surroundings of Choma, Zambia, since 2005. As part of the Learning Center Initiative Project the organisation reaches out to the community through peer educators and male champions of SRHR. Men are targeted through group discussions (Insakas), after work mobile video shows, health talk sessions at health centres and other activities to initiate dialogue and influence men's attitudes and behaviours related to their roles as clients, agents of change and equal partners in SRHR. Since the project started, there has been an increase in the number of men utilizing SRH services such as STI screening; medical male circumcision; and condom utilization. Men have also increasingly accompanied their partners to ante-natal sessions and women have reported that their male partners have changed in a positive way since they became involved in the project, assisting with household chores traditionally carried out by women.

For more information see: <http://www.ppaz.org.zm/>

3

Designing a Programme for Male Involvement in SRHR

3.1. Model for male involvement: men as equal partners, clients and agents of change

It is important to operationalize ‘male involvement’ at the level of the individual and the community (or project site) for programming purposes. To such an end, organisations around the world working on SRH, including RFSU,ⁱⁱⁱ have been developing a model for male involvement in sexual and reproductive health (SRH) that involves three components.^{iv} These intersecting components, as described below, are all critical for building successful male involvement in SRH that is valued by men, women, and their communities.

While continuing to ensure women have access to SRH and their needs are met, if men are not equal partners, clients of SRH services, and agents of change, the result is limited in terms of successful and gender equal SRH that can benefit both men and women. This is illustrated in the examples below:

Men as equal partners

This includes addressing gender inequality and unfair gender roles, openness on issues of sexuality and tackling negative features of masculinity.

Example of “men as equal partners”:

A man shares child care and housework with his partner; he is not afraid to talk about his fears and insecurities with his partner; and he openly discusses her SRH concerns with her and supports the decisions she makes for her own SRH, including around contraceptives and abortion.

This is a great first step and men such as this should be encouraged to continue such behaviour. Men acting as equal partners in isolation, however, without the other two components described below, is not on its own strong enough for both men and women to gain the most from male involvement in SRHR. If this approach is implemented in isolation, for example, the man may do the above but not go the clinic himself for condoms or STI testing (not a client), and he also won't be engaged in promotion/delivery of SRH (not an agent of change).

Men as clients

This includes increasing men's utilisation of relevant SRH services.

Example of “men as clients”:

A polygamous man has contracted an STI. He comes in for treatment after he starts to experience painful and uncomfortable symptoms.

While this man is taking a positive step by coming to the clinic and should be encouraged to return to the clinic in the future, encouraging men to be clients without also implementing interventions that encourage men to act as equal partners and agents to change is insufficient. If this man, for example, does not choose to tell his multiple partners about the STI, and becomes angered when his service provider suggests he do so, he is not acting as an equal partner. Additionally if, three months later he comes in with the same STI and is treated again, but he still has not spoken to any of his peers about the importance of going to the clinic, he is not an agent of change.

Men as agents of change

This includes increasing men's utilisation of relevant SRH services.

Example of “men as agents of change”:

A man is actively involved in community forums, community radio talks, and workshops around promoting gender equality and the delivery of SRH services.

We hope to see many men actively engaged as agents of change such as this man. But, if we only approach men as agents of change, and it is not simultaneously coupled with engaging men as equal partners and as clients, the potential for men to truly be part of improving SRH health outcomes for both men and women will be limited. This man, for example, might be an agent of change, but if he is also found on most night in taverns, getting drunk and making passes at women, and he does not understand the importance and value of treating women well, he is not engaged as an equal partner. Additionally, if many of his peers have heard that he doesn't use condoms or go to the clinic because “he knows how to do it right”, he has

also not be engaged as a client. Similar to the examples given for engaging men as equal partners and as clients, this example speaks to the importance of implementing all three components of engaging men in SRH together, and that any one component in isolation will have limited effectiveness in addressing gender inequality and improving SRH for men and women.

Example of all three components at play:

A man shares housework with his partner; he is not afraid to talk about his fears and insecurities with his partner; and is open about SRH concerns and issues that they both have. When his partner finds out that she's pregnant (due to the condom breaking), they discuss it together and mutually decide that they are not ready to have a baby. He supports her through an abortion. At the next community forum on healthy relationships, he shares his story of supporting his partner in their decision to get an abortion, of discussing birth control options with her, and the fulfilment he gets from respecting his partner both in and out of the bedroom. A few months later, after they have ended their relationship, he comes into the clinic with his new partner so that they can both get tested before they become sexually active with each other. They also make an appointment for counselling services so that they can discuss what birth control methods would best work for them.

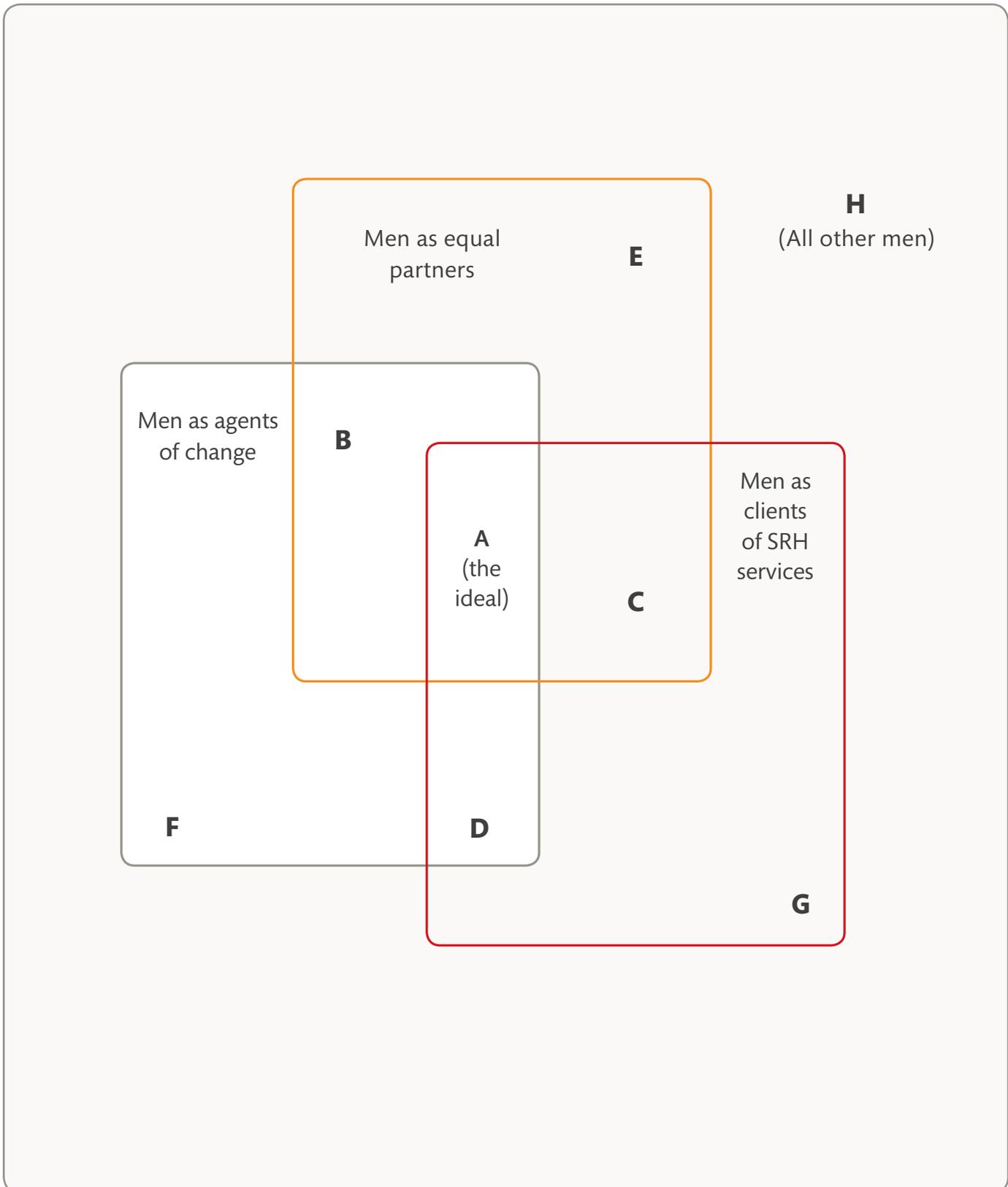
As stated earlier, each of these is an important component in building male involvement in SRHR. Each can be found separately—e.g. a man goes for STI treatment but keeps it a secret from his wife and peers, and maybe even criticises others getting STIs—or they can be found in different combinations as shown in the figure below. What is important here, however, is to recognise that each of these components, while separately important, should not be implemented alone: all three components are essential in order for both men and women to gain the most from male involvement in SRHR, and for this approach to also take gender equality into account.

