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# ENGAGING MEN

Lessons from programmes promoting the involvement of men to improve health outcomes for women, children and men

VSO

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This paper considers the role of men and boys in improving their own health outcomes, their role as partners and fathers, and their role as change agents within the community and wider society. It draws on case studies from programmes in Sierra Leone, Zimbabwe, Mozambique and Papua New Guinea.

# INTRODUCTION

## Two areas of focus for VSO's health programming include:

- Maternal and newborn health
- Adolescent and youth sexual and reproductive health and rights

Programming in these areas has traditionally focused on women and girls, identifying their needs, raising their awareness, changing their behaviour and empowering them with the aim of improving health outcomes.

In 1994, the International Conference on Population and Development[1] highlighted the significance of gender and gender inequalities in reproductive health. This acted as a catalyst for considering the role that men and boys play and this, in turn, led to some small-scale programming by a number of agencies[2], which focused on challenging unequal power dynamics and transforming harmful forms of masculinity with the aim of improving reproductive health outcomes for men and women.

There is a common concern that programming directed towards men diverts scarce resources away from women and girls however it is important to remember that female vulnerabilities are rooted in gender roles and norms, which support men to maintain a disproportionate share of the decision-making and control of resources. Male engagement programmes aim to promote a change in gender power dynamics which influence women's lives.

Women still remain the primary focus of programming in maternal and newborn health and sexual and reproductive health because of their physiology and their social roles. There is, however, a growing body of evidence to indicate that engaging men and boys in programmes can result in a significant increase in support for and actual use of contraception which can in turn result in positive family planning[3], reduction in HIV and STI transmission[4] and reduction in preventable maternal and child deaths.[5] There is also evidence to suggest that programmes that promote shared responsibility and decision-making can be effective in challenging gender norms. Furthermore synchronising male engagement with programmes that promote the empowerment of women even if they are not part of the same programme can result in greater health and gender benefits as the impacts can build on each even if conducted separately.[6]


[1]International Conference on Population and Development. United Nations Population Fund. http://www.un.org/popin/icpd/conference/ offeng/poa.html. Published 1994. Accessed 19 October 2018. [2]Eg. Promundo, EngenderHealth and UNFPA [3]Hardee, K. Croce-Galis, Gay, J. Men as Contraceptive Users: Programs, Outcomes and Recommendations USAID WORKING PAPER SEPTEMBER 2016 [4]PEPFAR 2012. PEPFAR Blueprint: Creating an AIDS Free Generation. The Office of the Global AIDS Coordinator. https://www.pepfar.gov/documents/organization/201386. pdf. Published 2017. Accessed 19 October 2018. [5]https://www.usaid.gov/sites/default/files/documents/1864/USAID_2017_AOTC_final.pdf Accessed 19 Oct 2018 [6]Engaging men and boys in gender equality and health Promundo, UNFPA, and MenEngage (2010) https://www.unfpa.org/sites/default/files/pub-pdf/Engaging%20Men%20and%20Boys%20in%20Gender%20Equality.pdf Accessed 22 Oct 2018

# AIM OF THIS PAPER

**This aim of this paper is to reflect on good practice in engaging men and boys in health programming, drawing on evidence from VSO's experience to date, documented through evaluations and case studies[7], and supporting this with a wider document review.**

It is useful, for the purpose of this paper, to use an ecological framing which focuses on the determinants of health and interventions at the individual, interpersonal, community and societal/population level[8]. Figure 1 below has been adapted from ecological systems theory and social ecological models intially developed by the Chicago School[9] and further developed by Bronfenbrenner who focused on a system approach to understanding human development[10]. Programmes working across the different levels provide greater opportunity for supporting sustainable change on health behaviours and gender transformation.

Using this framework this paper therefore considers the engagement of men:

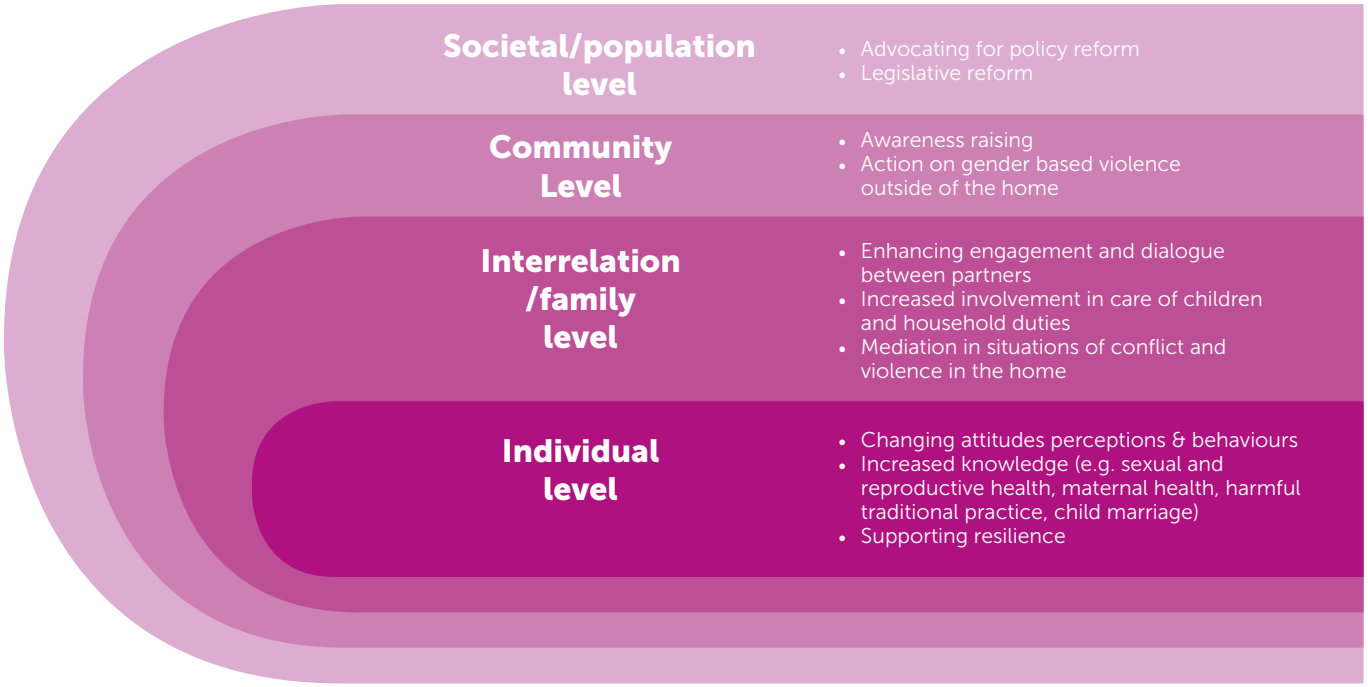
**In their own health and wellbeing**[11]

**As partners and fathers**[12]

**As agents of change within the community and wider society**[13]

Whilst each of these components is separately important, they should not be implemented alone. All three are essential to ensure successful and equitable sexual and reproductive health outcomes.

**Figure 1: Adaption of ecological systems theory model for male involvement**




[7]For all VSO examples fieldwork has been carried out which has involved data collection with a range of stakeholders
[8]McLeory, KR. Bibeau, D. Steckler, A. Glanz, K. An ecological perspective on health promotion programs. Health Educ Q 1988 Winter; 15(4): 351-77
[9]Emerging in the 1920s and 1930s specialising in urban sociology and later criminology bridging the gap between behavioural and anthropological theories
[10]Bronfenbrenner, Urie (1989). "Ecological systems theory". In Vasta, Ross. Annals of Child Development: Vol. 6. London, UK: Jessica Kingsley Publishers. pp. 187–249
[11]Sperm by HeadsOfBirds from the Noun Project
[12]Husband listening to Baby in Wife Womb by Gan Khoon Lay from the Noun Project
[13]Gender Equality by Paul Verhulst from the Noun Project

# MEN'S OWN HEALTH AND WELLBEING

## General health

In most parts of the world men generally enjoy more opportunities, privileges and power than women, yet these multiple advantages do not translate into better health outcomes. Health outcomes for men and boys are typically substantially worse than for women and girls[14 15] with evidence that the gap in life expectancy between men and women is increasing.[16 17] A key reason for this is that men are less likely to visit a doctor when they are ill and, when they see a doctor, are less likely to report on the symptoms of disease or illness.[18] A number of studies have also shown that men are less likely to get tested for HIV and are more inhibited coming to terms with an HIV positive status than women, less likely to access ART, more likely to start ART later in the disease course than women and more likely to not adhere to treatment regimes.[19] Men are also more likely to commit suicide[20] and are more likely to have higher rates of exposure to tobacco and alcohol which influence poor health outcomes.[21]

If men are encouraged and supported to seek care, the benefits can extend beyond their own health, as enhanced health knowledge can translate into increased motivation and concern for the health and wellbeing of their partners and families.

## Sexual and reproductive health and rights

Men have significant sexual and reproductive health needs, including the need for contraception, prevention and treatment of HIV and other sexually transmitted infections, sexual dysfunction, infertility and male cancers.

Table 1 below shows years of life lost to SRH ill-health among men and boys using global male disability-adjusted life years (DALYs)[22]

**Table 1 - Years of life lost to SRH ill-health among men and boys using global male disability-adjusted life years[23]**

| | |
|---|---|
| HIV | 48 million (almost 44 million for females) |
| Sexually transmitted infections (other than HIV): | close to 5 million (over 5 million for females) |
| Prostate cancer | almost 6 million |
| Infertility | almost 1 million |

These needs are often unmet due to a combination of factors, including a lack of service availability, poor health-seeking behaviour among men, health facilities often not considered "male-friendly," and a lack of agreed standards for delivering clinical and preventative services to men and adolescent boys. Norms that promote the image of men as being self-sufficient and invulnerable also cause hesitation and delay in seeking help.[24]

In order to overcome these issues, care must be safe, effective and reliable, acceptable/client-centred, timely, efficient and equitable.[25] Services must be available, accessible and acceptable[26] and clients have the right to information, choice, privacy and confidentiality, dignity and comfort, and continuity of services and consistent professional medical opinion.[27]

