

Sexual And Reproductive Health



The international commitment to engage men in sexual and reproductive health (SRH) and its importance in the context of promoting gender equality was affirmed in the International Conference on Population and Development (ICPD) Programme of Action and in the Beijing Platform of Action in 1994 and 1995, respectively (see Box 1). The commitment to include men in SRH formed part of a paradigm shift from a demographic to a more holistic and rights-based understanding of SRH (UNFPA, 2000; Greene et al., 2006).

This shift entailed rooting programmes and policies in human rights and prioritizing individuals and their needs over demographic goals. In many ways, the HIV epidemic was also responsible for increased attention to how gender and other socio-cultural norms influence men's and women's SRH (UNFPA, 2003).

It is now widely acknowledged that engaging men in SRH programmes and policies is necessary both for their own health and well-being, as well as that of women and children. Furthermore, as discussed in the introduction, engaging men and boys in SRH requires addressing the rigid traditional gender norms and power dynamics that underlie their SRH-related attitudes and behaviours and interactions with partners.

Worldwide, boys and men are raised to believe that to be "real" men they need to be strong and in control—particularly with respect to their intimate and sexual relationships. Sexual experience, frequently associated with initiation into manhood, may be viewed by men and boys as a sign of sexual competence or accomplishment, rather than acts of intimacy (Marsiglio, 1988; Nzioka, 2001).

Indeed, although men and women construct their identity through their sexuality and sexual experiences, societal norms regarding both tend to differ. Having multiple sexual partners, for example, may be seen as proof of manhood. Contraception, in turn, may be considered a "woman's concern".

Research undertaken worldwide finds that between 28 per cent and 59 per cent of unmarried sexually experienced young men have had two or more sexual partners during the last year and, of these, 39 to 68 per cent did not use a condom the last time they engaged in intercourse (Guttmacher, 2003). Because it is often men who wield most of the decision-making power¹⁶, their knowledge and attitude concerning family planning and prevention of STI/HIV can have serious implications for both themselves and their partners.

Norms that promote the idea of men as being self-reliant and invulnerable may make them hesitant or unwilling to seek help for their SRH needs. Research has found that men and boys in many settings (North America, parts of Europe, Latin America and parts of sub-Saharan Africa) may delay seeking help longer than women and girls and often will only do so after they have suffered significant personal consequences (Kutcher et al., 1996; Addis and Mahalik, 2003; Hudspeth et al., 2004).

Health professionals may in turn believe that men are disinterested in information and services and focus their efforts on women (WHO, 2000). These norms and barriers to men's help-seeking behaviour may also discourage men from being involved in their partners' health.

¹⁶ This "control" over reproductive decision-making varies across contexts, and seems to be weakening, particularly among young generations and in contexts where women's levels of education and literacy are increasing (UNFPA 2000).

BOX 1**INVOLVING MEN IN SEXUAL AND REPRODUCTIVE HEALTH:
AN INTERNATIONAL COMMITMENT**

The 1994 International Conference on Population and Development (ICPD) in Cairo called for a rights-based approach to SRH including a recognition of the active role that men can play with regard to childrearing as well maternal health. The ICPD marked the beginning of an international consensus on how gender norms harm both men's and women's health and impede development, and the need for more systematic attempts to address gender norms in programming and policies.

The "family planning approach," which predominated before ICPD, mainly targeted women and prioritized contraceptive use and fertility as indicators of progress. A prominent aspect of this shift to a broader and more rights-based health agenda has been the evolving dialogue about engaging men in health programming and policies. Below are some excerpts from the Programme of Action which specifically address the need to engage men in the promotion of SRH:

"The objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. ICPD Programme of Action (Paragraph 4.25)."

"Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be

included in education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children. ICPD Programme of Action (Paragraph 4.27)."

"In terms of young men and sexual and reproductive health, the ICPD recognizes that the 'health needs of adolescents as a group have been largely ignored' and that the 'responsible sexual behaviour, sensitivity, and equity in gender relations instilled during the formative years (will) enhance and promote respectful and harmonious partnerships between men and women.' ICPD Programme of Action (Paragraph 7.41 and 7.34)."

The 1995 Fourth Conference on Women in Beijing, China emphasized the need to achieve gender equity in order to improve reproductive health. Below are some excerpts from conference documents which specifically address the need to engage men in the promotion of sexual and reproductive health:

"Encourage men to share equally in child care and household work and to provide their share of financial support for their families, even if they do not live with them; 107(c)."

"...facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases; 108 (e)."

"Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to in paragraph 107 (e) above, aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour...108(l)"

A number of factors—socio-economic status, age, religion, race, and ethnicity for example—interact with gender to shape male SRH needs and behaviours. In terms of socio-economic status, poverty and poor employment prospects can undermine the ability of men to fulfil their traditional role as providers—some research has found that men may compensate for this perceived loss of "manhood" by having more sexual partners, or by using violence, including sexual violence (see, for example, Silberschmidt, 2001).