3. II. How is this model useful?

This model, expanded into 8 scenarios of various levels of male involvement below (A-H), can be used to analyse the situation of individual men, groups of men, or the community level more generally. Whilst there are many ways in which individuals and communities can achieve greater male involvement for the improvement of SRH for both men and women—i.e. there is not only one path or order of events—this model provides a powerful tool for identifying the questions we should be asking, the practical solutions we need to find, and the types of actions that we should prioritize.

"While continuing to ensure women have access to SRH and their needs are met, if men are not equal partners, clients of SRH services, and agents of change, the result is limited in terms of successful and gender equal SRH that can benefit both men and women"

3. III. Illustration: Model for male involvement in SRHR



"Men are gender aware and have become active in SRHR promotion and service delivery"

3. IV. Men as equal partners, clients, and agents of change: expanded

There are eight scenarios that have some combination of overlap of the three components (Men as equal partners, clients, and agents of change). Each scenario will be expanded into a more in-depth description following the model below. The ideal scenario is shown in A. Scenarios B through to H represent less than ideal situations characterised by varying types of male involvement.

The eight scenarios, as shown in the box above, can be summarised as follows:

- A** The ideal (The empowered gender equal man) – engaged with all three components of ideal male involvement with SRHR. Men are involved as users of SRH services, actors in SRHR promotion and service delivery, understand the critical importance of men taking responsibility for their own SRH, and have an understanding of gender and sexuality. This is reflected in men's behaviors and attitudes. Male involvement is being achieved. The impact of this is felt not only by men but also, significantly, by women. Men's greater awareness and engagement are expected to catalyze increased access to and utilisation of SRH services for women, as well as positive changes to social norms and in particular to gender roles. Men in this scenario are valuable allies to women in the process of securing SRHR for all, and can act as powerful role models to encourage and guide other men.
- B** Lacking services—engaged as equal partners and agents of change, but not yet users of SRH services. Men are gender aware and have become active in SRHR promotion and service delivery. However for some reason they are still not utilising services according to their needs (e.g. perhaps services are not user-friendly).
- C** Untapped potential—engaged as equal partners and clients, but not yet agents of change. Men are gender aware and committed to be equal partners and are using SRH services. However for some reason they have not become active in SRHR promotion or service delivery.
- D** Unequal partners—engaged as clients and agents of change, but not yet as equal partners. Men are involved in SRHR promotion or service delivery and accessing SRH services but gender norms and power relations remain unchallenged. Men resist change because of deeply embedded cultural and religious norms.
- E** Aware but not involved—engaged as equal partners only. Men are gender aware and committed to be equal partners, but still not accessing SRH services or involved in SRHR promotion or service delivery. Their lack of utilisation and engagement in turn limits their ability to assist women to access services and secure their rights.
- F** Activist but not changing—engaged as agents of change only. Men are involved in SRHR promotion or service delivery but do so without commitment to gender equality and are not themselves using services (i.e. they do not 'practice what they preach'). It may be that men's involvement is simply a way of reinforcing their sense of masculinity, i.e. being important actors in the community.
- G** Healthy but not involved—engaged as clients only. Men are users of services but do not contribute to SRHR promotion or service delivery and they are not acting as equal partners to women. In such cases, gender-based violence continues and women remain unable to secure their SRHR.
- H** Raw Material—not engaged in any of the three components of male involvement in SRHR yet. This is the group of men who are not yet involved in a positive way. They are not aware or engaged in gender equality or active in promoting or delivering SRHR, and they are not even accessing the SRH services they themselves require. There are many possible explanations for this situation—reluctance, disempowerment, services that are not user-friendly, etc. However whilst it is easy to view these men as 'the problem' it is also important to understand them as raw material with the capacity to positively change. If their views and actions can be transformed they are of great potential value to their fellow community members.

Good practice from Hoima, Uganda

Reproductive Health Uganda (RHU) has carried out activities to strengthen male involvement in SRHR in the Hoima district as part of the Learning Center Initiative project. In partnerships with local stakeholders men have been involved as agents of change, equal partners and clients through for example gender focused discussions and male only information and testing days at a local clinic. Religious leaders and politicians act as agents for change and have been endorsed as male champions for SRHR as part of the project. Results stemming from the project include men’s increased use of SRHR services (especially HIV counseling and testing and safe medical male circumcision), increasingly shared child care and greater male involvement in the immunization of children. Sensitization and information dissemination has also led to an increased demand for SRH services by men.