[14]Sex-disaggregated data show that, globally, men have a shorter life expectancy (4.4 years less in 2016 (Global Health Estimates 2016: Life expectancy, 2000–2016. http://www.who.int/gho/mortality_burden_disease/life_tables/en/ Geneva, World Health Organization; 2018.),
[15]Men have a three times higher disability-adjusted life y). GBD Compare. Data (Visualization Hub. http://vizhub.healthdata.org/gbd-compare
ear (DALY) burden than women (Seattle: Institute for Health Metrics and Evaluation. Seattle, University of Washington, 2016).
[16]Wang H, Dwyer-Lindgren L, Lofgren KT, Rajaratnam JK, Marcus JR, Levin-Rector A, et al. Age-specific and sex-specific mortality in 187 countries, 1970–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet. 2012;380:2071-94.
[17]Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, et al. Global Health 2035: a world converging within a generation. Lancet. 2013;382:1898-955.
[18]UCL Institute of Health Equity [Internet]. Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: World Health Organization, Regional Office for Europe; 2013. Available from: http://www.instituteofhealthequity.org/projects/who-european-review [cited 2014 Feb 21].
[19]Cornell M, McIntyre J, Myer L. Men and antiretroviral therapy in Africa: our blind spot. Trop Med Int Health. 2011;16:828-9.
[20]WHO (2016) male to female suicide ratio of 1.8 http://www.who.int/gho/mental_health/suicide_rates_male_female/en/
[21]http://www.who.int/news-room/fact-sheets/detail/gender
[22]DALY is the summary measure used to give an indication of overall burden of disease. One DALY represents the loss of the equivalent of one year of full health.
[23]World Health Organization. Global Health Observatory Data Repository: Disability-adjusted life years (DALYs), 2000- 2012.
[24]Addis, M.E. and Mahalik, J.R (2003) Men, masculinity and the contexts of help seeking. American Psycologist, 58 (1): 5-14
[25]Institute of Medicine (2001) Crossing the Quality Chasm: A New Health System for the 21st Century; WHO (2006) Quality of Care: A process for making strategic choices in health systems.
[26]UNFPA and World Health Organization (2015) Ensuring human rights within contraceptive service delivery Implementation guide.
[27]IPPF Integrated Package of Essential Services Quality of Care Toolkit

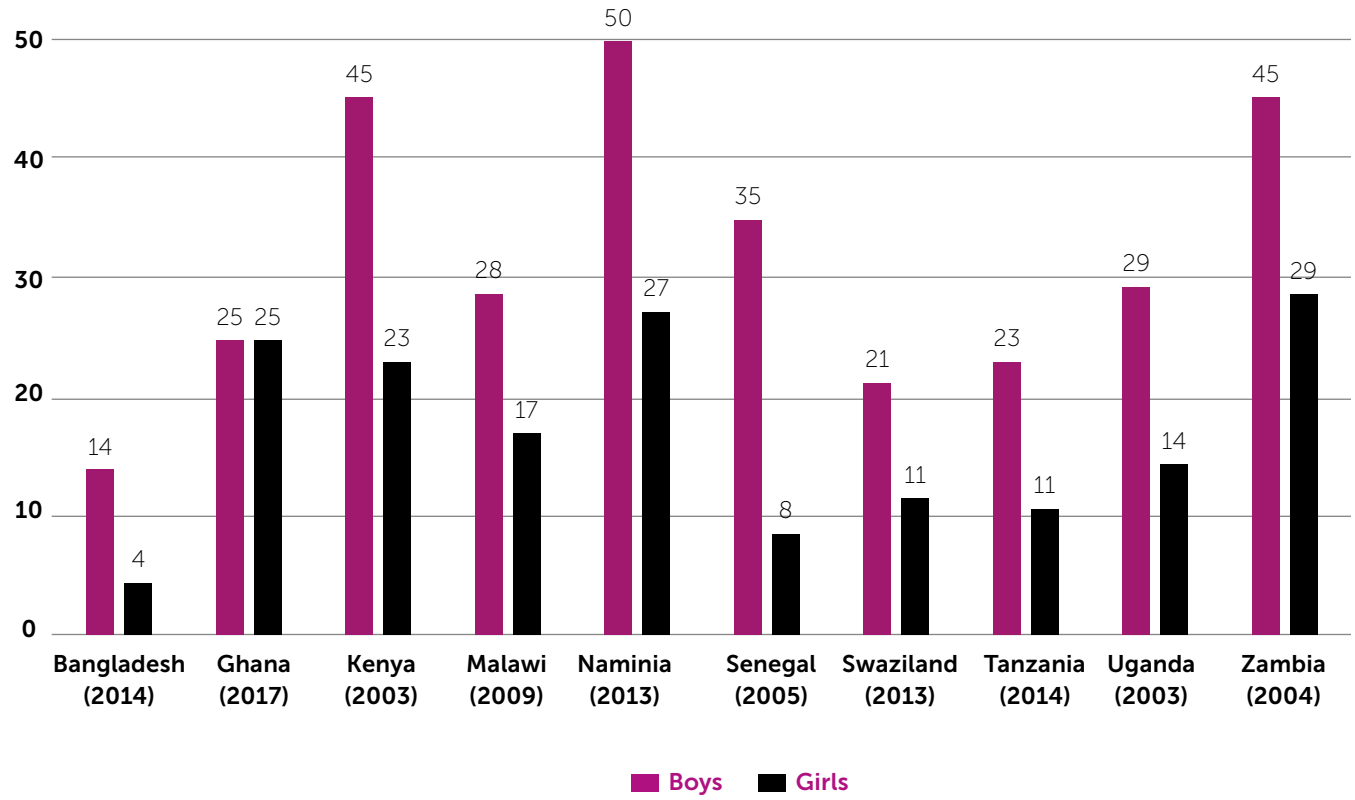
# MEN'S OWN HEALTH AND WELLBEING

Well-implemented gender-transformative approaches at the community level with men can bring about significant changes in their attitudes and practices related to gender, SRH and HIV, improving not only the wellbeing of women and girls, but of men and adolescent boys themselves.[28]

Studies show that a substantial proportion of youth, especially boys, are sexually active before the age of 15 as shown in figure 2[29] which highlights that a higher percentage of boys aged 13-15 consistently engage in earlier sexual debut than girls of an equivalent age.

Research on sexual debut has tended to focus on girls and far less is known about the health and wellbeing impacts of early sexual debut on boys. However there is some evidence to suggest that boys experiencing sexual debut under the age of 15 are more likely to report risky behaviours at first sexual experience such as not using a condom, having a casual partner and not feeling ready to have sex.[30] It is therefore important that programmes do not just target older men but also consider how to engage boys and young men.

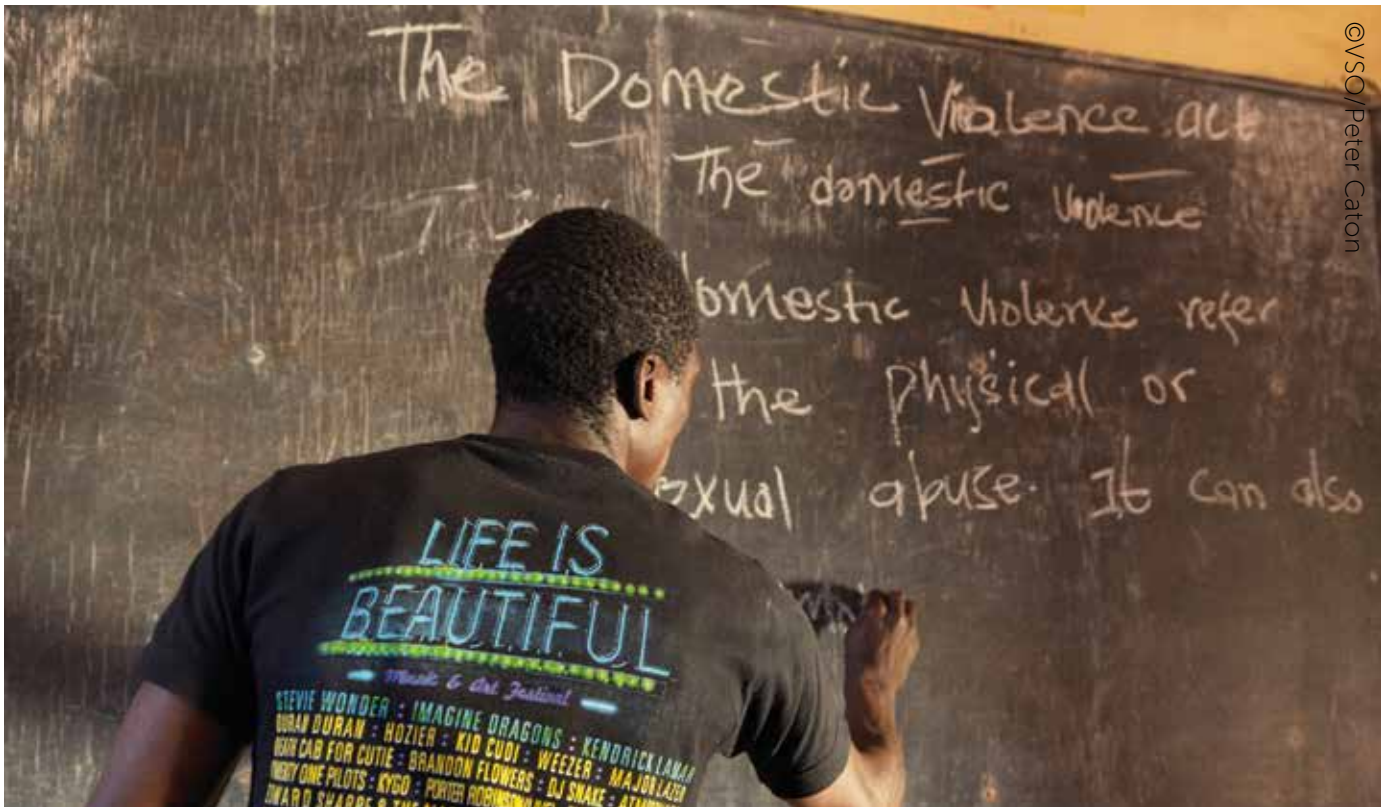
**Figure 2: Proportion of students aged 13-15 who reported ever having sexual intercourse by gender**




[28]WHO (2007) Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions; IPPF (2010) Men are Changing: case study evidence on work with men to promote gender equality and positive masculinities; IPPF (2013) Gender, Masculinities & Sexual Health in South Asia: IPPF South Asia Region.

[29]Data taken from Vanessa Woog and Anna Kågesten, "The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10–14 in Developing Countries: What Does the Evidence Show?" (2017), https://www.guttmacher.org/sites/default/files/report_pdf/srh-needs-very-young-adolescents-report_0.pdf. Accessed on 23 Oct 2018

[30]Harrison, A. Cleland,J. Gouws, E, Frohlich, J (2005) Early sexual debut among young men in rural South Africa: heightened vulnerability to sexual risk? Sex Transm Infect 2005;81:259–261. doi: 10.1136/sti.2004.011486



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## Interventions to improve men's health

**It has been argued that public and policy action to improve men's health should have three areas of focus:**

- Schools to challenge stereotypes about masculinity
- Workplaces to promote men's health and wellbeing
- Health services and health promotion towards marginalised men, such as men in prisons and men who have sex with men, as they have a higher burden of disease and early death than other men.

Group education is viewed as an important component as it can create a space for dynamic discussion within a safe environment where men and boys can critically reflect on their attitudes and behaviour linked to gender norms, relationships, and health. It is important that group education does not tell participants how they should and should not behave, but rather encourage them to analyse and question their own experiences and explore factors that inform their decision-making. Bringing men of different ages and backgrounds together can provide a valuable educational opportunity. However, it will be important that they also have spaces to focus on concerns and experiences that are relevant to their particular identity, context and situation.

Promoting increased accessibility, acceptability, and use of male family planning options has the potential to increase use of modern contraceptives, increase healthy timing and spacing of births and improve health and wellbeing for men, women, and children. Increasing demand for and use of male contraceptive methods requires raising awareness and combatting common misconceptions that those methods decrease virility or sexual pleasure.