Unemployment may also force men (especially young men) to leave their homes and families in search of work. This separation may prompt some to engage in high-risk sexual relationships (Guttmacher 2003; Yang et al., n.d.). Low socio-economic status may also mean that men have limited access to information and services.

In contrast, there is evidence that education and economic security can have a positive impact on SRH behaviours—for example, lengthier schooling and increased prospects for a better standard of living often result in the postponement of marriage and childbearing to later ages for both men and women. Improved schooling and employment levels among women, in particular, can lead to positive changes not only in the perceptions of gender roles, but also in the actual relationships and dynamics between men and women.

Conversely, other studies suggest that, in some situations, the demands of poverty can also lead to greater flexibility with respect to gender roles: An unemployed low-income man, for example, may take on domestic tasks, including child care, so that his partner can work (Barker, 2000). Youth who migrate to cities for work and live away from

rigid family and community controls may be exposed to alternative and more equitable models of male-female relationships and behaviours.

These contrasting examples underscore the fact that there is no formulaic way in which class or other factors influence gender or SRH—rather, it is a confluence of many factors that vary from individual to individual.

In discussing the linkages between gender and SRH, it is also important to think about how men's SRH needs, vulnerabilities and behaviours change over the life cycle. Although SRH is most often associated with adults and adolescents, the norms of male power and risk-taking that lead to SRH vulnerabilities are taught through socialization that begins in infancy and continues throughout childhood. It is therefore necessary that SRH programmes and policies also consider how to engage both parents and children with messages about gender-equity and the importance of sharing life roles and responsibilities.

During adolescence and youth¹⁷, men's SRH needs and vulnerabilities are influenced by social expectations surrounding their transition from childhood to young adulthood, including sexual debut, marriage, education and work. In Sub-Saharan Africa, Latin America and the Caribbean, and the United States, about 6 to 10 years elapse between the age at which men first have sex and the age at which they first marry. This is a period during

which many men will be unmarried but sexually active—often with more than one partner.

Most men between the ages of 20–24 report having had sex by the age of 20. Comparatively few men in this age range have children, fewer even among men aged 15–19. Many are in school or acquiring work experience or are searching for work, unemployed or working in low-paying jobs. Though young men may have sex with more partners than older men, it is generally more sporadic. In one study undertaken in 17 countries, only one-half of sexually active men between the ages of 15–24 had reported having sex during the last three months (Guttmacher, 2003).

Research has found that peers significantly influence adolescent and young men's behaviours and attitudes particularly with regard to relationships and sex. Surveys have also revealed that adolescent and young men remain largely ignorant of their own or their partner's sexuality, do not discuss health and HIV prevention with partners and have misconceptions about and often limited access to condoms and other contraceptive and prophylactic methods (UNFPA, 2003).

Most men between 25 and 39 years of age have already married at least once and are generally employed. In most countries, employment is seen as a precursor to marriage, without which a man is not considered marriageable. Following marriage, most men will

BOX 3

WHAT IS SEXUAL AND REPRODUCTIVE HEALTH?

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination and violence.

Reproductive health is a state of physical, emotional, mental and social well-being in relation to the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, 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.

SOURCE: WHO TECHNICAL CONSULTATION ON SEXUAL HEALTH, JANUARY 2002



¹⁷ Adolescents are generally defined as those aged 10–19 and youth as those aged 15–24.

become fathers. A study across 10 countries found that 80-90 per cent of men between the ages of 30-39 have married and the vast majority of these have fathered a child (Guttmacher, 2003). Only when they are in their early 30s (in the United States and in Latin America and the Caribbean), and in their mid-50s (in Sub-Saharan Africa), do half of the men surveyed decide that they have had all the children they want. At this point, although many men may remain capable of fathering children, a larger proportion do not want any more children and need the skills and methods to avoid further pregnancies (see Box 6 - Men and Vasectomies, for example).

Almost all men in their 40s or 50s are married while

some are on their second or third marriages. In developing countries only about 1-8 per cent of men in this age range have never had a child and up to 11-18 per cent in industrialized countries (Guttmacher, 2003).

The majority of married men also report that they have had as many children as they want, except those living in Sub-Saharan Africa. As men age, they (and their health care providers) may assume that they no longer have a need for preventive measures and SRH services. However, many older men (and women) may be at risk for STIs/HIV and not realize it. Medical services to treat infertility and impotence or that offer vasectomy and cancer screening also become increasingly important as men age.