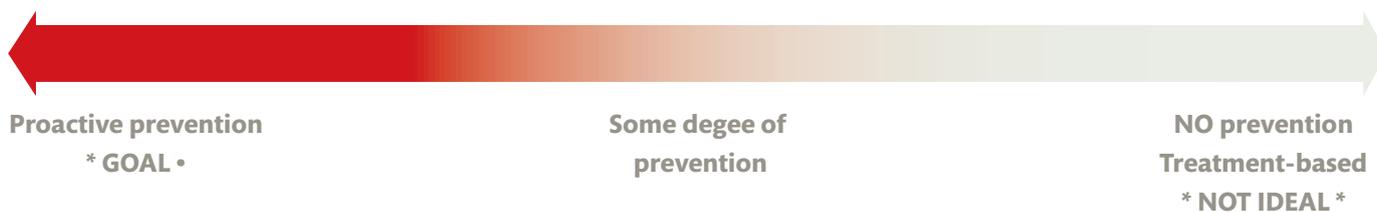
For more information see: <http://www.rhu.or.ug/>

3. V. Clients of SRH services: How preventive is men’s service use?

In the 8 scenarios laid out above, there are four that include, along with some combination of the other two components, men who are engaged as clients of SRH services (scenarios A, C, D, and G). Getting men to go to the clinic is critical, as we have discussed. But, as we have also discussed, men as clients is not enough, and treatment is far less cost efficient than prevention. So, before we check off “clients of SRH services” as a success, it will be important to consider what services men are coming in for, how often they are coming in, whether they are participating in services with their partners, and whether their service use is intended to avoid STIs or pregnancies before they occur, or whether the services they are seeking are dealing with a pregnancy and/or STI after it has already happened. This will tell us the degree to which men are accessing SRH services as preventive care, or as only treatment or to perpetuate behaviour that puts themselves and their partners at risk (not preventive). This will also help us assess how a man might view his use of services in relation to how he treats his partners. Are men coming in to prevent a pregnancy or

STI (proactive prevention), or are they coming in because their partner accidentally got pregnant, or they see signs of an STI and it is too painful now to ignore (not preventive)? Are men coming in frequently, but not taking any actual preventive actions towards pregnancy and STIs? Are there men who come in initially with little knowledge about SRH and how to prevent pregnancies and STIs, but begin to demonstrate proactive, preventive behaviour such as always wearing condoms and getting tested before they become sexually active with a new partner?

The following table—using the four scenarios described above that include men who are already clients or users of SRH services (A, C, D, and G) as a reference point—provides examples along a “degree of prevention” scale, as illustrated below. The ideal degree of prevention, “Proactive prevention”, is the goal to work towards. Using this degree of prevention scale will help us assess what kind of services are being used and how in order to understand how we may best engage with men around SRH. Service utilisation that is as prevention-based as possible is both cost-effective and maximises the benefits of men as clients for men and women.



Men as clients of SRH services: examples of degrees of prevention

Degree of prevention	Definition - for self	Definition - with partner	Example
<p>Proactive prevention</p> <p>An example linked to "A. The Ideal Partner"</p>	<p>Has demonstrated being responsible and accountable for own SRH, and seems empowered by playing this role. Appears to want to get SRH services to take care of self, and seems comfortable with the knowledge about both prevention methods and how to negotiate those in relationships. Seems to have plenty of knowledge about SRH and is willing to share this with peers.</p>	<p>Has talked to partner, is willing to come for appointments if agreed, has demonstrated willingness to get tested again with each new partner. Seems invested in gender equality as part of engagement in these services</p> <p>Uses condoms regularly, is not threatened by his female partner carrying condoms and is open to using the female condom and carrying the female condom with him.</p>	<p>Moses has been in to the clinic regularly (every 6 months) for the last two years. He recently got out of one relationship and is starting another, so he came in to get tested in order to make sure he was safe and clean before embarking on an intimate relationship with his new partner. When he came in to get tested, he also brought his friend, Akiki, to get tested. Akiki seemed hesitant at first but Moses' calmness and demonstration of being comfortable in the clinic made Akiki at ease. Moses explained the importance of getting tested regularly to Akiki, and also how much better his relationship had got when he took the time to listen to his partner and treat her with respect. Moses also told Akiki that he had discussed birth control options with his partner and was supportive of the choice she made. Both Akiki and Moses left with condoms.</p>
<p>Proactive prevention</p> <p>Another example linked to "A. The Ideal Partner"</p>	<p>Both him and his partner intended to get pregnant; he is supportive of partner coming in to confirm pregnancy, or also accompanies partner for this appointment.</p>		<p>Lutalo and Nabulungi were using condoms regularly (and she was on birth control) until they decided they were ready to get pregnant. They had kept an open dialogue about SRH, including birth control. When they believed she was pregnant, Lutalo offered to accompany her to a doctor's appointment to confirm the pregnancy. She decided she would prefer to go alone but he made sure he was home and ready to support her when she returned from her appointment.</p>

"Getting men to go to the clinic is critical, as we have discussed. But, as we have also discussed, men as clients is not enough, and treatment is far less cost efficient than prevention"

Men as clients of SRH services: examples of degrees of prevention

Degree of prevention	Definition - for self	Definition - with partner	Example
Proactive prevention An example linked to "C. Untapped Potential"	<p>Appears to be wanting to get SRH services to take care of self and wanting to prevent pregnancy and STIs, but still doesn't seem to know a lot about options. Seems to be aware of the information around, but hasn't internalized all of that <i>information</i> and into <i>knowledge</i>.</p>	<p>Has talked to partner about SRH, has demonstrated willingness to get tested regularly and again with each new partner, and uses condoms regularly. Still seems a bit hesitant about doing this however, as if he still doesn't feel this is "his" choice, or "his" responsibility.</p>	<p>Chibesa comes to the clinic every six months and also when he is starting a new relationship. He has told the SRH provider that he uses condoms regularly and he and his partner talk openly about SRH. Whenever he comes in to the clinic, however, he seems quiet and nervous and is clearly worried that someone he knows might see him while he's there.</p>
Some degree of prevention An example linked to "D. Unequal partners"	<p>Appears to be wanting to get SRH services to take care of self, and comes in sporadically to get tested, but doesn't seem entirely comfortable with doing so and seems to be struggling with the expectation that he should be coming to get tested. Is still coming in for testing without actually having any symptoms, however. Has some knowledge around SRH and is aware of information available, but still has not taken ownership of this.</p>	<p>Understands that talking to his partner(s) is important, but has not yet managed to do so. Knows partner is on birth control but has not spoken with her about this, and expects her to take care of this. Is careful about using condoms most of the time, but sometimes doesn't use them, especially if his partner doesn't say anything.</p>	<p>Taban shows up at the clinic sometimes every three months, sometimes only once a year. He has brought a friend with him this time to the clinic, and seems excited that he has "recruited" a new client. However, he does not talk to his friend about SRH and instead they make jokes and talk about soccer while they wait. When the SRH provider asks Taban during his appointment if he's been responsible about his SRH and using condoms, he says that he is, "most of the time", but that he has stayed clean and is "pretty sure" he hasn't gotten a woman pregnant, so he has, in his view, been responsible. He laughs about this, and doesn't seem to be taking his or her SRH very seriously despite demonstrating knowledge about how to protect himself and a willingness to do so.</p>

"We must continue to support and promote accessible SRH services and freedoms for women; these are critical services that still and always will need a lot of support"