Men need access to accurate, clear and unbiased information in appropriate formats to increase their awareness and knowledge about health. It is important that information is developed in partnership with representatives from the target audience to maximise the chances of appropriateness and relevance. Interventions to raise awareness may need to be undertaken through outreach services at locations that men frequent such as sports grounds, schools, community centres, workplaces and bars.

Male peer educators, mentors and navigators can also play an important role in raising awareness about health issues and supporting men to access services. In some cases peers may work with men on a one-to-one basis, especially when working with more marginalised groups and/or supporting service access. In other types of work peers may work with groups of men to support educative activities.

[31]White A, McKee M, Richardson N, de Visser R, Madsen SA, de Sousa BC. Europe's men need their own health strategy. BMJ. 2011;343:d739.
[32]Peer education interventions: Improving health outcomes through people centred development- the use in VSO health programmes (VSO)

# CASE STUDY 1

## Facilitating dialogue, promoting awareness and challenging gender norms in schools through boys clubs

**Kenema District, Sierra Leone**

### Programme outline

VSO works in partnership with FINE (Fambul Initiative Network for Equality) Sierra Leone on a project that aims to encourage men to change their attitudes and behaviours in order to make life safer for women and girls. Work began with adults in the community but a decision was made to extend this work to schools to target boys. Boys clubs have been established in nine schools in the district and additional work is also done with out of school youths. The aim of this work is to foster learning and promote attitude behaviour change with young men before they become adults.

### Programme learning

Members of the boys club said that it has provided them with an opportunity to learn, challenge their own attitudes and inspire others. They now recognise the consequences of early sexual debut and discuss this with peers whilst also providing information about safe sex and contraception. Boys have also become advocates in school settings for the prevention of teachers abusing girls in return for favourable grades. Teachers and youth workers reported a reduction in teenage pregnancy, a reduction in truancy, increased engagement in community projects, improved confidence and self-esteem amongst boys and improved interaction between boys and girls.

"Previously boys in class didn't want to interact with girls, they separated themselves and displayed discriminatory attitudes towards them. Now there is more positive interaction between them"

**Teacher**

# CASE STUDY 2

## Peer educators promoting treatment and testing for men who have sex with men

**Madang, Lae and Morobe, Papua New Guinea**

### Programme outline

This project was funded by Global Fund and Oil Search and ran from June 2016 to Dec 2017. It aimed to increase awareness and testing of key populations. Men who have sex with men worked as peer educators to target this key population. The main tasks for the peer educators were outreach and awareness-raising on HIV, STIs and TB, condom demonstrations, condom distribution and referrals and accompaniment to local clinics for testing. Some sensitisation work was also carried out with local gatekeepers, which includes police, clinicians and community leaders. Outreach took place in hotspot areas which are local areas, often markets, which are known as hubs for transactional sex. Each peer educator worked in a geographically specific location which is within a locality in which they live.

### Programme learning

The project reached marginalised groups with multiple and complex needs. These needs were amplified by stigma and discrimination from families, service providers and the broader population and in many cases experiencing homelessness and the threat of violence. The peer educators played a key role in facilitating the work of this project to reach men who have sex with men as they act as a bridge to support access to services. The numbers of people being tested and screened was reported to have increased in all three clinics and one clinic specified that a high number of referrals coming through the project had reactive HIV tests. The peer educators also often played a role in helping to track patients who have had a reactive HIV test and had not come back for treatment and also those who were not adhering to treatment.

# CASE STUDY 3

## Promoting and supporting testing and treatment in a prison environment with through peer educators

**Chikurubi maximum security prison, Zimbabwe**

### Programme outline

Prison populations have a high incidence of HIV and TB and low treatment uptake. Chikurubi Maximum is the largest prison in Zimbabwe, averaging 2,600 inmates with many classified as high-risk, serving long sentences; 17% of the prison population is HIV positive. Funded by SDC and the Big Lottery, VSO has trained 178 peer educators within the prison and established seven support groups. The peer educators provide information on HIV and TB and encourage testing and support treatment adherence. The support groups provide psycho-social support and coping mechanisms to manage TB/HIV, poor living conditions, and stresses of separation from family.

"I have seen a growth in imparting knowledge and it has improved things socially, medically and psychologically"

**Inmate**

"Early in the morning I check all of the inmates in my cell. If someone is not well I take them to the hospital. If they can't walk we carry them."

**Peer Educator**

### Programme learning

This approach has resulted in risk reduction of STIs, TB, HIV and AIDS transmission for inmates through prevention, ART adherence, care and support, increased knowledge, attitudes and behaviour change. Formal training and informal peer-to-peer interactions, have reached over 90% of inmates with 27,062 referrals made to the prison hospital in 2017 (2,250 referrals per month). ART adherence improved from 50% in June 2015 to almost 100% in February 2017. The prison recorded a significant reduction in prisoner deaths from 50 in 2015 to eight in 2017, which was considered to be influenced by improved ART adherence, improved awareness, peer support and role of support groups. The peer educators support bedridden inmates through cell-based care; bed baths, feeding sick peers, administering prescribed medication and offering counseling support and encouraging ART adherence. These activities have also enhanced accountability from the prison system and empowered inmates to demand quality health services from the prison authorities. This model has also contributed towards greater inclusion of prisoners from key populations

# CASE STUDY 4

## Engaging young men in conversations about sexual and reproductive health and rights through male champions and peer educators

**Masvingo province, Zimbabwe**

### Programme outline

The GENDER (Gender Empowerment and Development to Enhance Rights) project started in December 2013 and had a life span of four years. It operated at both a community and a policy level across six countries in southern Africa to improve SRH outcomes. In the cost extension, during the final year the project, it adjusted its targeting and design in Zimbabwe to place a greater emphasis on engaging men and boys. It trained male peer educators in schools and also recruited male champions who were older men in the community.

> "People now want to learn from you as a male champion, you actually get into the community and find boys, girls and young women waiting to ask you SRHR questions"
>
> **Male champion**

### Programme learning

Male peer educators were able to cascade SRHR information quickly in schools and peers were influenced to go and get tested for HIV and STIs and reported using protection whenever they engaged in sexual activities. Peers within schools also helped in highlighting the dangers of drugs and alcohol which impairs judgement and indirectly affects SRHR decisions. This awareness has resulted in reduced cases of drug abuse within schools, increased use of protection during sex and boys accessing STI screening and HIV testing services at their nearest health centres. The involvement of male champions at the community level helped to fill a gap created by urbanisation and the breakdown of the extended family. Uncles used to play an important role in passing on SRHR information to the next generation and the male champions have helped to fill this gap providing up-to-date and accurate SRHR information. Boys within communities have opened up on SRHR issues and the champions have referred them to appropriate health services. The male champions have also played a significant role in engaging traditional leaders and religious leaders within their communities on the dangers of early marriages. This has led to traditional leaders in Nyamande imposing fines and penalties to families that practice child marriages.

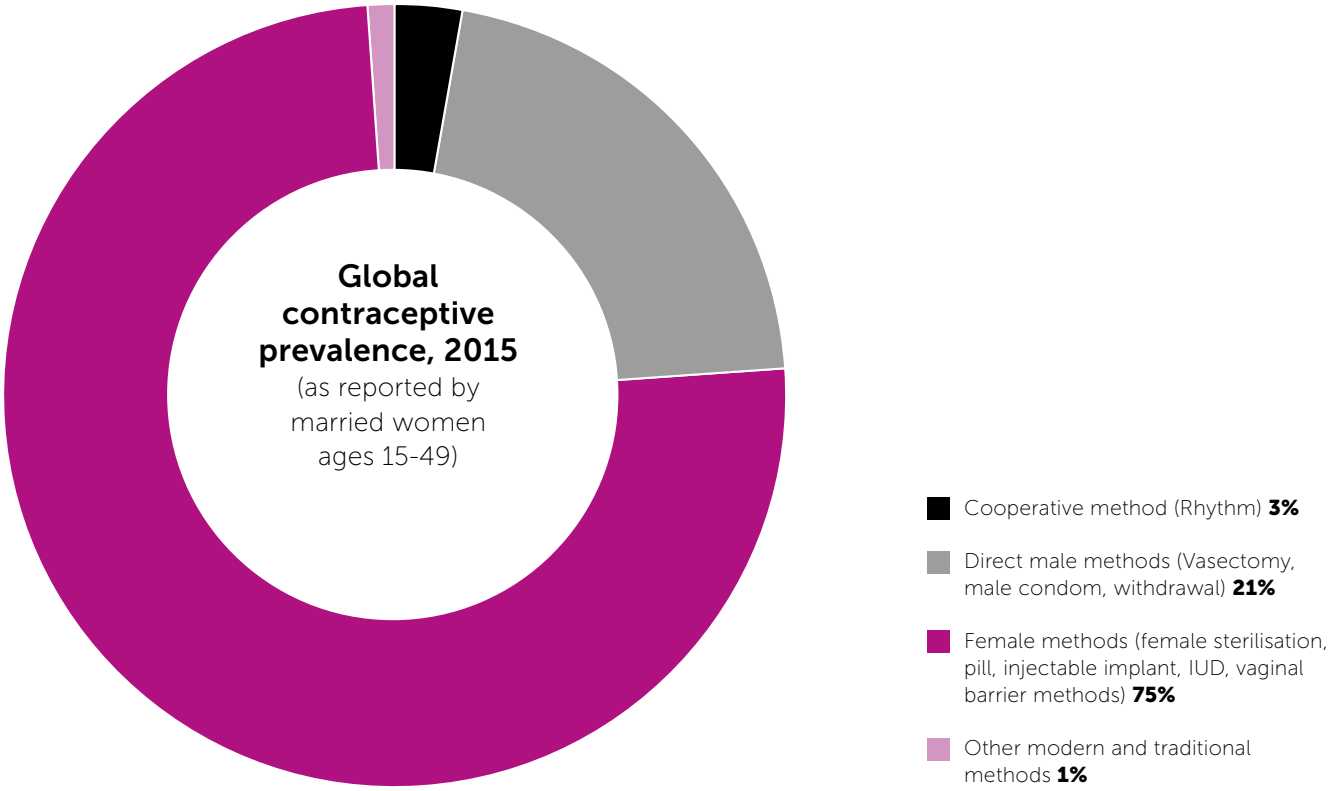
# THE ROLE OF MEN AS PARTNERS AND FATHERS

## Family planning

Whilst there is evidence that men perceive that men and women have a joint role to play in decisions about family planning women continue to bear most of the responsibility for family planning worldwide. The majority of men in 26 DHS countries in sub-Saharan Africa agree that contraception is a shared responsibility of both men and women.[33] However the use of direct male and collaborative methods of contraception is low as illustrated by figure 3 below with prevalence of condoms at 8% prevalence, withdrawal at 3% prevalence, male sterilisation/ vasectomy at 2.4% prevalence and standard days method at 0.6% prevalence.[34]

In many contexts men still hold most of the decision-making and economic power over decisions about women's health and bodies such as contraception, family size and access to health services. It is therefore important that programming aimed to improve sexual and reproductive health outcomes for women includes elements of education and awareness-raising amongst men which is undertaken within a context of reflection on gender norms and the influence that they as men have.