BOX 3

WAYS FOR MEN AND BOYS TO BECOME ENGAGED IN SEXUAL AND REPRODUCTIVE HEALTH¹⁸

- Learn about their bodies and changing SRH needs
- Learn how to talk about sex, sexuality and reproduction in gender equitable and open ways; admit when they have doubts and ask questions about them; get the information they need from good sources
- Seek care/getting regular health checkups, including for STIs
- Share responsibility for family planning, contraception and/or prevention of STIs
- Use contraception consistently (when it has been agreed upon by both partners) and support partner's contraceptive use, including male and/or female condoms
- Plan their families and support their partner's use of Maternal and Child Health services as necessary
- Only engage in sexual relations that are equitably negotiated, mutually desired and non-coercive; focused on giving as well as receiving pleasure
- Reject, avoid and try to prevent all forms of GBV including domestic violence, sexual violence, and harmful practices such as child marriage, bride kidnappings, dowry related violence, honour killings, female genital mutilation/cutting and prenatal sex selection
- Understand their partners' needs regarding SRH and sexual pleasure
- Support partners' decisions regarding their own body
- Support and promote sexual education in their communities

WHAT ARE MEN AND BOY'S SEXUAL AND REPRODUCTIVE HEALTH NEEDS?

Worldwide, men report needing accurate, clear, and non-judgmental information, including about the physiology of reproduction, healthy and mutually enjoyable sexual relationships, and skills-building on how to communicate with partners about SRH, protection against STIs, contraception, and condom use. It is important to remember, however, that information needs change over the course of a man's life. For example, before puberty boys need to learn about the physical and hormonal changes that are about to transform their bodies and their sexual and emotional

feelings. Young and adult men also need basic SRH information, as well as a more detailed understanding of their bodies and how to give and receive pleasure. For example, many young and adult men (in some settings) may worry about the quantity and quality of their semen, of which they believe they have a limited supply, and some worry about the size and shape of their sexual organs and about their ability to perform sexually. From an early age, boys and younger men also need the opportunity to build skills to help them resist peer pressure and communicate with their partners

¹⁸ This list is adapted from the programming experiences of EngenderHealth and Promundo and is not meant to be exhaustive.

about personal and sexual matters. Older men also need to learn about the changes their bodies will undergo and learn how to accommodate these so as to continue to enjoy fulfilling sexual relations.

Before becoming sexually active, young and adult men need information about the difference between male and female sexual response cycles, how to communicate mutually about sexual needs and preferences, how to effectively use condoms and other methods to prevent STIs and unplanned pregnancies. A common belief among many young men is that they should "know it all" about sexuality and sex, when in fact they are frequently uninformed or misinformed on these matters.

Data from around the world indicates that only 40 per cent of young men have accurate knowledge about HIV and the proportion of men aged 15–54 who know that condoms can prevent HIV varies widely in developing countries—from 9 per cent in Bangladesh to 82 per cent in Brazil (UNAIDS, 2008; Guttmacher, 2003). It is also important, for example, that men are made aware that HIV is more easily transmitted sexually from men to women than from women to men and that their own high-risk behaviours have implications for the health of their partners and families (Link – See HIV section for more information about how to engage men and boys in HIV prevention).

In addition to information, men also need to learn about how to communicate with their partners about STI prevention and contraception, to use methods correctly and consistently, and to deal with unplanned pregnancies. Men also need access to family planning methods, counselling, testing and treatment for STI/HIV and the support and skills related to voluntary partner disclosure and notification. In some settings, men who become infected with STIs (including HIV) may try to treat themselves, seek care from pharmacists, traditional healers, or others who may not have formal training in the treatment of STIs.¹⁹ Research has found that men might prefer consulting with informal practitioners because they are more affordable and/or because they believe that they are more respectful and less judgmental than private doctors or health care workers working out of family planning clinics (Guttmacher, 2003). Later in this section, strategies for ensuring that health professionals, clinics and other service spaces are more welcoming to men, are discussed.

As previously mentioned, many men may view reproduction and family planning as a female responsibility. This is in part owing to norms that emphasize men's sexuality and undervalue responsibility with regards to reproduction and in part to the fact that most contraceptive methods and family planning

programmes and services are female-centred. Research has shown, however, that many men have an unmet need for family planning (UNFPA, 2000).

It is estimated that between 20–46 per cent of men aged 25–54 in Sub-Saharan Africa and 15–30 per cent of those in Latin America and the Caribbean do not want a child soon or at all but are nevertheless not protected against unplanned pregnancy (Guttmacher, 2003). Furthermore, a large proportion of married men aged 25–39, particularly in sub-Saharan Africa, say that they have not discussed family planning with their partners—highlighting the extent to which lack of communication between partners leads to lost opportunities to meet family planning preferences and needs (UN Millennium Project, 2006).

At the same time, it is important that family planning efforts address the dynamics of a couple's reproductive decision-making (UNFPA, 2000). Men may have their own perspectives and preferences regarding fatherhood and how many children they want and they need to be able to balance these with their partners' preferences and the health benefits of planning pregnancies.

Family planning efforts therefore need to include support and skills building aimed at enhancing communication and negotiation between couples as well as information about, and access to, methods. It is important that couples discuss the number and spacing of children and decide together which contraceptive method (or combination of methods) best meets their needs (see, for example, Box 7 Promoting Men's Use of Condoms and Box 6 Men and Vasectomies).