Men as clients of SRH services: examples of degrees of prevention

Degree of prevention	Definition - for self	Definition - with partner	Example
<p>Some degree of prevention</p> <p>An example linked to “G. Healthy but not involved”</p>	<p>Hasn't really taken any precautions, is in because worried might have an STI. But will leave with some kind of preventive measure they seem likely to use. Is willing to take in <i>information</i> about SRH, but does not yet have this information internalized into <i>knowledge</i> about SRH.</p>	<p>Hasn't talked to partner(s) about SRH at all, perceives SRH as a woman's responsibility, and does not go to the clinic unless there is a problem too uncomfortable to ignore. Understands that using condoms is important to prevent both STIs and pregnancy, but has not yet decided if that is more important than the pleasure he gets from sex without a condom and the value of being considered fertile. Leaves with condoms and seems committed to being more responsible and willing to talk to his partner(s).</p>	<p>Okello knows about the clinic but has heard that the providers are very rude and judgmental and doesn't really see why he should have to get tested. He has “mostly” been with one partner in the last year, with maybe a few exceptions. He assumes his partner(s) would tell him if they have an STI or are not on birth control, and he far prefers sex with no condom. Besides, sometimes he gets annoyed or threatened when a partner asks him to use condoms, as he feels that is them telling him he is “unclean” or not worthy of fathering their children. However, he now thinks he has an STI and finds his way to the clinic. He is pleasantly surprised to find the SRH providers kind and nonjudgmental about the reason for his visit. After talking with them about the importance of respecting one's partner and ways to understand condom use as something other than a barrier to pleasure, he leaves with condoms and seems committed to using them more regularly.</p>
<p>Some degree of prevention</p> <p>An example linked to “D. Unequal partners”</p>	<p>Has taken some preventive measures (uses condoms) but hasn't been using them regularly so has come to clinic because worried has contracted an STI.</p>	<p>Understands that talking to his partner(s) is important, but has not yet managed to do so. Perceives SRH as her responsibility and does not go to the clinic unless there is a problem. Is not sure if partner(s) is on birth control, but thinks she is. Uses condoms a lot of the time, but often doesn't, even when his partner(s) ask him to use them.</p>	<p>Mwenya has heard about the clinic and knows friends who go regularly but has not yet gone himself. He has had more than three partners in the last year, and is not sure if any of them have been faithful to him either. He usually tries to use condoms, but when he's had a lot to drink or is feeling really excited, he isn't always very good at using them, even when his partner asks him to. He is now showing signs of an STI and wants to get tested. Mwenya has questions about aspects of SRH, but does not seem comfortable asking the SRH provider. He leaves with more condoms but it is unlikely his behaviours will change to be more responsible.</p>

Men as clients of SRH services: examples of degrees of prevention

Degree of prevention	Definition - for self	Definition - with partner	Example
<p>No prevention/ treatment-based</p> <p>An example linked to "G. Healthy but not involved"</p>	<p>Hasn't really taken any precautions, is in because he is worried he might have an STI. Does not leave with preventive measures or is unlikely to use preventive measures offered. This client is wary of information available about SRH.</p>	<p>Hasn't talked to partner(s) about SRH at all, perceives SRH as a woman's responsibility, and does not go to the clinic unless there is a problem. Is not at all sure that using condoms is more important than the pleasure he gets from sex without a condom and the value of being considered fertile. Leaves with condoms but does not seem very willing to change his behaviour.</p>	<p>Kunda, similar to Okello, knows about the clinic but has heard that the providers are judgmental and doesn't really see why he should get tested. He has had a few partners in the last year, is against them using birth control, blames them for any STIs and expects them to take care of them (although he also expects them to stay faithful to him and stay clean). He doesn't use condoms (even when his partner asks him to) as they take away his pleasure, but he also isn't very willing or supportive if a girlfriend of his gets pregnant. He now is pretty sure he has an STI and it has become so uncomfortable he has no choice but to seek treatment. Despite the SRH provider making the appointment as easy and comfortable for him as possible, he declines the condoms she offers and offers no thanks for her services.</p>

"Engaging and educating men around their own sexual and reproductive health is imperative in preventing STIs including HIV, preventing unwanted pregnancies, and reducing the burden of these issues on women"

3. VI. Operationalizing the model: questions to ask and priority actions

As we have seen, there are many levels of “male involvement” we might see among individuals, groups, and communities. Using the general scenarios (A-H) provided above to illustrate we can start to ask ourselves which scenario(s) best fit the men (and women) we are working with. Once we have a better sense of what our current

situation is in the site we are working, the following table will be useful in deciding how to operationalize the model provided above, including what questions to be asking and priority actions to be taking to build positive male involvement in SRHR that benefits both men and women without negating the interests of women and girls. The table below also includes advice to enhance SRH service utilisation depending on the extent to which the target group utilizes SRH services in a proactive and preventive way.

Scenario (A-H)	Questions we should be asking include ...	Priority actions include ...
A. The ideal	<ul style="list-style-type: none"> ▪ What has catalyzed and supported this positive situation? Can those lessons be used for involving other men in SRH? ▪ What is the positive impact? ▪ How does his partner feel about his attitudes and choices? ▪ How do we continue to support him to remain in this category and to resist negative cultural and religious norms? ▪ Is he a peer educator? Would he be interested in becoming one? 	<ul style="list-style-type: none"> ▪ Maintaining the situation (e.g. evaluating programmes, educational outreach, documenting client experience to show benefits) ▪ Sharing success (e.g. role models, success stories, exchange visits) ▪ Mobilising these men as change agents ▪ Recruiting men in this category to be peer educators and vocal catalysts for positive change in their community
B. Lacking services	<ul style="list-style-type: none"> ▪ Do men know about SRH services? ▪ What are the barriers to service utilisation? ▪ How can we support and shift him to the ‘empowered, ideal category?’ ▪ How are cultural norms still influencing him? 	<ul style="list-style-type: none"> ▪ Steps to increase utilisation of SRH services by men
C. Untapped potential	<ul style="list-style-type: none"> ▪ What attempts have been made to mobilise men? What worked, did not work, and why? ▪ Are men unwilling or unable to get involved in SRHR promotion or service delivery? <p>Advice to enhance SRH service utilization:</p> <ul style="list-style-type: none"> ▪ What has catalyzed his desire to seek preventive SRH care? ▪ Why does he not yet feel as though these are his “own” or “empowered” decisions? ▪ How does his partner feel about his attitudes and choices? ▪ Is he a peer educator? Would he be interested in becoming one? 	<ul style="list-style-type: none"> ▪ Mobilising men as change agents ▪ Finding and promoting male role models <ul style="list-style-type: none"> ▪ Engaging men in activities geared towards “empowering” them around their SRH and gender equality ▪ Providing spaces for men to safely and supportively engage in dialogue about SRH and gender equality