**Figure 3: Male use of contraception is low**




[33]Kristin Bietsch, "Men's Attitudes Towards Contraception in sub-Saharan Africa," African Journal of Reproductive Health 19, no. 3 (2015): 41-54.
[34]United Nations Department of Economic and Social Affairs, Population Division (2015)

## Maternal and newborn health

The World Health Organisation estimates that approximately 302,000 maternal deaths occur every year[35] and a large proportion of these deaths are preventable. Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy and other complications may exist before pregnancy but are worsened during pregnancy, especially if not managed as part of the woman's care. The major complications that account for nearly 75% of all maternal deaths are:

- severe bleeding (mostly bleeding after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- complications from delivery
- unsafe abortion.

The remainder are caused by or associated with diseases such as malaria, and AIDS during pregnancy.[36] Maternal health and newborn health are closely linked. It was estimated that ging newborn infection at community level approximately 2.7 million newborn babies died in 2015[37], and an additional 2.6 million were stillborn.[38]

Almost all of maternal deaths (99%)[39] occur in the global south and the risk of maternal mortality is highest for adolescent girls under 15 years and a leading cause of death for this group in the global south.[40 41] Poor women in remote areas are the least likely to receive adequate health care and this is especially true for regions with low numbers of skilled health workers where levels of attended deliveries are low with millions of births not assisted by a midwife, doctor or trained nurse. Access to antenatal care is another factor which impacts on maternal outcomes. In 2015, only 40% of all pregnant women in low-income countries had the recommended antenatal care visits.[42] Other factors that prevent women from receiving or seeking care during pregnancy and childbirth are poverty, distance, lack of information, inadequate services and cultural practices.

Men still hold most of the decision-making and economic power over maternal health in the global south. Often it is men that make decisions about whether to pay for a midwife, antenatal scans and transport to hospital. Their decisions may often be taken without full knowledge and awareness of the issues and when complications arise these decisions can be a matter of life or death. Men also often play a role in decisions that affect maternal nutrition and also access to services to support prevention of mother-to-child transmission of HIV. There is evidence to suggest that where men attend ANC with their partners there is increased utilisation of maternal health services.[43 44] Research suggests that this association is because men's knowledge about the importance of maternal services increases with active involvement which in turn increases the likelihood of them encouraging and supporting their wives to use them.[45 46 47]

There is evidence from the global north to suggest that men's presence during delivery can result in beneficial maternal outcomes [48 49 50 51] but a significant lack of evidence from the global south on any potential impact.[52]

Beyond decision-making, there is an important role for men to play to support their partners during pregnancy and delivery both in terms of practical support and emotional support. Practical support can include reducing women's workload during pregnancy and ensuring they rest sufficiently. There is some evidence to suggest that male involvement is associated with decreased likelihood of childbirth complications.[53]

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[35] Trends in Maternal Mortality 1990 to 2015 World Health Organisation (2015)
[36] WHO factsheet Maternal Mortality (Feb 2018)
[37] Levels and Trends in Child Mortality. Report 2015. The Inter-agency Group for Child Mortality Estimation (UN IGME). UNICEF, WHO, The World Bank, United Nations Population Division. New York, USA, UNICEF, 2015.
[38] National, regional, and worldwide estimates of stillbirth rates in 2015, with trends from 2000: a systematic analysis. Blencowe H, Cousens S, Jassir FB, Say L, Chou D, Mathers C et al. Lancet Glob Health. 2016 Feb;4(2):e98-e108. doi: 10.1016/S2214-109X(15)00275-2.
[39] WHO factsheet Maternal Mortality (Feb 2018)
[40] Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. Conde-Agudelo A, Belizan JM, Lammers C. American Journal of Obstetrics and Gynecology, 2004, 192:342–349.
[41] Global patterns of mortality in young people: a systematic analysis of population health data. Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, Vos T, Ferguson J, Mathers CD. Lancet, 2009, 374:881–892.
[42] WHO factsheet Maternal Mortality (Feb 2018)
[43] Redshaw M, Henderson J, Fathers' engagement in pregnancy and childbirth: evidence from a national survey. BMC Pregnancy Childbirth 2013;13:1–15
[44] Tweheyo, R. Konde-Lule, J. Tumwesigye, NM. et al Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda. BMC Pregnancy Childbirth 2010;10:53.
[45] Ahmed, A. Hossain, SAS. Quaiyum, A. et al Husbands' knowledge on maternal health care in rural Bangladesh: an untapped resource? Trop Med Int Health 2011;16:291.
[46] Ali, M. Rizwan, H. Ushijima, H. Men and reproductive health in rural Pakistan: the case for increased male participation. Eur J Contracept Reprod Health Care 2004;9:260–6.
[47] Kakaire, O. Kaye, DK. Osinde, MO. Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. Reprod Health 2011;8:12.

Male engagement can support increased awareness of danger signs and complications.[54] This in turn prevents delays in accessing care and decreases the risk of developing complications.[55]

There is evidence that support from a male partner during and after pregnancy can have a positive impact on maternal and post-natal depression.[56 57 58 59] This includes practical support with childcare and domestic tasks and emotional support, which can boost self-esteem.

## Fatherhood

Perceptions and definitions of fatherhood are rooted in cultural values, tradition and religion as but gender roles have changed over time factors such as urbanisation and increasing employment of women have shifted family dynamics. In some cases the roles played by fathers have shifted in response to these changes but often traditional values still dominate.

Men often typically play a role as decision-makers and disciplinarians. Women spend three to four times as much time as men on childcare, even in countries where women work outside of the home for similar or equal amounts of time as men.[60] Evidence from the global north identifies benefits of fathers' involvement with their children however there is little comparable research in the global south. The three components of fathering considered to be of crucial importance to the child's emotional and social wellbeing are interaction, availability to children, and taking responsibility for children.[61] Fathers also play a role in defining and shaping their children's constructs of masculinity and fatherhood which can be especially important for boys' development during adolescence. [62]

Often men are the major decision-makers on matters relating to child health. Because they typically hold and make decisions about economic resources within the household, they have significant influence over diet and access to health services, immunisation and decisions that directly affect children's wellbeing. For example they may make decisions about whether a daughter will be married early, have chance to complete her education or be exposed to traditional harmful practices such as FGM.

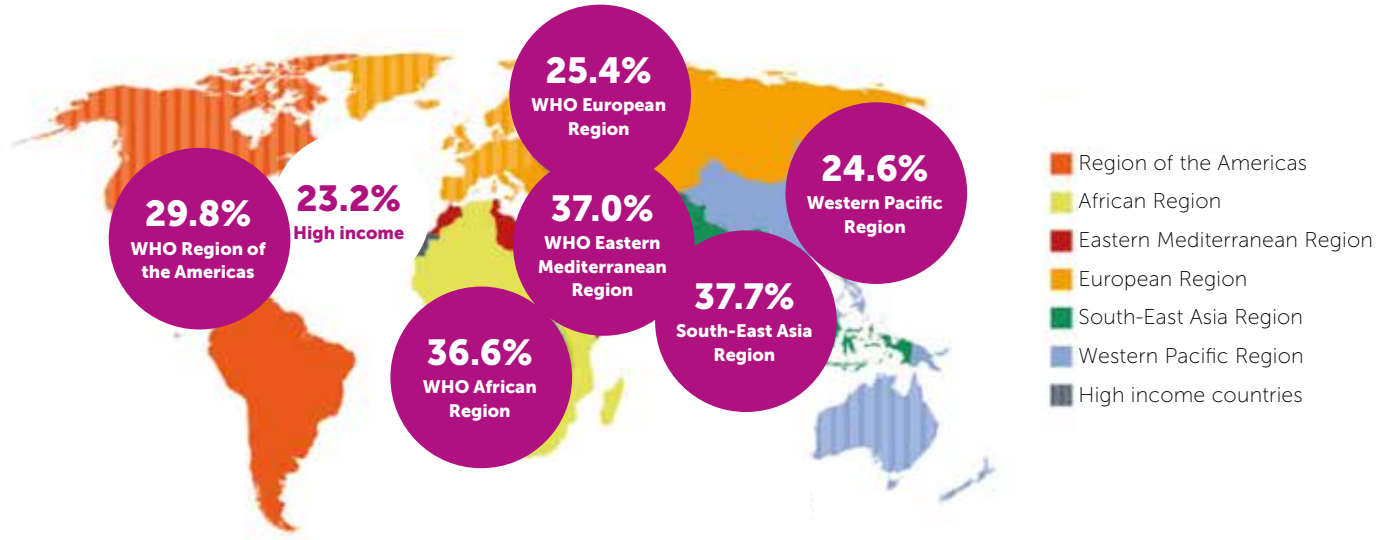
## Gender-based violence

Violence against women and girls is one of the most systematic and widespread human rights violations. The term "violence against women" encompasses many forms of violence, including violence by an intimate partner (intimate partner violence) and rape/sexual assault and other forms of sexual violence perpetrated by someone other than a partner (non-partner sexual violence), as well as female genital mutilation, honour killings and the trafficking of women.

According to a 2013 global review of available data, 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Figure 4 maps the prevalence of intimate partner violence, which globally stands at 30%.[63]

[48] D'Aliesio L, Vellone E, Amato E, et al. The positive effects of father's attendance to labour and delivery: a quasi experimental study. Int Nurs Perspect 2009;9:5–10.
[49] Block CR, Norr KL, Meyering S, et al. Husband gatekeeping in childbirth. Fam Relations1981;30:197–204.
[50] Guthrie K, Taylor DJ, Defriend D. Maternal hypnosis induced by husbands during childbirth. J Obstet Gynaecol 1984;5:93–5.
[51] Henneborn WJ, Cogan R. The effect of husband participation on reported pain and probability of medication during labour and birth. J Psychosom Res 1975;19:215–22. [PubMed]
[52] Yargawa, J. Leonardi-Bee, J. Male involvement and maternal health outcomes: systematic review and meta-analysis Journal of Epidemiology and Community Health Vol 69 Issue 6
[53] Yargawa, J. Leonardi-Bee, J. Male involvement and maternal health outcomes: systematic review and meta-analysis Journal of Epidemiology and Community Health Vol 69 Issue 6
[54] Bhatta, DN. Involvement of males in antenatal care, birth preparedness, exclusive breast feeding and immunizations for children in Kathmandu, Nepal. BMC Pregnancy Childbirth 2013;13:14.
[55] Kakaire, O. Kaye, DK. Osinde, MO. Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. Reprod Health 2011;8:12.
[56] Sreelekshmi F, Sharika S, Vidyakrishna V, et al. Risk factors of postpartum depression among married mothers attending SAT Hospital, Trivandrum. Aust Med J 2010;3:222.
[57] Wan EY, Moyer CA, Harlow SD, et al. Postpartum depression and traditional postpartum care in China: role of zuoyuezi. Int J Gynaecol Obstet 2009;104:209–13. [PubMed]
[58] Aydin N, Inandi T, Karabulut N. Depression and associated factors among women within their first postnatal year in Erzurum province in eastern Turkey. Women Health 2005;41:1–12. [PubMed]
[59] Lteif Y, Kesrouani A, Richa S. Depressive syndromes during pregnancy: prevalence and risk factors. J Gynecol Obstet Biol Reprod (Paris) 2005;34(3 Pt 1):262–9. [PubMed]
[60] UN Commission on the Status of Women (2007)
[61] Lamb, M. E., Pleck, J. H., & Levine, J. A. (1987). Effects of increased paternal involvement on fathers and mothers. In C. Lewis & M. O'Brien (Eds.), Reassessing fatherhood: New observations on fathers and the modern family (pp. 109–125). London: Sage
[62] Munroe, R. L., & Munroe, R. H. (1992). Fathers in children's environments: A four culture study. Fatherchild relations: Cultural and biosocial contexts (pp. 213–230). New York: de Gruyter