As men grow older, they need to know about vasectomy, the diagnosis and treatment of infertility, sexual function and dysfunction or cancers of the reproductive system. Throughout the life cycle of men, however, the emphasis needs to be on continued safe sexual practices, including correct and consistent condom use, and an understanding of the potential vulnerabilities that exist in all stages of life, whether a man is married or single.

Finally, it is important to remember that many men are already fulfilling (and in some cases expanding) their roles and responsibilities to engage in loving, pleasurable and life-enhancing sexual relations. They are also avoiding the potentially negative consequences of sexual activity—primarily unintended pregnancies and STIs—despite receiving little guidance or support from peers, services or their communities. These men, too, can benefit from information and services that will help them adapt to their changing needs and circumstances and enhance both their own sexual fulfilment and that of their partners.

¹⁹ In the section on HIV, we discuss in more detail the specific considerations and strategies for engaging men in prevention, care and treatment.

PROGRAMMING FOR ENGAGING MEN AND BOYS IN SEXUAL AND REPRODUCTIVE HEALTH

Historically, most SRH programmes and policies have focused on clinical or service settings. As discussed earlier, however, education and community-level efforts are also necessary to change the behaviour and social norms that stand in the way of promoting SRH.

SRH providers need to be more responsive and spaces more attractive. It is also critical that providers work with men to increase health-seeking behaviours and mobilize peer counsellors and utilize community spaces to promote positive sexual and reproductive behaviours while, at the same time, questioning rigid norms that lead to SRH vulnerability.

GROUP EDUCATION

Most existing SRH education efforts have centred on condom use, STIs, and HIV with relatively little information paid to men, family planning, and sexual health more broadly. Specific topics which need to be addressed include: male and female anatomy, sexual pleasure, sexual dysfunction, STIs, contraceptive methods, consistent and correct condom usage, shared decision-making and communication among sexual partners. Providers should also encourage discussions around diversity of sexual identities and practices.

Group education should offer a space where men can acquire accurate information. Participants should learn how to care for their own SRH as well as that of their partners. They should learn how to better communicate and share decision-making with women concerning a range of issues—such as if and when intercourse occurs, what each partner likes and doesn't like, how many children to have and when and what contraceptive method to use.

In many settings, SRH education can be a contentious and taboo topic—particularly when it involves boys and young men. Parents, family, teachers, religious leaders and policymakers may be uncomfortable talking about it or even supporting the notion that youth have access to SRH-related information or services. These "gatekeepers" may also be unaware of the links between gender and SRH vulnerability and doubt the need for, or utility of, educating young men and boys.

Ongoing advocacy is needed to make sure that men and boys enjoy an enabling and supportive environment. From the very outset, programmers should invite gatekeepers and other partners to participate in, and contribute to, programmes. Whenever possible, programmers should integrate education efforts into health services and social communication campaigns, as well as in school and vocational training programmes.

Schools are a good place to reach large numbers of boys and young men with information about SRH. In many settings, schools already offer health and family life curricula, alongside general information about how to prevent STIs. However, these rarely include critical examinations of gender and sexuality and how these increase the likelihood of acquiring STIs (including HIV), increase the risks of unplanned pregnancy and other SRH-related problems.

To effectively establish, review and adapt curricula requires both advocacy and technical effort. Administrators and educators need to be sensitized to the necessity of including a gender perspective into all programming and to impress upon students the need to take a stand against violence. Programmers should offer students, families, and other stakeholders an opportunity to review material. Images and messages should be vetted to make sure that they do not contain harmful stereotypes while specific activities with respect to gender and masculinity should be added. Moreover, it is important to provide students with an opportunity to ask questions about the SRH issues that really concern them.

In addition to integrating a gender perspective into programming, staff should offer sensitization, comprehensive training and support to school staff, especially for those teachers or other educators who directly implement gender, sexuality and SRH curricula. Many teachers may be unaware of how critical it is to work with boys or young men, or about how to undertake gender and sexuality activities that are appropriate and sensitive. Such training allows teachers an opportunity to examine their own attitudes about gender and sexuality.

Furthermore, many teachers and educators may not possess a great deal of experience with non-didactic

and highly participatory teaching methodologies. Most will need to develop the relevant facilitation skills. Local organizations that specialize in health education using participatory methods can help teachers to learn these techniques. It is essential that peers and students trust sex education teachers. This will minimize the risk of abusive, violent or disrespectful behaviour both on the part of students and of the teachers themselves.

Implementing a gender perspective into curricula should not be an isolated effort. Broader efforts to promote a more gender-equitable school environment should reinforce programming. Schools can be violent places characterized by bullying, abuse, sexual harassment and other violence between students as well as by teachers. School administrators need to establish reporting and sexual harassment policies, and offer instruction to educators about how to be more gender equitable in the classroom, including how to encourage girls and boys to participate in activities traditionally dominated by one sex or the other. School-based efforts should also promote links with local SRH services through referrals, onsite services or other strategies.