Scenario (A-H)	Questions we should be asking include ...	Priority actions include ...
D. Unequal partners	<ul style="list-style-type: none"> ▪ What are the prevailing gender norms and power relations in the community? ▪ What attempts have been made to improve gender awareness and gender equality? What worked and did not work <p>Advice to enhance SRH service utilization:</p> <ul style="list-style-type: none"> ▪ What is motivating his decision to get preventive SRH care if it's not yet that he believes it's his responsibility as much as his partner's? ▪ How does his partner feel about his attitudes and choices? ▪ What are the barriers to preventive SRH service utilisation? ▪ Will a positive experience at seeking care change his behaviours/attitudes about safe sex and preventive SRH care? How? ▪ What education have men gotten about prevention, condom use, gender equality, and consent? 	<ul style="list-style-type: none"> ▪ Assisting men to challenge inequalities, negative notions of masculinity, become more open on sexuality, etc. ▪ Engaging men in activities geared towards "empowering" them around their SRH and gender equality ▪ Providing spaces for men to safely and supportively engage in dialogue about SRH and gender equality ▪ Mobilising men as change agents ▪ Finding and promoting male role models ▪ Assessing SRH provider "bedside manner" and engaging them in trainings to improve their capacity in providing judgment- and stigma-free and informative visits ▪ Engaging men (alongside women) to challenge inequalities around gender and SRH
E. Aware but not involved	<ul style="list-style-type: none"> ▪ What are the barriers to service utilisation? ▪ What attempts have been made to mobilise men? What worked, did not work, and why? ▪ Is he unwilling or unable to get involved in SRHR promotion or service delivery? 	<ul style="list-style-type: none"> ▪ Mobilising men as change agents ▪ Assisting men to challenge inequalities, negative notions of masculinity, become more open on sexuality, etc.
F. Activist but not changing	<ul style="list-style-type: none"> ▪ What is motivating men if it is not gender equality or their own experiences as SRH service users? ▪ What attempts have been made to improve gender awareness and gender equality? What worked and did not work, and why? ▪ What are the barriers to service utilisation? 	<ul style="list-style-type: none"> ▪ Assisting men to challenge inequalities, negative notions of masculinity, become more open on sexuality, etc. ▪ Steps to increase utilisation of SRH services by men
G. Healthy but not involved	<ul style="list-style-type: none"> ▪ What are the prevailing gender norms and power relations in the community? ▪ What attempts have been made to improve gender awareness and gender equality? What worked and did not work, and why? ▪ What attempts have been made to mobilise men? What worked, did not work, and why? ▪ Are men unwilling or unable to get involved in SRHR promotion or service delivery? 	<ul style="list-style-type: none"> ▪ Assisting men to challenge inequalities, negative notions of masculinity, become more open on sexuality, etc. ▪ Increasing men's involvement in SRHR promotion and service delivery

	<p>Advice to enhance SRH service utilization:</p> <ul style="list-style-type: none"> ▪ What are the barriers to preventive SRH service utilisation? ▪ Will a positive experience at seeking care change his behaviours/attitudes about safe sex and preventive SRH care? How? ▪ What education have men gotten about prevention, condom use, gender equality, and consent? ▪ How does his partner feel about his attitudes and choices? 	<ul style="list-style-type: none"> ▪ Assessing SRH provider “bedside manner” and engaging them in trainings to improve their capacity in providing judgment- and stigma-free and informative visits ▪ Meeting men “where they are” - making education and engagement around SRH and gender equality issues a normal part of community life, including specific messages that are youth- or adult-friendly ▪ Finding and promoting male role models ▪ Community sensitization and mobilisation on gender and SRH
<p>H. Raw material</p>	<ul style="list-style-type: none"> ▪ What SRH services are available, and why are men not using them? ▪ What are the priority issues relating to gender that need to be addressed? ▪ Which areas of community life are men active in? How can this knowledge be used to encourage male involvement in SRHR? 	<ul style="list-style-type: none"> ▪ Community sensitization and mobilisation on gender and SRH, as well as widening access to SRH services

"I realized that spending time with my daughter, and making time to listen to her, will improve my relationship with her and hopefully positively impact her life and choices"

4

Ingredients list

Understanding what kind of men (and women) you and your organization might see at your location—or what kind of men (and women) you would like to see at your location—as well as what questions and priorities to engage in is a great start. In order to increase male involvement in SRH, however—and with particular attention to doing so without negating the needs or interests of women and girls—we must continue to think through concrete actions and activities around SRH in which to engage men and women. The following section lays out various activities you and your organization may want to engage in, as well as whom to engage with and what resources you may need.

4.1. Activities

Some of the main ‘men as clients activities’, ‘men as equal partners activities’ and ‘men as change agents activities’ are as follows:

Activities related to men as clients

Create demand and awareness raising through activities such as:

- Campaigns
 - Messages such as “being strong=taking care of your health”; “being a ‘man’ is treating your partner with respect”
 - Positive messages for men that encourage responsibility and accountability, as opposed to just blaming men
- Information products and information dissemination
 - SMS info services about SRH and/or health relationships (i.e. weekly SMS to those who subscribe with messages such as “If you’re gonna party, be prepared. Bring condoms and respect you and your partner’s sexual limits”
 - Easy to read pamphlets about SRH, STIs, and/or communicating with partner
 - IEC material in local language

- Counseling services for individual men by male counselors
 - Training more male counselors
- Community dialogues and events
 - Dramas or “ambush theatre”
 - Community forums about healthy relationships, getting tested, etc.
 - Work with local organizations with similar goals to create collaborative events around gender issues
 - Radio Shows
 - Sports events
 - Mobile Video Shows
- Local role models and champions
 - Invite them to come and get tested
 - Get them to be the face of the campaigns, community forums, etc.
 - Speak out publicly against gender based violence i.e. about the harassment of women for wearing revealing clothing; forced marriages; female genital cutting
- Counseling services for couples
 - Educate men (and women) on the benefits of couples counseling
 - Encourage men to bring their female partners

Improvements in SRH services, including things such as:

- Better advertisement/information
 - Talk to men (and women) in your community and find out what would appeal to them (get them to use the services and promote gender equality)
 - Make information user-friendly, such as via SMS, or music
 - Make local role models and champions the face of your services
 - Radio Programmes

- Improved opening hours to be more suited to target audience
 - Evening and weekend hours
- Male-only facilities or male-only times at general facilities
- Special times for service delivery by male staff (older and younger)
- Making facilities more male-friendly (also important to make facilities female-friendly!!)
 - Create an informal, stigma-free setting that men/women feel comfortable being at
 - Make the information and the messages at your facility tailored to men's/women's needs
 - Paint murals on the walls which include men/women in services
- Training service providers in SRHR, male-friendly (and female-friendly) services, client-oriented service delivery
 - Provide workshops about judgment- and stigma-free services; how to build trust with clients; the importance of confidentiality
 - Exploring values clarification with service providers particularly around key population groups such as men who have sex with men, women who have sex with women, sex workers, and persons living with HIV
- Orientation of local health management team; support to and advocacy towards these decision-making teams
 - Help your local health management team to work together towards common goals
- Providing information to local health management teams and service providers
 - In-staff training about STIs, HIV, birth control methods; improving partner communication
- Community outreach
 - Go where your clients are and where you have their attention: work, schools, bars, petrol stations, radio shows, newspapers, door-to-door
 - Establish and maintain youth clubs in and out of schools

- Exchange visits amongst schools in the project sites
- Open days for school youth
- Mobile clinics
- Improving access to condoms
 - Work with schools, bars, petrol stations, etc. to have condom dispensing machines in their establishments, public transport areas
 - Ask men for suitable places to dispense male and female condoms as men sometimes do not want to be seen taking condoms
 - Ask women for suitable places to dispense condoms where they are comfortable taking condoms

Policy and advocacy to increase access and/or improve quality of services, ensure supplies and commodities and appropriate human resources and finance for SRH services:

- Goal is to make SRH services as easy and "normal" to seek as possible (regularly and preventively) for men and women. Work towards integrated SRH services for men (and women) that maximizes efficiency of providing the most information and services as a "one-stop shop" for clients who come in (birth control, STI testing, HIV testing, follow-up appointments for HIV positive clients, counseling, etc.)
- STIs testing kits and rapid HIV tests
- STI treatments
- Funds for in-staff trainings (including money for travel and catering)
- Funds for record-keeping equipment (computers, filing system, etc.) and other administration development and maintenance
- Stable funds for SRH service providers
- Funds to do community outreach activities
- Funds to do focus groups etc. with local clients to find out how to package services to be most relevant to them
- Funds to do monitoring and evaluation

Example of SRH package of services for men'

- Assessment based on SRH history
- Testing, education, counselling, treatment and support for STIs/HIV
- Listening to and answering questions about sexual function, pleasure, and sexual orientation without judgement
- Screening for testicular and penile cancer
- Voluntary Medical Male Circumcision (VMMC)
- Information about alcohol or drug dependence or abuse
- Screening for depression and referral for mental health support
- Screening for GBV
- Counselling on the prevention of GBV
- Counselling for and access to family planning methods, including how to make condom use sexy and safe
- Infertility counselling and services
- Information on pre-natal and post-partum care and support
- Care-giving and parenting skills
- Communication and negotiation skills-building
- Sexual dysfunction counselling and services, including for premature ejaculation, erectile dysfunctions, and impotence
- Vasectomies
- Information on sexual pleasure (for the clients and their partners)
- Positive images of gentle, gender-equitable men
- Access to support groups for new fathers
- Access to support groups for men dealing with violence

Activities related to men as equal partners

- Work with individual men
 - SRH and gender equality-focused discussions and workshops around healthy and positive communication with partners (including about birth control), meaning of consent, and preventive SRH measures
 - SRH and gender equality-focused discussions and workshops around gender based violence, sexism, sexuality and negative notions of masculinity the clients and their partners)
- Work with men in partnerships
 - Workshops and open forums with couples around gender equality, healthy communication and SRH
 - Workshop with men around men's sexuality and their own sexuality in relation to women
 - Workshop around harmful gender norms that say 'men can have sex with their partners, at any time, whenever they want to.'
- Work with mixed groups (for example young men and women)
 - Addressing unequal gender roles in relationships and sexual relationships between men and women
 - Understanding men and women's sexuality (as individuals and in relation to each other)
 - Tackling different topics together such as gender based violence, HIV, SRHR, sexuality issues
- Work with men in groups
 - Edutainment and sports activities
 - Gender-focused discussions
 - Male only discussions
- Work with leaders
 - Business leaders
 - Community elders
 - Faith leaders
 - Female and male leaders
 - Local politicians
 - Religious leaders
 - Traditional leaders
- Work with community structures
 - Schools (create youth groups, do exchange visits with other schools)
 - Training of teachers
 - Community/district sensitizations
 - Training of, and support to, local folk media such as puppetry, drama groups, etc.
 - Churches
 - Government
 - Health structures
- Work with women
 - To mobilise support for changed, more equal gender roles and positive redefinition of masculinity
 - Gender-focused discussions
 - Work with women in groups with men, and work with women-only groups
 - Invite female leaders/elders to get involved

Activities related to men as change agents

- Becoming peer educators
 - Getting trained on SRH and gender equality
 - Getting training on exploring values and attitudes on masculinity, culture and tradition
 - Getting training on exploring values and attitudes towards for example key population groups such as men who have sex with men, women who have sex with women, sex workers and people living with HIV
 - Translating this training and knowledge to the community and beyond, using it to support women's efforts to advocate for their own SRH as well as speaking out and calling attention to issues surrounding SRH and gender equality
 - Taking the lead on community outreach, community forums, and talking with community stakeholder/elders
- Getting trained on facilitation skills and how to facilitate a process of change and to deliver gender equal messages
- Talking to their peers
- Helping out on sports teams, in schools etc. to talk to youth about SRH and gender equality
- Working with women (in community and in personal life) to arrive at common goals about how to operationalize "gender equality" (i.e. sharing household tasks, childcare, being responsible about social time and drinking)
- Supporting women's rights campaigns
- Reaching out to male leaders of organizations and government in order to encourage them to promote SRHR and gender equality

"Understands that using condoms is important to prevent both STIs and pregnancy, but has not yet decided if that is more important than the pleasure he gets from sex without a condom and the value of being considered fertile"

4. II. Actors

Delivery of the above actions requires a range of actors, including:

- Peer educators
- Counselors
- Trained SRH service providers
- Trained teachers
- Trainers and trainers of trainers
- Advocacy groups/organizations/individuals
- Policy makers and decision-makers
- Men and women (of all ages)
- Leaders/stakeholders who are on board

4. III. Skills

- Knowledge of SRH and gender equality
- Knowledge of local setting and associated priorities/needs
- Knowledge of and ability to work with youth and their SRH needs
- Ability to be nonjudgmental with clients (regardless of sexuality or choices)
- Ability and willingness to build trust with clients and commitment to confidentiality
- Ability to work and educate in groups and one-on-one about SRH, communicating with partners, the meaning of consent, etc.
- Ability and willingness to treat individuals of both genders with respect, kindness, and compassion and work towards common goals
- Facilitation skills
- Values Clarification

4. IV. Relationships in the community

- With leaders/elders in community (Local politicians, business leaders, community elders, faith leaders, female and male leaders)
- With hospitals and other health service providers in the area
- With schools and teachers in the area
- With sports teams and coaches in the area
- With local clubs/groups in the area that may help with furthering goals

4. V. Equipment

- STI testing kits; rapid HIV testing kits
- STI treatment
- Condoms (and condom dispensing boxes)
- Pamphlets/brochures on STIs, HIV, birth control, SRH services, and building healthy (romantic) partnerships and talking with your partner (about sex, birth control, communication, consent, etc.)
- Recording system (computers, filing cabinet, etc.)
- Security for equipment (cabinet with locks, alarm system for clinic)
- Resource binder/information database about related resources for clients (including info about organizations/groups that deal with: substance and drug abuse, sexual and domestic violence, other health issues, employment, etc.)
- Resource binder/information database for providers about national and international guidelines for providing comprehensive and user-friendly SRH services (UNFPA frameworks, SRH national policy framework (i.e. <http://www.paho.org/english/ad/ge/MenSRH.pdf>; <http://www.ippf.org/en/What-we-do/Access/Engaging+men+and+boys+in+SR+HR+and+HIVAIDS.htm>; other documents from IPPF (www.ippf.org), Instituto Promundo (www.promundo.org), and Guttmacher Institute (www.guttmacher.org))
- Mobile clinic if possible.