**Figure 4: Prevalence of intimate partner violence**




Gender-based violence is a significant cause of death and injury. Globally 38% of all murders of women are committed by their intimate partners, and 42% of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result.[64]

Partner violence is a major contributor to women's mental health problems, with women who have experienced partner violence being 2.6 times as likely to experience depression compared to women who have not experienced any violence.[65] Exposure to traumatic events can lead to stress, fear and isolation, which, in turn, may lead to depression and suicidal behaviour.[66] There is also evidence that women with severe mental health difficulties are more likely to experience violence.[67 68] Developmental and early life exposures to violence and other traumas may also play an important role in predicting both violence and depression.[69 70]

Women experiencing intimate partner violence are also 2.3 times more likely than other women to have alcohol-use problems.[71] The nature of this association is likely to be complex. Women may drink alcohol to cope with abuse, but, also women's consumption of alcohol may result in abuse from their partners, for example, because their partners believe that they should not drink. Alcohol is often an important facilitator of men's use of violence.[72]

[63] WHO, LSHTM, South African Medical Research Council. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013; June
[64] WHO, LSHTM, South African Medical Research Council. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013; June
[65] WHO, LSHTM, South African Medical Research Council. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013; June
[66] Hyde JS, Mezulis AH, Abramson LY. The ABCs of depression: integrating affective, biological, and cognitive models to explain the emergence of the gender difference in depression. Psychological Review, 2008, 115(2):291–313
[67] Hyde JS, Mezulis AH, Abramson LY. The ABCs of depression: integrating affective, biological, and cognitive models to explain the emergence of the gender difference in depression. Psychological Review, 2008, 115(2):291–313. 75.
[68] Khalifeh H, Dean K. Gender and violence against people with severe mental illness. International Review of Psychiatry, 2010, 22(5):535–546.
[69] Bifulco A et al. Adult attachment style as mediator between childhood neglect/abuse and adult depression and anxiety. Social Psychiatry and Psychiatric Epidemiology, 2006, 41(10):796–805.
[70] Doumas DM et al. Adult attachment as a risk factor for intimate partner violence: the "mispairing" of partners' attachment styles. Journal of Interpersonal Violence, 2008, 23 (5):616–634.
[71] WHO, LSHTM, South African Medical Research Council. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013; June
[72] Vos T et al. Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. Bulletin of the World Health Organization, 2006, 84:739–744

Sexually transmitted infections is another common negative health outcome for women who experience physical and/or sexual partner violence, being 1.5 times more likely to acquire syphilis infection, chlamydia, or gonorrhoea and in some regions (including sub-Saharan Africa), they are 1.5 times more likely to acquire HIV.[73 74 75 76 77]

Both partner violence and non-partner sexual violence are associated with unwanted pregnancy.[78 79 80] Women experiencing physical and/or sexual partner violence are twice as likely to have an abortion compared to women who do not experience this violence[81] and almost half of these abortions take place in unsafe conditions.[82] Women who experience partner violence also have a 16% greater chance of having a low birthweight baby as living in an abusive and dangerous environment marked by chronic stress can be an important risk factor for maternal health, as well as affecting the birth weight of the baby.[83]

## Interventions to engage men in their role as partner and fathers

Many of the components and approaches identified as important for engaging men to enhance their own health and wellbeing also apply to programmes focusing on changing men's attitudes and behaviour in their role as partners and fathers. Group education for critical reflection and peer interventions have an important role to play. Interventions focusing on men as partners and fathers will generally, but not exclusively, tend to focus on men who are already partners and fathers, some of whom may be older and possibly have more entrenched attitudes and behaviours. It is therefore particularly important that safe spaces are opened up to facilitate critical reflection and that those facilitating have a deep understanding of the cultural and social contexts of the men they are working with. It is also important that where peers are involved they reflect the demographic of the groups to maximise their credibility and also their insight into the specific contexts.

A significant component of work in this area is about the relationships that men have with their partners and children and understanding how their attitudes and behaviours impact on these relationships which can in turn have a significant impact on the health and wellbeing of family members. Interventions need to explore how men can enhance these relationships by encouraging them to open up dialogue and communication and also through increasing their understanding and empathy. Also encouraging practical involvement with household duties and childcare can help to bring about positive change in family dynamics.

[73] Maman S et al. The intersections of HIV and violence: directions for future research and interventions. Social Science and Medicine, 2000, 50(4):459–478. 46.
[74] Andersson N, Cockcroft A, Shea B. Genderbased violence and HIV: relevance for HIV prevention in hyperendemic countries of southern Africa. AIDS, 2008, 22(Suppl. 4):S73–S86. 47.
[75] Campbell JC et al. The intersection of intimate partner violence against women and HIV/AIDS: a review. International Journal of Injury Control and Safety Promotion, 2008, 15(4):221–231. 48.
[76] Coker AL. Does physical intimate partner violence affect sexual health? A systematic review. Trauma Violence and Abuse, 2007, 8(2):149–177. 49.
[77] Fernandez-Botran R et al. Correlations among inflammatory markers in plasma, saliva and oral mucosal transudate in post-menopausal women with past intimate partner violence. Brain, Behavior, and Immunity, 2011, 25(2):314–321.
[78] Goodwin MM et al. Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996–1997. Maternal and Child Health Journal, 2000, 4(2):85–92. 66.
[79] Pallitto CC, Campbell JC, O'Campo P. Is intimate partner violence associated with unintended pregnancy? A review of the literature. Trauma, Violence, and Abuse, 2005, 6(3):217–235. 67.
[80] Silverman JG et al. Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women. BJOG: An International Journal of Obstetrics and Gynaecology, 2007, 114(10):1246–1252.
[81] Singh S. Abortion worldwide: a decade of uneven progress. New York, Guttmacher Institute, 2009.
[82] Sedgh G et al. Induced abortion: incidence and trends worldwide from 1995 to 2008. The Lancet 2012, 379 (9816):625–632.
[83] WHO, LSHTM, South African Medical Research Council. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013; June

# CASE STUDY 5

## Men in the kitchen programme

**Maputo, Mozambique**

### Programme outline

VSO's partner HOPEM's Men in the Kitchen programme promotes gender equality and addresses violence against women and girls by increasing men's participation in domestic activities. Its objectives are:

- To promote male engagement in household tasks by increasing their cooking knowledge;
- To prevent violence against women, challenging the strict division of social roles for men and women by expanding the participation of men in household activities;
- To challenge gender stereotypes that contribute to social imbalances between men and women and restrict their personal development.

"I was motivated to get involved because I wanted to understand about inequality and how it works and to bring equality into my own life."

**Participant**

### Programme learning

The programme combines dialogue and reflection on gender-related topics with workshops on nutrition, education, agro-processing and preparation of nutritious recipes based on local resources. It also runs educational campaigns in public places, bars, nightclubs and other entertainment venues. As part of the campaign, the organisers use a mobile kitchen to arouse curiosity, then attract observers with artistic activities such as poetry, music and theatre, or by initiating debates on gender issues.

Sixteen hundred young men have participated in this initiative since it began in 2012. A survey of participants of the week-long course found that 90% of respondents were in favour of equal sharing of domestic responsibilities between women and men.

"I grew up in an environment where my father was very sexist. I have one brother and two sisters and now I help my sisters ... I cook and I do washing. Before this I was forbidden to help but now my father does not complain."

**Participant**

# CASE STUDY 6

## Raising awareness for behaviour change through husband schools

**Kenema District, Sierra Leone**

Before we were always quarrelling but since the start of the husbands' school he has been much more responsible, he has accompanied me to the clinic".

**Wife**

### Programme outline

VSO works in partnership with FINE (Fambul Initiative Network for Equality) Sierra Leone on a project that aims to encourage men to change their attitudes and behaviours in order to make life safer for women and girls. A total of 22 husband schools have been set up across the Kenema district. Each school has approximately 25 members recruited from the local community. The schools are based on voluntary membership and community involvement and aim to encourage men to take responsibility for their own family development. Members attend regular meetings and trainings, which are designed to be delivered over a period of six months. Male Advocators and Peer Educators play an important role in coordinating and facilitating this training, bringing in a range of specialists to deliver components of the training which include:

- Sexual and reproductive health community health officers
- Family planning service providers
- Family support units of the police
- Legal experts
- Gender experts
- Human rights experts

### Programme learning

Amongst those attending husband schools there was an increase in awareness of women's rights and an appreciation of the work that their wives carry out in the home with men realising the importance of helping out with chores. There was also a change in attitude towards family planning, with many husbands now actively encouraging partners to use contraception such as implants, as they recognise the benefits of birth spacing. There was an increased awareness of the importance of financial transparency and sharing, which has increased women's access to resources, which in turn had led to better diet and health outcomes for the family. Husbands have increased awareness of the importance of supporting wives to access health facilities, accompanying them to health appointments, hospital delivery and encouraging birth spacing. Husbands had an increased awareness of child rights and legislation; the impacts of child labour, teenage pregnancy and child marriage and this had resulted in a reduction in child marriage and FGM amongst girls under 18. Some also reported improved relationships with children through greater involvement in their lives. The community reported more harmonious relationships between men and women in the home and a reduction in conflict both in the home and more generally in the community.

# CASE STUDY 7

## Addressing conflict and violence in the home and the community through Male Advocates and Peer Educators

**Kenema District, Sierra Leone**

### Programme outline

ale Advocates and Peer Educators (MAPEs) deliver sensitisation sessions in the community focusing on rape and gender-based violence alongside other issues such as family planning and teenage pregnancy. They carry out family mediation and conflict resolution work between husbands and wives in the community (the work is known as PaMama). They work closely and directly with the community members but also work alongside the chiefs and village elders and make referrals on to other institutions as appropriate such as the police, the court, the Family Support Unit and in some cases FINE Sierra Leone's offices in Kenema. If cases are challenging they may gain support from the FINE coordinators in Kenema or in some instances a FINE social worker may become directly involved with the case. They support individuals to refer cases to chiefs and traditional leaders where appropriate and also support rape and gender-based violence cases to go to court which may involve supporting witnesses to attend court as well as supporting the police to identify perpetrators. They also play a role in the reduction of FGM by working with the soweis (FGM practitioners) in the Bondo societies to make them aware of the law (which confirmed no FGM should be carried out on any girl under 18) and have reported cases of forced FGM.

### Programme learning

From May 2016 – April 2017 the monitoring data available showed that MAPEs were engaged with a total of 77 cases where an identified law-breaking activity had taken place. The most common type of case was sexual penetration of a minor with over half of the cases falling into this category.