Finally, many of the same elements offered in school-based education apply to education efforts with out-of-school youth and adults—particularly the need for participatory activities and well-trained facilitators. Other elements, however, need to be adapted according to a specific context or target group. For example, out-of-school youth and/or working youth and adults will need more flexibility with regards to scheduling sessions. Whenever possible, programmers should try to link out-of-school youth to ongoing school-based SRH

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education efforts in order to try to reintegrate them into the school system.

Services that are welcoming and responsive are more likely to attract male clients. Unfortunately, despite evidence that shows that male involvement results in better health outcomes, health services still tend to exclude men—particularly when it comes to respecting their personal needs and acknowledging that they play a valuable role in childbearing, contraception, and STI/HIV prevention (UNFPA, 2000 ; Kunene, et al., 2004).

Where youth sexuality and reproductive health is a taboo topic, laws and policies may prevent young men and women from accessing SRH services. Even when these services are made available, they often require the presence or authorization of a parent or guardian, thus prohibiting or limiting opportunities for youth to access confidential services.

Men may also resist using services too closely associated with women because they feel staff might be insensitive to their needs. Many men actually prefer to seek assistance from their peers and from local pharmacies rather than through formal health services. They are also more likely to only seek health services in an emergency or when they need to obtain condoms (Barker, 2000; Pearson, 2003). Research conducted by Promundo in Rio de Janeiro, Brazil for example, showed that young men living in low-income neighbourhoods are more likely to use "home remedies" or medicines recommended by colleagues and peers to treat suspected STI symptoms, than to seek out formal health services (Promundo, 2006).

In order to attract men, services should be accessible, welcoming, sensitive to male needs and consonant with existing community values. Programme staff should seek men out where they tend to congregate; and projects must be carefully tailored to meet the special needs of young, low-income, minority, gay and bisexual men. Programmers also need to reach men living with disabilities, and other groups historically marginalized from social and health services.

The good news is that research has shown that accommodating men can be undertaken with low-cost, simple changes. These include changing the clinic layout, shifting hours of service, and either retraining female health workers or hiring more male staff (See Tool "Checklist for Gender Friendly Health Services" in the Introduction).

Services should also be flexible and respond to changing SRH needs. For example, a young man in an unstable relationship will have different needs than a middle-aged married man with two children or an older man

BOX 4

REVIEWING SEXUAL HEALTH CURRICULA

When creating SRH curricula programmers need to consider if images and messages:

- Polarize women and men, and if so: Are men presented as the bad guys and women as passive?
- Address emotional aspects of male sexuality, or do they present male sexuality as primarily physical?
- Present a narrow definition of what it means to be a man?
- Prescribe roles for men that are restrictive or constraining?
- Represent male sexual desire as more potent, more urgent than female sexual desire?

SOURCE: SEX EDUCATION FORUM FACT SHEET 11



dealing with prostate cancer. In addition to making men and boys feel welcome, it is also necessary to inculcate men and boys with more positive views about gender equity and to provide services and activities that help to facilitate more open and equitable communication with partners. Service providers also need to be more open and non-judgemental when it comes to listening to the concerns and needs of men who express sexual behaviour and identities outside of the norm.

An inventory of SRH services geared towards men and boys will include the following categories:

1. Screening:

This involves taking a full medical history—including SRH history that includes STI and HIV screening—substance use and mental health needs; anger management and violence risk screening (See Tool – “Taking a Comprehensive Sexual History”).

2. Information and Counselling:

This involves listening to questions and concerns in a non-judgmental way and providing information and counselling on various topics related to SRH. This includes issues relating to male and female anatomy, the sexual response cycle, genital health and hygiene, basic fertility, sexual pleasure and dysfunction, contraceptive methods, STI and HIV prevention, pre-natal and postpartum care and inter-personal communication skills, condom use and VCT with partners²⁰.

3. Clinical Diagnosis and Treatment:

This is the provision of services and/or referrals for the diagnosis and treatment of problems detected during the screening procedure. This includes STI and/or HIV diagnosis (including anal examination), treatment for impotence, fertility evaluations and vasectomy counselling (Source: UNFPA, 2000).

It is unlikely that any single clinic or agency can directly provide all of these services. Nevertheless it is critical that programmers understand the range of services required and to be prepared to refer clients to services unavailable on-site. Likewise, including SRH care within a broader menu of services is another way to attract men and boys. Offering other types of services can help to reduce the embarrassment or stigma associated with a SRH health or HIV prevention clinic.

For example, in New York City the Young Men's Clinic (see Case Study 3 in the Introduction), primarily provides SRH health-related services, yet, it also provides a range of other services, including general physical examinations, counselling and the treatment of sports injuries and acne. These “other” services allow men to broach more delicate and intimate questions about sexuality, relationships, reproductive health, mental health, and HIV prevention without fear of stigma (Armstrong, 2003).