5

Programming guidelines

- **Link the activities of all three components as much as is possible.** Potential impact is reduced if your activities relating to 'men as clients', 'men as equal partners', and 'men as change agents' are not linked. This is because, as we have seen throughout this model, each component in isolation from the other two is insufficient in increasing male involvement such that there is benefit for men and women, and done so without negating the interests and needs of women. You can make sure that your activities link together through, for example, ensuring that your target audience for one component is the same target audience for another component. For example: a specific group of men in a specific geographical area are encouraged to use SRH services (clients) and are also mobilised to become peer educators (agents for change). You could also aim to reach one group with one component (e.g. mobilising peer educators to encourage other men in the community to use SRH services) who would in turn reach out and encourage different target group to become (preventive) users of SRH services.
- **Get the balance right** - there is a strong link between effective monitoring and evaluation (M&E) and good project management. If your M&E data shows that your efforts to mobilise men are moving faster than your ability to work with those change agents on gender equality, then it is important to shift the balance. Change agents who have unhelpful motivations, or whose attitudes or behaviours outside of being change agents remain gender inequitable are not, ultimately, very helpful to the achievement of improved SRHR.
- **Make the information and education relevant to your local context and youth-user-friendly.** While information is imperative, the transition of this information into knowledge is something that requires an internalization of this information within institutions, peers, and, most importantly, individuals.
- **Commit to confidentiality.** Clients, both men and women, need to feel as though accessing services is not only easy, but also safe and trustworthy. Confidentiality is essential for the success of your project.
- **Aim is to empower clients (including youth) to make healthy decisions for themselves.** Remember that providers can't ultimately make these decisions for clients, but can provide them with enough resources and a safe space to come to that clients are capable of making health decisions that are right for them.
- **Remember:** Our ultimate goal in increasing male involvement in SRH is to increase men's accountability not just to themselves, but, more importantly, to women. Engaging men in SRH is intended to promote gender equality—not further compromise it—and ensure that women have the agency, capacity, and safety to access the services they need and want. As such, it is essential that women's safety and well-being is at the forefront of our work and we make sure that interventions do not put women in danger or undermine their right to choose.

"Research has consistently shown that men are keen to be more involved, and women are generally supportive of their partner's increased participation"

6 | Monitoring and Evaluation

It is important for health officials at the clinic and the district level to collect data on the numbers of men accessing services every month and for which services:

- Number of men and women accessing family planning; medical male circumcision; STI treatment; couples counseling; individual counseling; HIV testing and counseling
- Number of times each male frequents the clinic and for which services
- Waiting times during peak and off-peak hours
- Transportation costs and travel time
- Number of men bringing their children for immunization or for other health care
- Number of men who come with their partners
- Qualitative feedback from women who interact with men who have been reached by the activities (to detect change in terms of men as equal partners). This could be done through for example focus group discussions

"This will tell us the degree to which men are accessing SRH services as preventive care, or as only treatment or to perpetuate behaviour that puts themselves and their partners at risk (not preventive)"

7 | Documentation

Documenting is critically important to be able to track the progress of your work and be able to evaluate what works and what does not work. Statistics should be age and sex specific.

It is also important to show the effectiveness and impact of your work to different stakeholders (participants/beneficiaries, partner organizations, donors, politicians etc.).

7. I. Peer Educators who work in the field should...

- Use pre- and post-workshop questionnaires to measure changes in attitudes and beliefs of participants
- Provide opportunities for participants of activities to offer feedback on strengths and weaknesses of activities (can be done via written comment cards or verbal feedback)
- Write monthly reports on activities implemented
- Use the monthly report; record the number of men and women who have attended workshops, discussions, events etc.
- Write down the numbers of people who have been referred and to which clinics, hospitals they have been referred to and for what particular service
- Have a monthly discussion with peer educators about what worked, what did not work, what are the challenges
- Address challenges as much as possible, including being responsive to feedback of participants and adjusting activities accordingly
- Plan for the next upcoming months

7. II. Collecting stories of change from men and women

It is also very important to collect individual stories of change from men who have positively changed (or women who interact with these men) as a result of the programme. This information is important to show that the work you do with men is effective and a benefit to both men and women.

The following are some basic questions you could ask to beneficiaries or anyone who is a part of the programme:

Question 1: What was your situation like? What was your behaviour like?

- E.g. I used to beat my wife, I never washed the dishes, I never used to bath my daughter, I never talked to my wife about family planning.

Question 2: What has caused the positive change in your attitudes and behaviour?

- E.g. I attended a male focused discussion on gender equality and SRH and started to think about how it wouldn't actually be that hard to go and get tested regularly, and that perhaps it would improve my relationship if I was more open to discussing issues around sex and SRH.
- E.g. After hearing testimonies on a community radio show of young women who didn't have positive male role models growing up and how that has negatively impacted their self esteem, I realized that spending time with my daughter, and making time to listen to her, will improve my relationship with her and hopefully positively impact her life and choices.

Question 3: What has changed? How has your attitude as a man changed?

- E.g. I started to assist with house work, I go to the clinic to have regular STI checks BEFORE I think there is a problem, I go to VCT with my partner, I take my daughter to the clinic, I became involved in SRH activities, I am now a peer educator

How do we document stories?

As stated earlier, documenting success stories and lessons learned is essential for building the infrastructure and resources for successful and sustainable male involvement in SRH. Plus, it reminds those who are in the thick of this work that their efforts do matter. In order to get these stories written and, more importantly, written from the perspective of the individual who directly experienced the positive change, you can:

1. Write down what they say
2. Ask men to write their own stories
3. Record their stories on your cell phone (but you have to ask for permission first and get permission to use their stories)
4. Take photos of an event to prove that the events are taking place
5. Take a photo with a man and his wife going to the clinic together, sitting in clinic, you could take a picture of a man doing the washing; you could take a picture of a father playing with his daughter or helping her with her schoolwork. You could take a photo of a man carrying his baby on his back.

It is VERY IMPORTANT – To ask if you can take a photo first and if you can use their photo – if they say no you have to respect their privacy. If they say yes let them know that the photos will be used in reports, or newsletters, workshops etc and they must be ok with being seen in the photo.

"However, while women often have greater risks associated with sexual and reproductive health than men, including the risk of unwanted pregnancy, women have also borne the brunt of the responsibilities around SRH, negating men's responsibility of sharing the benefits and burdens of SRH"

8 Involving men in SRH: improving the health and well-being of women

This document is intended to build male involvement in sexual and reproductive health and rights. It is important to note, however, that this cannot and should not come at the cost of women's access to sexual and reproductive health and rights. Women continue to face disproportionate risk related to sexual and reproductive health, such as greater risk for STIs than men, risk of unwanted pregnancy and consequent decision-making around that pregnancy, and maternal mortality. Furthermore, as a result of numerous factors, including gender-based violence, economic instability, and often primary responsibility and concern over children, women are much less likely to have power to wield in a relationship with regard to decision-making around

sexual and reproductive health. The power differentials between men and women are often so great that engaging men in SRHR might still reduce a woman's ability to have control over her own SRH and decision-making, despite best of intentions. As such, embarking on efforts to build male involvement in SRHR must be done cautiously, and must take into account all three components covered in this model: men as clients, men as equal partners, and men as agents of change. Engaging a multi-pronged approach such as this ensures that men not only learn to take responsibility for their own and their partner's SRH, but do so in a way that does not negate the health and well-being of women and girls.