MAPES reported reduction in crimes involving sexual violence and rape as they felt that people are more aware of the laws and the increased possibility of being held to account for their actions. They considered that conflict resolution/mediation work has led to a reduction in domestic violence levels, less negligence of children by fathers and in particular an increase in fathers supporting their children to access education. There is now discussion in communities about the need to change and this has resulted in bringing sexual offenders to account and handing them over to the police. Previously communities felt it was not their business to interfere, but there is engagement and much less compromise now than before.

Staff from the Family Support Unit said that they now deal with approximately 50 – 60 cases per month which is still high but there has been a reduction from over 100 per month since the project began and they considered that the project has influenced a change in behaviours. There is increased numbers of witnesses taking cases to court which is leading to more successful prosecutions of serious sexual assault and GBV cases. Cases now go through court more quickly than before because MAPEs provide better support to victims and witnesses who are also better prepared to testify as a result. Additionally, there are fewer 'no shows' of witnesses and victims at court. These were more frequent previously which delayed the legal process and sometimes led to cases being thrown out of court. Lack of transport to court is another issue for victims and witnesses. Many cannot afford the high cost, especially if they are poor and living a long way from Kenema where the courts are situated. MAPEs arrange for transportation and cover charges for them which support the legal proceedings. Representatives from the magistrate's court also confirmed that there has been a reduction in the number of offences but an increase in the number of witnesses attending court to support prosecutions.

# RESOURCE 1

## Sensitisation flipchart for community volunteers

### Sierra Leone

**Resource outline**

The flip chart has been developed to engage men to understand more about pregnancy and the role that they as partners can play to support women throughout the life of the pregnancy, during delivery and care for the newborn. It provides diagrammatic and narrative explanations covering pregnancy, family planning, birth spacing, nutrition, breastfeeding, childcare and family health to promote behaviour change. The aim of the flipchart is to help men to improve their knowledge on reproductive health and change their perception, behavior and attitude towards women and create a safe social space for women to live their life with dignity and respect.

**Resource use**

The resource is being used by community volunteers who have been trained as MAPEs (Male Advocates and Peer health Educators) as part of the pilot project being undertaken by Fambul Initiatives Network for Equality (FINE), Sierra Leone with the financial and technical support from VSO, Sierra Leone. They are using the content this of flip chart as a sensitisation tool to mobilise other male members of the community to join the men's network of change-makers who support women during pregnancy and at birth.

# RESOURCE 2

## Husband schools: a facilitator's guide

### Sierra Leone

**Resource outline**

The guide provides basic content for the curriculum for the husband school sessions providing topics, sub-topics and the general direction the sessions should cover to meet the specific objectives of the husband school training. Its content has been designed to cover 16 sessions and the guide aims to give facilitators guidance on the content of the session and tools to lead group discussions and group activities.

**Resource use**

The resource is being used by community volunteers who have been trained as MAPEs (Male Advocates and Peer health Educators) as part of the pilot project being undertaken by Fambul Initiatives Network for Equality (FINE), Sierra Leone with the financial and technical support from VSO, Sierra Leone and KIT Netherlands. They are using the guide to facilitate a series of husband schools sessions.

# THE ROLE OF MEN AS AGENTS OF CHANGE

The ways in which boys and young men are socialised holds profound implications for the health, wellbeing, and security of men, boys, women and girls. Gender inequalities occur not only at the individual and family level but also at the community level and within wider society. Challenging the norms upon which socially constructed gender roles, identities and attributes are built can help to start to break down some aspects of inequality. In the past gender programming has tended to focus on women and girls however engaging men to play an active role in this process is central to bringing about lasting change. It should however been stressed that interventions focusing on changing the attitudes and behaviours of men should not replace but rather complement work with women and girls.

Whilst it can be argued that men can act as agents of change at all levels outlined in figure 1, this section focuses on the roles that men can play as agents of change at the community level and also beyond their immediate communities.

## Awareness raising

Raising awareness within the community may take a range of forms and target a number of different stakeholder groups. At the community level it may take the form of community meetings, training, sensitisation with traditional or religious leaders, service providers, and traditional practitioners, marches, demonstrations and activities such as theatre and sports events.

Some activities aim to reach much further than the community level through mass media campaigns using TV, radio and social media. The most effective campaigns and community mobilisation strategies generally rely on upbeat messages that show what men and boys can do to change their behaviour, affirming they can change and making use of characters that they can identify with, in radio or theatre, drama or print materials, who are acting in positive ways.[84] The most effective campaigns also highlight to men what they can gain from changing their behaviour.[85] Whilst there have been some successful single issue campaigns (e.g. condom use and detecting the signs of maternal distress) the evidence points to the need to include single health issues within the context of an overall gender-equitable male identity or lifestyle.[86]

Promoting strong gender and health-sensitive male role models such as traditional leaders, sportsmen or celebrities can be a helpful mechanism for campaigns. It is important that those role models adopt both model gender equitable behaviour and also command the respect of the target audience.

## Advocacy

One of the ways in which men can play a significant role as change agents is to act as advocates for change to political, legal, cultural and economic structures, which shape the lives of women and men and often perpetuate gender inequalities. Advocacy can be defined as building support and positively influencing decision making and policy on issues that perpetuate inequality. It can be undertaken at different levels such as engaging community leaders in dialogue or gaining political commitment at a higher level to support policy or legislative change or resources to scale up interventions or services.

## Interventions to engage men as agents of change

Interventions at a community level need to be developed based on a detailed understanding of the local context, the most appropriate ways to bring about change and the key stakeholders that need to be engaged to support and influence the change. Making changes to local policies or legislation for example may require bringing together traditional leaders and local government and legal officials. Legal or policy changes once passed or agreed then need to be accompanied by work to communicate these changes to the wider population. More practical work to improve health outcomes in the community may focus more on bringing community members together but will generally benefit from gaining support from community leaders and influencers to increase the chances of success. Interventions may also need to target health and education service providers to challenge the way services are delivered and highlight changes that can reduce gender inequalities, make services more accessible for men and challenge perceptions about the role that men may play in relation to the health of their families.

Interventions targeting an audience beyond the local community at a regional or national level will benefit from research to test ideas and approaches and gain insight into what approaches and content may be most effective for different subgroups of the target audience.

[84] Barker, G. Ricardo, C and Nacimento, M (2007) Enagaing men and boys in changing gender inequity in health; Evidence from programme interventions. Geneva, WHO

[85] Promundo, UNFPA, and MenEngage (2010) Engaging men and boys in gender equality and health

[86] Barker, G. Ricardo, C and Nacimento, M (2007) Enagaing men and boys in changing gender inequity in health; Evidence from programme interventions. Geneva, WHO

# CASE STUDY 8

## Male involvement in community home based HIV/AIDS care

### Chitungwiza, Makoni and Marondera districts, Zimbabwe

**Programme outline**

Awareness campaigns on male involvement were conducted in conjunction with the key stakeholders, including the National AIDS Council, the District AIDS Action Committees, hospital staff and staff from the local clinics. To promote the male involvement programme, VSO provided each of the partners with small grants for technical support. The grants enabled training for secondary care facilitators and health centre staff on income generating activities, community home-based care, voluntary counselling and testing, and palliative care and provided for ongoing refresher training courses. In addition grant money was used for uniforms, medical and home-based care kits and bicycles.

As part of their volunteer work, secondary care facilitators conducted home visits to clients, with frequency of visits determined by the nature and severity of each client's illness. Hence, bed-ridden clients and clients new to the programme receive more frequent visits than other clients who may be home or community bound. During these home visits, the secondary care facilitators conducted individual and family counselling, assisted in household chores, offered basic training in care to primary caregivers and checked on drug adherence. The caregivers (both primary and secondary) received mentorship at household level when the clinic and partner staff visited the households as part of routine monitoring and capacity building.

In addition both male and female secondary care facilitators conducted awareness campaigns at community halls, shops, beer halls and schools, through drama, storytelling, poetry and dancing, at least once a month. HIV/AIDS and gender messages were embedded in all these activities. The key messages delivered aimed to change the attitudes and practices of men towards their wives and other women in their families, and to demystify negative thinking around the provision of care by men.

**Programme learning**

There was evidence of a positive change of behaviour in terms of knowledge, attitudes and practices both for men and the community at large, as a result of male involvement in community home-based care. Whilst these changes cannot be attributed solely to the increase of male involvement, the emphasis the programme placed on male involvement at inception and strategic interventions, such as men taking a lead in awareness campaigns in public places contributed to identified change which included:

- Increased seeking of treatment for sexually transmitted infections
- Increased support to spouses during pregnancy
- Increased use of contraception
- Decreased gender-based violence

# CASE STUDY 9

## The Man Who is a Man media programme

**Maputo, Mozambique**

### Programme outline

VSO's partner HOPEM uses media and social media platforms to promote debates within society. A weekly programme is broadcast on national TV. Participants discuss taboos, behaviours, attitudes and practices from a male perspective and commentators are invited to give their views about themes such as gender, masculinity and sexual and reproductive health. Viewers are asked to phone-in to give their views and clarify issues.

The program aims to:

- Contribute towards the eradication of violence against women by men and boys.
- Sensitise young and adult males to gender-based violence from a human rights perspective; and the role they can play in fighting this.
- Encourage the adoption of more just, respectful and equitable attitudes towards women.
- Promote critical and transformational discussion about current perspectives on masculinity and their implications in the lives of women, men and children.
- Contribute towards the creation of a more favourable environment for male adherence to efforts aimed at preventing and fighting violence against women.

### Programme learning

A range of issues have been raised through the TV programme including:

- Attitudes, values, norms, and beliefs on gender that are harmful to men and women
- Violence against women, multiple and concurrent partnerships, negative manhood
- Messages against violence against women using men-to-men approaches
- Policy gaps and issues around the work with men and boys

The programme has resulted in an increase in the number of men who recognise gender vulnerabilities and almost 40 celebrities, personalities and intellectuals have broken the silence on violence against women. It was also reported that the government of Mozambique, through the Ministry of Women and Social Action is increasingly integrating men and boys' approaches into its work.

> "Debates at a national level can support and facilitate work at the community level"
>
> **Peer Educator**

# CASE STUDY 10

## Mobilising traditional leaders to address early marriage

**Mbire District – Zimbabwe**

### Programme outline

Mbire has the highest cases of child marriages in Zimbabwe. Young women drop out of school each year as a result of early marriage fuelled by poverty, lack of adequate information on SRHR and a lack of value for girls' education. The VSO G.E.N.D.E.R project working with Katswe Sisterhood is specifically addressing child marriages through the active involvement and participation of traditional leaders who are the community gatekeepers with power and influence over the elimination of such practices.

Katswe brought together and trained 12 traditional leaders, 40 youth leaders, three junior counsellors and police representatives on SRHR issues in two wards with a particular focus on the legal implications of marrying children when they are underage. This capacity building enabled the traditional leaders and the police to speak out against early marriages and resulted in perpetrators being fined.