²⁰ For more information on HIV testing and counselling see the UNAIDS guidelines for service providers at http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf

BOX 5**EXAMPLES OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR MEN²¹**

- An assessment based on SRH history
- Testing, education, counselling and treatment for STIs/HIV
- Listening to and answering questions about sexual function, pleasure and sexual orientation without judgment
- Screening for testicular and penile cancer
- 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
- Information on pre-natal and post-partum care and support
- Care-giving and parenting skills
- Communication and negotiation skills-building
- Sexual dysfunction and impotence services and counselling
- 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

BOX 6**MEN AND VASECTOMIES**

Because vasectomy services are not widely available many men are unaware of their existence and of how simple the procedure is. Indeed, the procedure is extremely rare in all but a few industrialized countries and in China (Guttmacher, 2003).

Common misperceptions about the effect of vasectomy on sexual function may also discourage men from considering the procedure despite the fact that it offers many advantages. Chief among these is that it is simpler and more

cost-effective than female sterilization, offers men a convenient, effective form of contraception that they control and most importantly, allows them to share responsibility for family planning. Nevertheless, despite these advantages, vasectomy continues to be underutilized as a family planning method.

SOURCE: LANDE AND KOLS, 2008

As discussed earlier, engaging men and boys at the service delivery level means that staff need to be prepared. Many providers have little or no experience working with men and/or issues related to SRH. Moreover, traditional medical training often emphasizes technical knowledge but not necessarily an understanding of issues such as power relations between and among men and women and the various, interpersonal and societal factors that influence SRH decision-making and behaviours.

A simple needs assessment (See Tools "Needs assessment questionnaire for Health Facilities Staff")

can help to identify the degree to which staff are committed and prepared to work with men. All should receive the requisite training as to why it is necessary to work with men as well as an opportunity to deconstruct their own gender beliefs—including assumptions about heterosexuality being the only (acceptable) norm, and how these can affect their professional interactions with men and boys.

Staff should also try to move beyond stereotypes that frame male sexuality as irresponsible, uncontrollable or predatory. These limit the extent to which health professionals are able to reflect critically on, and address

²¹ This list is adapted from programming experiences of EngenderHealth and Promundo and is not meant to be exhaustive.

the specific SRH needs of men. It is also important to provide training and support culturally appropriate care because there may be particular sensitivities related to sexuality and reproductive health among men from different backgrounds.

Furthermore, staff should also be trained to actively encourage or “recruit” men to use services. Many

men, for example, will often accompany their partners to clinics but may be too shy themselves to actually approach the staff or to ask questions. Peer educators who are available to engage men in the waiting room and the presence of targeted materials can help overcome their hesitation. As discussed below, campaigns and other community-based activities can also play a key role in attracting men to services.

BOX 7

PROMOTING THE USE OF CONDOMS AMONG MEN

When used consistently and correctly male condoms are effective against STIs and unplanned pregnancies. Because many men access health services specifically to obtain condoms, it is critical that health providers take advantage of this opportunity to provide accurate information and education with respect to condom use, as well as to provide materials and information about SRH and other available services.

Many sexually active men—particularly young men—are concerned with unplanned pregnancy. Health professionals and educators should promote condom use in the context of dual protection—that is, emphasizing that condoms are suitable both as a birth control method as well as a prophylactic against STIs and HIV.

Too often, healthcare providers only target women with information about condoms and other forms of family planning. Because of their relative powerlessness many women are unable to discuss contraceptive or prevention methods with their partners. It is therefore essential to develop strategies that specifically raise male awareness and encourage them to take the initiative, given that women may not be able to discuss contraception and SRH issues with their partners.

Condoms should be easily available—within clinics, schools, youth centres, sports clubs, and pharmacies. In some countries, male condoms are distributed for free through the public health system. However, free distribution does not necessarily mean free condoms. Many men report indirect costs, including long waiting lines, bureaucratic paperwork, and unpleasant interactions with judgmental or unfriendly staff.

Men need to feel comfortable coming to the clinic or health post for condoms. If they do they are more likely to return when they require other services. Confidentiality (not having to provide personal information just to retrieve condoms), speed of service, and respect are paramount.

Unlike women, men generally have a very limited range of contraceptive options. Offering a variety of condoms can help motivate men's uptake and can show clients that staff are truly dedicated to promoting condom use and other healthy behaviours (Hancock, 2004). If possible, services should provide a broad variety of condoms for distribution (different flavours, sizes, textures, etc.). Lubricants should also be offered alongside information about how to use condoms in ways that will augment pleasure and enhance satisfaction.

Services providers should demonstrate how to use condoms and provide male clients with an opportunity to improve communication and negotiation skills. It should not be assumed that every man knows how to use a condom—indeed; a very significant proportion of men may not have any sexual or reproductive health education whatsoever.

Staff should also be encouraged to speak to men about the female condom. The female condom is a polyurethane sheath or pouch, which lines the vagina and, like the male condom, it helps to prevent pregnancy, STIs and HIV. It is slowly becoming more widely available in most countries and can enhance both partners' pleasure as well as contribute to their safety. The female condom can also generate discussion about equitable roles and decision-making within the context of intimate male-female relationships.