9 Conclusion

Sexual and reproductive health and rights are critical to the health and well-being of men, women, girls and boys. Historically, sexual and reproductive health focused on fertility control and controlling women's bodies; today, global efforts are committed to promoting the rights of women (and men) to have the knowledge, resources, and safety net needed to make decisions most appropriate for their own life and context. However, while women often have greater risks associated with sexual and reproductive health than men, including the risk of unwanted pregnancy, women have also borne the brunt of the responsibilities around SRH, negating men's responsibility of sharing the benefits and burdens of SRH. A result of placing the burden of SRH on women and inadequate attention on men's SRHR needs has been that women must bear the majority of the responsibility for

their own and their families' sexual and reproductive health. This exacerbates gender inequality, leads to poor health outcomes, and detrimentally excludes nearly half of the population.

This model includes a framework, guidance, and concrete recommendations for building male involvement in SRHR. Using three intersecting approaches for engaging men to achieve this goal—men as clients, men as equal partners, and men as agents of change—this model seeks to provide organizations looking to building male involvement in SRHR the tools required to envision, assess, plan, develop, implement, monitor, and evaluate such programmes. The model is intended to improve SRH outcomes for men and women as well as support and promote gender equality.

Appendix One:

Definition of terms

The following definitions are pulled directly from “Sexual and Reproductive Health: Reviewing the Evidence”, a document drafted by the South African Department of Health in early 2011.^{vi}

Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all individuals, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services
- seek, receive, and impart information related to sexuality
- sexuality^{vii} education
- respect for bodily integrity
- choose their partner
- decide whether or not to be sexually active
- consensual sexual relations
- consensual marriage
- decide whether or not, and when, to have children
- pursue a satisfying, safe and pleasurable sexual life

Sexual health

Sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied.

Reproductive rights

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of reproductive and sexual health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence as expressed in human rights documents.

Reproductive health

Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Appendix Two:

Additional Resources

Publications and resources on male involvement in SRHR

Men-streaming in sexual and reproductive health and HIV: A toolkit for policy development and advocacy, IPPF, 2010, <http://ippf.org/resources/publications/Men-streaming-sexual-and-reproductive-health-and-HIV>

Men are Changing: Case study evidence on work with men and boys, IPPF, 2010, <http://www.ippf.org/resources/publications/men-are-changing>

The Truth about Men, Boys and Sex: Gender-transformative policies and programmes, IPPF, 2009, <http://www.ippf.org/resources/publications/Truth-About-Men-Boys-and-Sex-gender-transformative-guide>

Men's Participation in Sexual and Reproductive Health and Rights: Training Manual, IPPF South Asia Region, 2008, www.ippfsar.org/en/Resources/SARO+publications

Medical and Service Delivery Guidelines for Sexual and Reproductive Health Services, third edition, IPPF, 2004, www.ippf.org/en/Resources – also available in Arabic, Bosnian, Bulgarian, French, Polish, Russian and Spanish.

Dicktionary: What Every Guy Needs to Know about his Knob, RFSU, 2008, www.rfsu.se/publications_rfsu.asp

Men's Reproductive Health Curriculum, EngenderHealth, 2008, www.EngenderHealth.org/pubs

It Takes 2: Partnering with Men in Reproductive and Sexual Health, UNFPA, 2003, www.unfpa.org/publications – also available in French and Spanish.

Publications and resources on male involvement in SRHR, GBV and HIV prevention and gender equality

Engaging Men and Boys in Gender Equality and Health: A Global Toolkit for Action, MenEngage Alliance (Promundo, UNFPA, World Health Organization), <http://www.unfpa.org/public/home/publications/pid/6815>

One Man Can Toolkit, Sonke Gender Justice Network, 2006, <http://www.genderjustice.org.za/one-man-can-toolkit/tools/one-man-can-toolkit>

Programme H: Working with Young Men series, Promundo, 2002, www.promundo.org.br – also available in Portuguese and Spanish.

Promundo, UNFPA, and MenEngage (2010), *Engaging Men and Boys in Gender Equality and Health: A Global Toolkit for Action*, UNFPA: New York

Young Men and HIV Prevention: A Toolkit for Action, UNFPA and Promundo, 2007, www.promundo.org.br – also available in Portuguese and Spanish.

ⁱ Barker, G., Contreras, J.M., Heilman, B., Singh, A.K., Verma, R.K., and Nascimento, M. *Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES)*. Washington, D.C.: International Center for Research on Women (ICRW) and Rio de Janeiro: Instituto Promundo. January 2011. Barker, G., Greene, M., Nascimento, M., Segundo, M., Ricardo, C., Taylor, A., Aguayo, F., Sadler, M., Das, A., Singh, S., Figueroa, J. G., Franzoni, J., Flores, N., Jewkes, R., Morrell, R. and Kato, J. *Men Who Care: A Multi-Country Qualitative Study of Men in Non Traditional Caregiving Roles*. Washington, D.C.: International Center for Research on Women (ICRW) and Rio de Janeiro: Instituto Promundo. March 2012.

ⁱⁱ Clinical services are understood here as services that relate to physiological SRH, such as the testing, diagnosis, and treatment of STIs, erectile dysfunction, and cancers; MMC; contraceptives and condom distribution. Educational outreach and other interventions that go beyond physiological needs are not included within this definition of clinical services.

ⁱⁱⁱ RFSU, or the Swedish Association for Sexuality Education, is a funding partner organization of Sonke. For more information, see their website: <http://www.rfsu.se>.

^{iv} Between 2005 and 2009, the Swedish Association for Sexuality Education (RFSU) implemented a major male involvement project in collaboration with the member associations of the International Planned Parenthood Federation of Kenya, Tanzania, Uganda and Zambia. This project used male involvement as a strategy to improve the SRHR of young people through adoption of safer sexual practices and utilisation of SRHR services. The current Male Involvement Learning Center Initiative project includes Learning Centres in Uganda (with Reproductive Health Uganda) and Zambia (with Planned Parenthood Association of Zambia) and is designed to ensure that good practices and lessons continue to be learned and actively shared to improve SRHR practice. The model for male involvement stemming from these projects (and especially the project document for the Learning Center Initiative) was the foundation for this document, which further operationalizes the model.

^v Adapted from Promundo, UNFPA, and MenEngage (2010), *Engaging Men and Boys in Gender Equality and Health: A Global Toolkit for Action*, UNFPA: New York

^{vi} Klugman, B., L. Treger, et al. (2011). *Sexual and Reproductive Health and Rights: Reviewing the Evidence*, South Africa Department of Health.

^{vii} Sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. Although sexuality can include all of these dimensions, not all are always experienced or expressed. Sexuality is affected by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors. (World Association for Sexual Health, no date)

SEXUAL AND REPRODUCTIVE health has historically mainly been concerned with population control and restricting the behaviour of women. When men don't share the responsibilities or benefits and burdens of sexual and reproductive health, women bear the majority of the responsibility for their own and their families' sexual and reproductive health. This approach exacerbates gender inequalities and leads to poor health outcomes.

This model includes a framework, guidance, and concrete recommendations for building male involvement in sexual and reproductive health and rights. Three intersecting approaches for engaging men to achieve this goal are used: men as clients, men as equal partners, and men as agents of change. Organizations looking to build male involvement in sexual and reproductive health and rights are provided with the tools required to envision, plan, implement, monitor, and evaluate such programmes. The model is intended to improve sexual and reproductive health outcomes for men, women, girls and boys and requires its users to view gender equality as a critical and non-negotiable element of improving sexual and reproductive health.

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