### Programme learning

The involvement of traditional leaders as male champions has contributed to a reduction in cases of early marriages in the two wards (8 and 10) in Mbire district and has also supported a reduction in school dropout and increase in family discussion about SRHR.

Traditional leaders are strongly advocating against early marriages and imposing fines and penalties to defaulters. Coupled with this, the police are working closely with traditional leaders to ensure that there is law enforcement. Families and communities are now complying and understanding the dangers of marrying off their children whilst they are young. In addition, male champions have been linking the issue of early marriages with birth related complications in their advocacy campaigns and this has led to a notable reduction in deaths among girls or young women.

"Last year we had 2 out of 110 form twos whom we lost as a result of early marriages. It should be noted that it is a cause for celebration mainly because in previous years we had 30-40 going in a year"

**Peer Educator**

# CASE STUDY 11

## Engagement of chiefs and harmonisation of bye-laws

**Kenema District, Sierra Leone**

### Programme outline

VSO works in partnership with FINE (Fambul Initiative Network for Equality) Sierra Leone on a project that aims to encourage men to change their attitudes and behaviours in order to make life safer for women and girls. This project supported the development of bye-laws through the consolidation of existing policies in the Child Rights Act, the Domestic Violence Act and the Sexual Offences Act to prevent FGM, child marriage and sexual and gender-based violence across three chiefdoms in the Kenema District. The aim was to promote gender equality and gender mainstreaming at all levels of Sierra Leone society.

Objectives of this component of the work were to:

- Increase community knowledge of existing laws for the protection of children, especially girls under the age of 18, from FGM, rape, child marriage, child abuse and child cruelty including abandonment and neglect.
- Increase and strengthen chiefdom policy stakeholders' commitment to ensuring that violations and abuses of sexual and gender-based violence are decisively dealt with in accordance with the law utilising stipulated referral pathways.
- Ensure that the government agenda for prosperity is actualised at every level of society in Kenema district.

A workshop was held to agree the harmonisation and this was led by the Provincial Secretary for the Eastern Region and included the Senior District Officer, Assistant Directors of Gender, Director of Public Prosecution, the Council Chairman, paramount chiefs from each chiefdom, 22 section chiefs, court chairman, justice sector, Kenema district council, religious leaders, town council, councillors, police family support unit, civil society organisations and MAPEs. The workshop was facilitated by a team of legal personnel from the justice sector headed by the Director of Public Prosecutions representing the resident magistrate of Kenema district. The bye-laws produced were reviewed and validated by the justice sector to ensure that they represented a true interpretation of the relevant legislation.

### Programme learning

Gaining the support of chiefs and traditional leaders at an early stage has been a key component to the effectiveness of this work as it has helped to lay strong foundations upon which to build the project. The bye-law harmonisation work at district level has had strong buy-in from traditional leaders and the authorities. Training through the husband schools and community sensitisation has then been used to disseminate information about the bye-laws more widely.

# CONCLUSION


**This paper outlines a significant body of evidence to support the concept that engaging men and boys in health interventions can improve outcomes not only for themselves, but also for women and girls. Programmes engaging men should not deflect from interventions that target women but rather should run in parallel to maximise impact. One of the errors of previous programmes was that they focused solely on women and this often resulted in tension between men and women and this dynamic can reduce the overall potential impact of the work. Male engagement is therefore essential in striving for equality in women and girls' sexual and reproductive health and rights and maternal and newborn health.**

VSO has delivered a range of interventions that engage men and boys to improve health outcomes and is using learning from this work to inform the future direction of global health programming. Encouraging men to become more aware of their own health needs can improve not only their own health outcomes but also act as a catalyst for increased motivation and concern for the health and wellbeing of their partners and families. Creating safe spaces for honest discussion and critical self-reflection can support men to change their behaviours in relation to their own health but also the health of their family in their role as partners and fathers.

VSO's expertise is in delivering male engagement programmes working through volunteers. Male community-based volunteers have played a significant and central role in work to engage men and boys as they understand the local context. They are well placed to build trust and model positive behaviours. They have taken on roles as educators, champions, peer advocates and peer navigators to work alongside men and boys in communities to encourage, support and drive change. Programmes which support men and boys to act as catalysts to bring about change in their own communities and beyond can be both powerful and sustainable. Ensuring that the volunteers playing this pivotal role are involved in the design and development of the work is of central importance and it is also critical to ensure that they have access to effective training and ongoing support in their work.

# REFERENCES


Ahmed, A. Hossain, SAS. Quaiyum, A. et al Husbands' knowledge on maternal health care in rural Bangladesh: an untapped resource? Trop Med Int Health 2011;16:291.

Ali, M. Rizwan, H. Ushijima, H. Men and reproductive health in rural Pakistan: the case for increased male participation. Eur J Contracept Reprod Health Care 2004;9:260–6.

Andersson N, Cockcroft A, Shea B. Genderbased violence and HIV: relevance for HIV prevention in hyperendemic countries of southern Africa. AIDS, 2008, 22(Suppl. 4):S73–S86. 47.

Aydin N, Inandi T, Karabulut N. Depression and associated factors among women within their first postnatal year in Erzurum province in eastern Turkey. Women Health 2005;41:1–12. [PubMed]

Barker, G. Ricardo, C and Nacimento, M (2007) Enagaing men and boys in changing gender inequity in health; Evidence from programme interventions. Geneva, WHO

Baker, P. Dworkin. SL, Tong, S. Banks, I . Shand & Yamey, G. The men's health gap: men must be included in the global health equity agenda (Submitted: 07 November 2013 – Revised version received: 12 February 2014 – Accepted: 19 February 2014 – Published online: 06 March 2014.) Bulletin of the World Health Organization 2014;92:618-620. doi: http://dx.doi.org/10.2471/BLT.13.132795

Bhatta, DN. Involvement of males in antenatal care, birth preparedness, exclusive breast feeding and immunizations for children in Kathmandu, Nepal. BMC Pregnancy Childbirth 2013;13:14.

Bifulco A et al. Adult attachment style as mediator between childhood neglect/abuse and adult depression and anxiety. Social Psychiatry and Psychiatric Epidemiology, 2006, 41(10):796–805.

Blencowe H, Cousens S, Jassir FB, Say L, Chou D, Mathers C et al. National, regional, and worldwide estimates of stillbirth rates in 2015, with trends from 2000: a systematic analysis. Lancet Glob Health. 2016 Feb;4(2):e98-e108. doi: 10.1016/S2214-109X(15)00275-2.

Block CR, Norr KL, Meyering S, et al. Husband gatekeeping in childbirth. Fam Relations1981;30:197–204.

Bronfenbrenner, Urie (1989). "Ecological systems theory". In Vasta, Ross. Annals of Child Development: Vol. 6. London, UK: Jessica Kingsley Publishers. pp. 187–249

Kristin Bietsch, "Men's Attitudes Towards Contraception in sub-Saharan Africa," African Journal of Reproductive Health 19, no. 3 (2015): 41-54.

Campbell JC et al. The intersection of intimate partner violence against women and HIV/AIDS: a review. International Journal of Injury Control and Safety Promotion, 2008, 15(4):221–231. 48.

Coker AL. Does physical intimate partner violence affect sexual health? A systematic review. Trauma Violence and Abuse, 2007, 8(2):149–177. 49.

Conde-Agudelo A, Belizan JM, Lammers C. Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. American Journal of Obstetrics and Gynecology, 2004, 192:342–349.

Cornell M, McIntyre J, Myer L. Men and antiretroviral therapy in Africa: our blind spot. Trop Med Int Health. 2011;16:828-9.

D'Aliesio L, Vellone E, Amato E, et al. The positive effects of father's attendance to labour and delivery: a quasi-experimental study. Int Nurs Perspect 2009;9:5–10.

Doumas DM et al. Adult attachment as a risk factor for intimate partner violence: the "mispairing" of partners' attachment styles. Journal of Interpersonal Violence, 2008, 23 (5):616–634.

Fernandez-Botran R et al. Correlations among inflammatory markers in plasma, saliva and oral mucosal transudate in post-menopausal women with past intimate partner violence. Brain, Behavior, and Immunity, 2011, 25(2):314–321.

Goodwin MM et al. Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996–1997. Maternal and Child Health Journal, 2000, 4(2):85–92. 66.

Guthrie K, Taylor DJ, Defriend D. Maternal hypnosis induced by husbands during childbirth. J Obstet Gynaecol 1984;5:93–5.

Hardee, K. Croce-Galis, Gay, J. Men as Contraceptive Users: Programs, Outcomes and Recommendations USAID WORKING PAPER - SEPTEMBER 2016

Henneborn WJ, Cogan R. The effect of husband participation on reported pain and probability of medication during labour and birth. J Psychosom Res 1975;19:215–22. [PubMed]

Hyde JS, Mezulis AH, Abramson LY. The ABCs of depression: integrating affective, biological, and cognitive models to explain the emergence of the gender difference in depression. Psychological Review, 2008, 115(2):291–313. 75.

Institute of Medicine (2001) Crossing the Quality Chasm: A New Health System for the 21st Century

International Conference on Population and Development. United Nations Population Fund. http://www.un.org/popin/icpd/conference/offeng/poa.html. Published 1994. Accessed October 19, 2018.

IPPF Integrated Package of Essential Services Quality of Care Toolkit

IPPF (2010) Men are Changing: case study evidence on work with men to promote gender equality and positive masculinities

IPPF (2013) Gender, Masculinities & Sexual Health in South Asia: IPPF South Asia Region.

Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, et al. Global Health 2035: a world converging within a generation. Lancet. 2013;382:1898-955.

Kakaire, O. Kaye, DK. Osinde, MO. Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. Reprod Health 2011;8:12.

Khalifeh H, Dean K. Gender and violence against people with severe mental illness. International Review of Psychiatry, 2010, 22(5):535–546.

Lamb, M. E., Pleck, J. H., & Levine, J. A. (1987). Effects of increased paternal involvement on fathers and mothers. In C. Lewis & M. O'Brien (Eds.), Reassessing fatherhood: New observations on fathers and the modern family (pp. 109–125). London: Sage

Lteif Y, Kesrouani A, Richa S. Depressive syndromes during pregnancy: prevalence and risk factors. J Gynecol Obstet Biol Reprod (Paris) 2005;34(3 Pt 1):262–9. [PubMed]

Maman S et al. The intersections of HIV and violence: directions for future research and interventions. Social Science and Medicine, 2000, 50(4):459–478. 46.

McLeory, KR. Bibeau, D. Steckler, A. Glanz, K. An ecological perspective on health promotion programs. Health Educ Q 1988 Winter; 15(4): 351-77

Munroe, R. L., & Munroe, R. H. (1992). Fathers in children's environments: A four culture study. Fatherchild relations: Cultural and biosocial contexts (pp. 213–230). New York: de Gruyter

Office of Population and Reproductive Health Bureau for Global Health - Essential Considerations for Engaging Men and Boys for Improved Family Planning Outcomes -Sept 2018

Pallitto CC, Campbell JC, O'Campo P. Is intimate partner violence associated with unintended pregnancy? A review of the literature. Trauma, Violence, and Abuse, 2005, 6(3):217–235. 67.

Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, Vos T, Ferguson J, Mathers CD. Global patterns of mortality in young people: a systematic analysis of population health data. Lancet, 2009, 374:881–892.

PEPFAR 2012. PEPFAR Blueprint: Creating an AIDS Free Generation. The Office of the Global AIDS Coordinator. https://www.pepfar.gov/documents/organization/201386. pdf. Published 2017. Accessed 19 October 2018.

Promundo-US and University of Pittsburgh Medical Center (2018). Manhood 2.0: A Curriculum Promoting a Gender-Equitable Future of Manhood. Washington, DC and Pittsburgh: Promundo and University of Pittsburgh.

Promundo, UNFPA, and MenEngage (2010) Engaging men and boys in gender equality and health

Redshaw, M. Henderson, J. Fathers' engagement in pregnancy and childbirth: evidence from a national survey. BMC Pregnancy Childbirth 2013;13:1–15

Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels JD, et al. Global Causes of Maternal Death: A WHO Systematic Analysis. Lancet Global Health. 2014;2(6): e323-e333

Sreelekshmi F, Sharika S, Vidyakrishna V, et al. Risk factors of postpartum depression among married mothers attending SAT Hospital, Trivandrum. Aust Med J 2010;3:222.

Silverman JG et al. Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women. BJOG: An International Journal of Obstetrics and Gynaecology, 2007, 114(10):1246–1252.

Singh S. Abortion worldwide: a decade of uneven progress. New York, Guttmacher Institute, 2009.

Sedgh G et al. Induced abortion: incidence and trends worldwide from 1995 to 2008. The Lancet 2012, 379 (9816):625–632.

Tweheyo, R. Konde-Lule, J. Tumwesigye, NM. et al Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda. BMC Pregnancy Childbirth 2010;10:53.

UNFPA and World Health Organization (2015) Ensuring human rights within contraceptive service delivery Implementation guide.

UNICEF, WHO, The World Bank, United Nations Population Division. New York, USA, UNICEF, 2015 Levels and Trends in Child Mortality. Report 2015. The Inter-agency Group for Child Mortality Estimation (UN IGME).

USAID - ACTING ON THE CALL Ending Preventable Child and Maternal Deaths: A Focus on Health Systems - May 2017

VSO: Peer education interventions: Improving health outcomes through people centred development- the use in VSO health programmes (2018)

Wan EY, Moyer CA, Harlow SD, et al. Postpartum depression and traditional postpartum care in China: role of zuoyuezi. Int J Gynaecol Obstet 2009;104:209–13. [PubMed]

Wang H, Dwyer-Lindgren L, Lofgren KT, Rajaratnam JK, Marcus JR, Levin-Rector A, et al. Age-specific and sex-specific mortality in 187 countries, 1970–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet. 2012;380:2071-94.

White A, McKee M, Richardson N, de Visser R, Madsen SA, de Sousa BC. Europe's men need their own health strategy. BMJ. 2011;343:d739.

Vanessa Woog and Anna Kågesten, "The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10–14 in Developing Countries: What Does the Evidence Show?" (2017), https://www.guttmacher.org/sites/default/files/report_pdf/srh-needs-very-young-adolescents-report_0.pdf. Accessed on 23 Oct 2018

Vos T et al. Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. Bulletin of the World Health Organization, 2006, 84:739–744

WHO (2006) Quality of Care: A process for making strategic choices in health systems.

WHO (2007) Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions

World Health Organization. Global Health Observatory Data Repository: Disability-adjusted life years (DALYs), 2000- 2012.

World Health Organisation (2015) Trends in Maternal Mortality 1990 to 2015

WHO, LSHTM, South African Medical Research Council. Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013; June

Yargawa, J. Leonardi-Bee, J. Male involvement and maternal health outcomes: systematic review and meta-analysis Journal of Epidemiology and Community Health Vol 69 Issue 6

# TOOLS AND RESOURCES

**Engaging men and boys in gender equality and health: a global toolkit for action**

The toolkit presents conceptual and practical information on engaging men and boys in promoting gender equality and health. Specific topics include sexual and reproductive health, maternal, newborn and child health, fatherhood, HIV and AIDS prevention, care and support and GBV prevention.

Produced by: Promundo, UNFPA, and MenEngage (2010)
Location: https://promundoglobal.org/wp-content/uploads/2014/12/Engaging-Men-and-Boys-in-Gender-Equality-and-Health-A-Global-Toolkit-for-Action-English.pdf
Accessed: 22 Oct 2018

**Engaging Boys and Men in Contraception Use and Family Planning: A Slide Deck**

Data-driven slides that can be used by advocates, programme planners and funders to make the case for engaging boys and men in family planning

Produced by: Population Reference Bureau (2018)
Location: https://www.prb.org/engaging-boys-and-men-in-contraception-use-and-family-planning-a-slide-deck/
Accessed: 23 Oct 2018

**Manhood 2.0: A Curriculum Promoting a Gender-Equitable Future of Manhood**

A gender-transformative curriculum developed to engage young men aged 15 to 24 in reflecting on the impacts of harmful gender norms, specifically those surrounding issues such as teen pregnancy prevention, dating violence and sexual assault, and the bullying of lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals. Created for use by facilitators working to engage young men in gender equity, violence prevention, and creating healthier and more equitable relationships. The curriculum includes a series of sessions to enable young men to reflect and build collective support for making positive, healthy changes in their lives. Employing a lens of intersectionality, Manhood 2.0 encourages young men to reflect critically on their identities within the particular contexts in which they are formed.

Produced by: Promundo and University of Pittsburgh (2018)
Location: https://promundoglobal.org/wp-content/uploads/2018/06/PM-Manhood-2-0-curriculum-v12-2-E.pdf
Accessed: 23 Oct 2018

**Family planning and reproductive health indicators database: male engagement in reproductive health programmes**

A subarea found in the men's health section of sexual and reproductive health section of the database. All indicators for this area include a definition, data requirements, data source(s), purpose, issues and—if relevant—gender implications.

Produced by: Measure Evaluation
Location: https://www.measureevaluation.org/prh/rh_indicators/mens-health/me/male-engagement-in-reproductive-health-programs.html
Accessed: 23 Oct 2018

**Engaging men in sexual reproductive health and rights: toolkit**

A guide is for anyone who may be engaged in developing or managing a project or programme to engage men in sexual and reproductive health and rights. It emphasises the importance of using a gender lens when planning and programming men's engagement in sexual and reproductive health and rights (SRHR), including family planning—which means engaging men as clients of SRH services, as supportive partners (to their intimate partners), and as agents of change in terms of SRHR.

Produced by: EngenderHealth and UNFPA
Location: https://www.engenderhealth.org/pubs/gender/gender-toolkit/toolkit.html
Accessed: 23 Oct 2018

**Engaging men in HIV and AIDs at the service deliver level: a manual for service providers**

A training manual for service providers working with men. The sessions in the manual teach participants to challenge the bias against engaging men in reproductive health and HIV services at the facility level. The sessions also identify ways to improve the quality of services for male clients and explore ways to market services to men.

**Engaging men and boys in gender equality and health: a global toolkit for action**

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Produced by: Measure Evaluation
Location: https://www.measureevaluation.org/prh/rh_indicators/mens-health/me/male-engagement-in-reproductive-health-programs.html
Accessed: 23 Oct 2018

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The activities are intended for use with all service providers, although some adjustments might be required, depending on the country and community context.

Produced by: EngenderHealth and UNFPA (2008)
Location: https://www.engenderhealth.org/files/pubs/acquire-digital-archive/7.0_engage_men_as_partners/7.2.3_tools/service_manual_final.pdf
Accessed: 23 Oct 2018

**Global sexual and reproductive health service package for men and adolescent boys**

A package developed to support providers of sexual and reproductive health services. It aims to increase the range and quality of sexual and reproductive services provided that meet the specific and diverse needs of men and adolescents boys. It focuses specifically on the provision of services integrated within clinical and non-clinical contexts and follows a gender-transformative approach. It covers men and adolescent boys in all their diversity and takes a positive approach to SRH, seeing this not just as the absence of disease, but the positive expression of one's gender, sex and sexuality.

Produced by: IPPF and UNFPA (2017)
Location: https://www.ippf.org/sites/default/files/2017-11/Global%20Sexual%20and%20Reproductive%20Health%20Package%20for%20Men%20and%20Adolescent%20Boys.pdf
Accessed: 04 Jan 2019

**Engaging men to improve maternal and newborn health**

Facilitators guide for a three day training of trainers workshop. Aims for the participants to be able to:

- Demonstrate facilitation skills needed to train volunteers to promote change among men
- Practice key methods including negotiation for behaviour change and supportive supervision
- Describe the concepts behind engaging men in improving maternal and newborn health and the process for working with men
- Plan the steps for selecting and training volunteer change agents and for developing materials they will use

Produced by: Catholic Relief Services (2014)
Location: https://www.crs.org/sites/default/files/tools-research/engaging-men-improve-maternal-newborn-health_0.pdf
Accessed: 04 Jan 2019

**Engaging men and boys in changing gender based inequity in health: Evidence from programme interventions**

This review seeks to assess the extent to which programmes move beyond simply promoting the "usual" changes in knowledge, attitudes and behaviour in specific health-related issues to programming that seeks to change or transform the social construction of masculinity. The review analysed data from 58 evaluation and considers:

- What is the evidence on the effectiveness of programmes engaging men and boys in sexual and reproductive health; HIV prevention, treatment, care and support; fatherhood; gender-based violence; maternal, newborn and child health; and gender socialisation?
- How effective are these programmes? • What types of programmes with men and boys show more evidence of effectiveness?
- What gender perspective should be applied to men and boys in health programmes?
- Does applying a gender perspective to work with men and boys lead to greater effectiveness in terms of health outcomes?

Produced by: WHO and Promundo (2007)
Location: https://www.who.int/gender/documents/Engaging_men_boys.pdf
Accessed: 04 Jan 2019

**Strengthening Civil Society Organizations and Government Partnerships to Scale Up Approaches to Engaging Men and Boys for Gender Equality and Sexual and Reproductive Health and Rights**

This publication provides guidance on best practices to promote partnerships between civil society organisations and government representatives on engaging men and boys in gender equality and sexual and reproductive health and rights. The goal of this publication is to strengthen these relationships to scale up and/or institutionalise evidence-based approaches to promoting gender equality and sexual and reproductive health and rights. This will be critical for moving beyond small scale and pilot initiatives.

Produced by: UNFPA, Promundo and the MenEngage Alliance (2016)
Location: https://www.unfpa.org/sites/default/files/pub-pdf/50694_-_Scaling_up_Men_and_Boys_-_revised.pdf
Accessed: 15 Jan 2019

**Adolescent boys and young men**

Achieving gender equality must, and has, involved efforts to understand the vulnerabilities and risks that adolescent girls and young women face every day – but how much do we know about the realities of adolescent boys and young men? This report takes a deeper look at the daily lives of adolescent boys and young men around the world and at how they can join the movement towards improved health and gender equality.

Produced by: UNFPA, Promundo (2016)
Location: https://www.unfpa.org/sites/default/files/pub-pdf/Adolescent-Boys-and-Young-Men-final-web_0.pdf
Accessed: 15 Jan 2019

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