BOX 8

A TRAINING CURRICULUM ON MEN'S REPRODUCTIVE HEALTH SERVICES

Engender Health, an international NGO, developed a three-part curriculum to provide a broad range of health care workers with the skills and sensitivity needed to work with, and to provide, reproductive health services to male clients. The first part of the curriculum is designed to assist health organizations and health care workers to overcome organizational and attitudinal barriers that may exist when initiating, providing, or expanding reproductive health services and programmes targeting men. It also provides basic information about a variety of reproductive health issues relevant to men. These include sexuality, gender, anatomy and physiology, contraception, and STIs.

The second part of the curriculum focuses on strengthening service provider ability to communicate with and counsel men about SRH issues –with or without their partners.

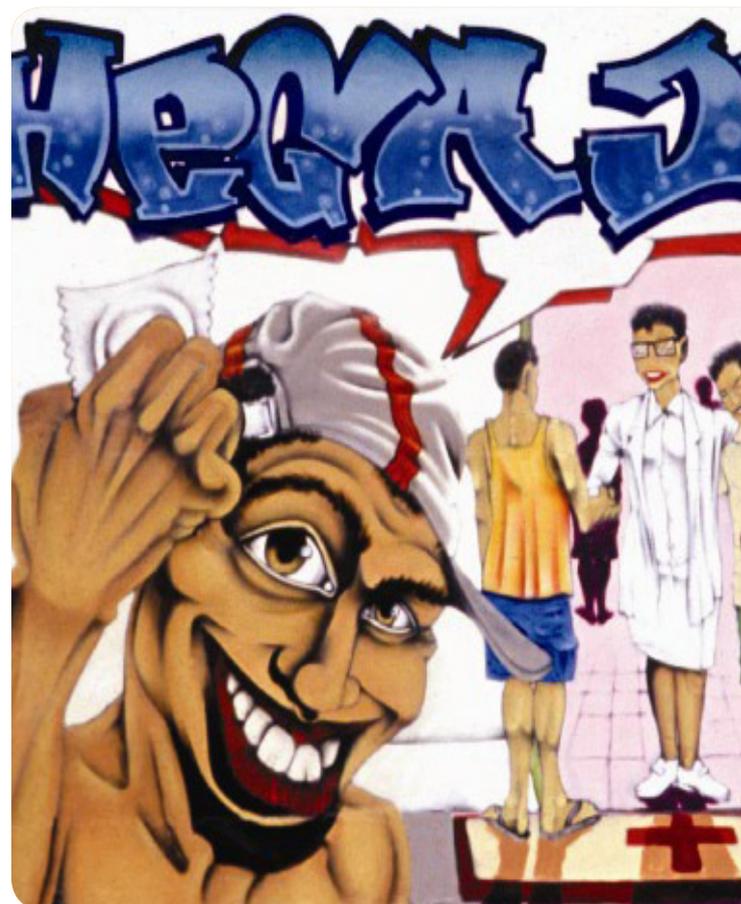
The final section provides information about diagnosing and managing reproductive health disorders in men. Topics include disorders of the male reproductive system, including infertility and STIs; SRH history assessment; and step-by-step instructions for performing a genital examination.

TO DOWNLOAD THE COMPLETE CURRICULUM (ENGENDERHEALTH. 2008. INTRODUCTION TO MEN'S REPRODUCTIVE HEALTH SERVICES - REVISED EDITION: TRAINER'S RESOURCE BOOK. NEW YORK), VISIT ENGENDERHEALTH'S WEBSITE: [HTTP://WWW.ENGENDERHEALTH.ORG/PUBS/GENDER/MENS-RH-CURRICULUM.PHP](http://www.engenderhealth.org/pubs/gender/mens-rh-curriculum.php)

CAMPAIGNS AND COMMUNITY MOBILIZATION

The degree to which service-level and education efforts are successful is linked to the extent to which positive messages about male involvement in SRH are also disseminated and absorbed at community and societal levels. Campaigns, for example, can encourage men to seek out SRH information and services and can also help to advertise what services are available and where. For out-of-school young men and other marginalized groups (see Case Study 1, for example), community-level efforts may in fact serve as the primary vehicle for SRH information and available services.

Influential public figures and community gatekeepers, such as religious leaders, can play an important role in campaign and community mobilization. As described in Case Studies 2 and 3, religious leaders can leverage their influence to promote positive messages about male engagement in SRH and encourage men and their partners to seek counselling and services for issues related to sexuality, relationships, marriage and parenting. Campaign and community mobilization efforts can also help to overcome men's fear and/or indifference and emphasize the importance of taking care of their health, as well as that of their partner.



CASE STUDY 1

COME ON IN!: ATTRACTING YOUNG MEN TO SERVICES IN RIO DE JANEIRO

(PROGRAM TYPE: GENDER SENSITIVE)

The above poster was part of a project to increase young men's use of health services in low-income communities in Rio de Janeiro. The picture and message is intended to deconstruct the idea that health posts are only for women and children or only for the sick. The picture depicts a young man being greeted at the door to a community health post and the message describes the post as a place where young men can ask questions,

take care of themselves and get condoms. The poster incorporates local cultural expressions including graffiti art and slang. It was painted as a mural on one of the outdoor walls of a community health post and printed on postcards which were distributed at community activities along with informational materials on available services.

FOR MORE INFORMATION: WWW.PROMUNDO.ORG.BR



CASE STUDY 2

TOGETHER FOR A HAPPY FAMILY, JORDAN

(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

Jordan's 'Together for a Happy Family' was an integrated campaign, which sought to mobilize males to support shared and informed decision-making about family planning with their wives.

The campaign promoted five main messages:

1. Men should discuss family planning with their wives;
2. Using family planning is consistent with Islam;
3. Modern family planning methods are safe, effective, and reversible;
4. Male and female children are of equal value;
5. Using modern family planning methods enhances the quality of life of the entire family.

The campaign enlisted religious leaders and Jordan's royal family prior to the campaign launch and throughout its implementation. To show his support, His Majesty King Abdullah agreed to have a photo of the royal family on the cover of nationally distributed family planning calendar. The Prime Minister and cabinet ministers also appeared at major public events while Islamic scholars wrote booklets informing readers that using family planning is consistent with the teachings of Islam.

Campaign messages were disseminated via three main channels—the mass media, community mobilization, and a national contest. TV and radio spots aired during prime time and featured religious leaders espousing support for 'Together for a Happy Family'.

Religious leaders discussed campaign themes during family programmes on TV and radio, responded to questions from the audience, and wrote newspaper articles in support of the campaign. Through major daily newspapers, the campaign launched a National Family Planning Contest, and offered a grand prize to motivate families to talk about family planning and to seek out more information.

To mobilize local communities, project staff trained teams of physicians, religious leaders, and social workers to discuss campaign themes with community leaders. These further disseminated campaign themes by discussing them with family, friends, and community members. A subsequent evaluation showed that Jordanian men and women reported improved knowledge regarding specific modern family planning methods and greater support for shared family planning responsibility.

SOURCE: JHU/CCP COMMUNICATION IMPACT, JAN 2003, NO 14. [HTTP://WWW.JHUCCP.ORG/PUBS/CI/14/14.PDF](http://www.jhuccp.org/pubs/ci/14/14.pdf) ACCESSED JANUARY 2010

CASE STUDY 3

THE MALE MOTIVATION

CAMPAIGN, GUINEA

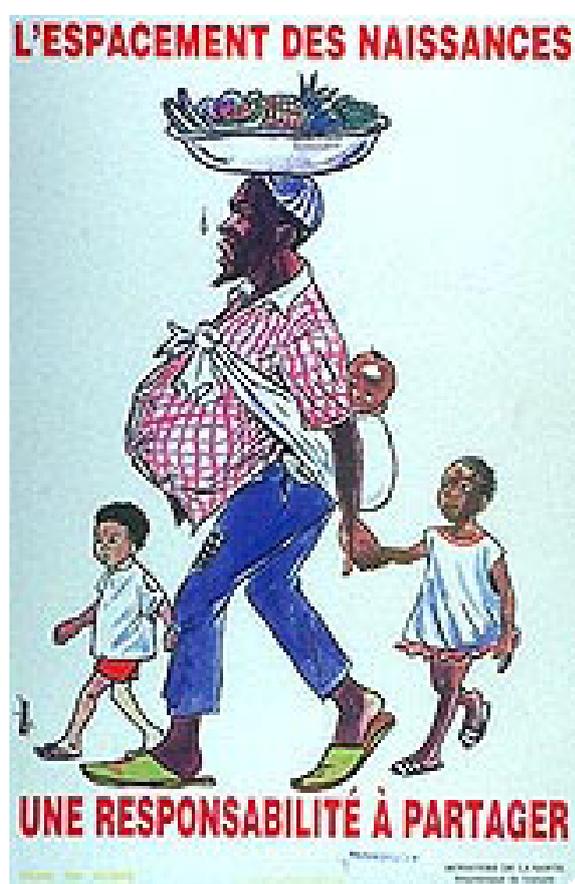
(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

The Male Motivation Campaign in Guinea sought to increase men's involvement in family planning. The first phase of the campaign included intensive advocacy work with religious leaders to attempt to gain social support for family planning. The second phase focused on married men and was designed to motivate them to talk to their wives about family planning and encourage them to use

available services. This latter phase included community mobilization and media activities, including the release of a short cassette and the broadcast of a short radio drama, which featured a popular local comedian who portrayed one husband's difficulty discussing family planning with his wife (Blake and Babalola, 2002).



TRANSLATION: CONTRACEPTION - A COUPLE'S BUSINESS



TRANSLATION: BIRTH SPACING - A SHARED RESPONSIBILITY

TOOLS

Education: Checklist for positive gender-equitable sex education for boys and men

Education: Understanding Sexuality

Services: Men's Reproductive Health Wall

Services: Values Clarification Exercise for Health Service Professionals