



USAID
FROM THE AMERICAN PEOPLE

Essential Considerations for Engaging Men and Boys for Improved Family Planning Outcomes

Office of Population and Reproductive Health
Bureau for Global Health



Cover Photo

Credit: Mubeen Siddiqui/MCSP

Released September 2018

TABLE OF CONTENTS

INTRODUCTION.....	3
Background	3
WHY ENGAGE MEN AND BOYS IN FAMILY PLANNING?.....	4
Trends in Global Contraceptive Use.....	4
Barriers to Men’s Use of and Support for Contraception.....	5
Facilitators of Men’s Use of and Support for Contraception.....	6
Engaging Boys and Men Early in Life.....	6
MALE ENGAGEMENT FRAMEWORK AND PROGRAMMATIC EXAMPLES.....	7
Men and Boys as Family Planning Users.....	7
Men and Boys as Supportive Partners.....	9
Men and Boys as Agents of Change.....	10
Approaches to Gender Integration.....	11
PROGRAMMATIC CONSIDERATIONS FOR ENGAGING MEN AND BOYS.....	12
Gender Analysis.....	12
Planning and Implementation.....	12
Engendering Supportive Policies.....	13
Monitoring and Evaluation.....	14
CONCLUSION.....	14
ANNEXES.....	i
Annex A: Effective Programmatic Approaches.....	ii
Annex B: Key Terms.....	x
Annex C: Resources.....	xii
Annex D: References.....	xvi

ACKNOWLEDGMENTS

USAID's Office of Population and Reproductive Health Gender Team would like to acknowledge and give thanks to the many contributors who made this document possible. We would like to give special recognition to Anne Sanicki for her time spent working on this document during her Presidential Management Fellowship rotation. We would also like to acknowledge Myra Betron, Jane Brown, Margaret Greene, Karen Hardee, Chisina Kapungu, Luis Martinez, Dominick Shattuck, Joanna Skinner, Carol Underwood, Lynn Van Lith and numerous USAID staff at both missions and headquarters for their technical review and valuable contributions to the development of this document.

Please forward questions about this document or its contents to Michal Avni at mavni@usaid.gov or Afeefa Abdur-Rahman at aabdurrahman@usaid.gov.

INTRODUCTION

The purpose of this document is to (1) increase understanding of the role that gender plays in family planning (FP) with a focus on men and boys, (2) articulate a framework for male engagement that incorporates the transformation of inequitable gender norms and dynamics while engaging men as users, supportive partners and agents of change and (3) provide examples of effective male engagement interventions that practitioners can incorporate into their FP programs. Annexes provide details on programmatic examples, key terminology and links to programmatic resources.

The primary intended audience of this document is USAID^a staff at missions and headquarters who plan, design, implement or support FP programs. Implementing partners, donors and stakeholders engaged in decision-making about program investments and strategic planning of FP programs may also find this document useful.

BACKGROUND

In 1994, the International Conference on Population and Development highlighted the significance of gender—the socially defined roles of men and women (Box 1)—and gender inequalities in reproductive health (RH). This emphasis led to programs that reached men and boys, as well as women and girls, to address gender to achieve FP and RH outcomes.¹ Since then, the majority of FP interventions that have worked with men and boys have tended to be “small-scale and short-term.”² Nevertheless, these and other efforts have demonstrated that engaging men and boys in FP

is critical to improving FP outcomes for men, boys, women and girls.

Box 1: Gender

Gender is a culturally defined set of economic, social, and political roles, responsibilities, rights, entitlements and obligations associated with being female and male, as well as the power relations between the sexes.

Gender norms refer to social and cultural expectations about prescribed behaviors for men and women, including roles in relationships.

Male engagement in FP refers to the involvement of men and boys across life stages as a) clients/users, b) supportive partners and c) agents of change. The goal of male engagement goes beyond the mere inclusion of men and boys as program beneficiaries. Integral to FP programs that engage males is intentional attention to challenging unequal power dynamics and transforming harmful forms of masculinity (e.g., male control over decision-making) in order to improve men and women’s RH and contribute to gender equality outcomes. Specifically, engaging men and boys includes broader efforts to increase empathy and support for women’s rights and well-being and promote norms (e.g., equal access to educational opportunities for girls and boys) that lead to greater equality between males and females in their relationships, families and roles as parents and caregivers, while maintaining a focus on voluntarism and informed choice as a foundational

^a USAID advances and supports voluntary FP and RH programs in nearly 40 countries worldwide.

principle of FP programs. Ultimately, this approach aims to improve FP and RH outcomes for men and women in cooperative ways that also protect and encourage women's agency.

Throughout the life course, boys, young men and men have varying levels of FP knowledge and different RH needs. This document defines "men" as males 25 years and older who are more likely to be making life decisions about their expressed fertility desires, and have concerns about planning for their current or future families. "Young men" are defined as males 15-24 years old who are more likely to be forming ideas about sexual relationships and desired fertility.

They are also more likely to establish initial patterns of contraceptive behaviors. "Boys" are defined as males 14 years old and younger who need information to help them understand their bodies and to set a foundation for attitudes toward positive gender norms. It is understood, however, that not **all** men are planning families and that **some** adolescent boys and young men are involved in early marriages. Additionally, this document uses the terms "family planning" and "contraception" interchangeably with the understanding that programming should be tailored to the full range of motivations and needs of males as they navigate through different life stages.

WHY ENGAGE MEN AND BOYS IN FAMILY PLANNING?

Globally, women remain the primary focus of FP programs in light of their reproductive physiology and social roles. However, data suggest the potentially powerful contribution of expanding male engagement programming to meet global initiatives and goals such as Family Planning 2020³, Accelerating HIV/AIDS Epidemic⁴ Control and Ending Preventable Child and Maternal Deaths.⁵ As discussed below, data highlight the potential for a significant increase in men and boys' use of contraception and their support for women and girls' contraceptive use in order to meet these goals, improve men's RH and increase shared responsibility for FP.

TRENDS IN GLOBAL CONTRACEPTIVE USE

Globally, 63.6 percent of married and in-union women reported using any method of modern and/or traditional male-controlled, female-controlled or cooperative methods of contraception.⁶ At closer look (see Table 1), contraception use in Africa is at

33.4 percent and Southern Asia's use is close to global levels at 58.6 percent.⁶ Unmet need for spacing and limiting remains high at 12.0 percent globally, 22.0 percent in Africa and 14.0 percent in Southern Asia.⁶ In all regions (developed and developing), among married and in-union women, the prevalence of modern

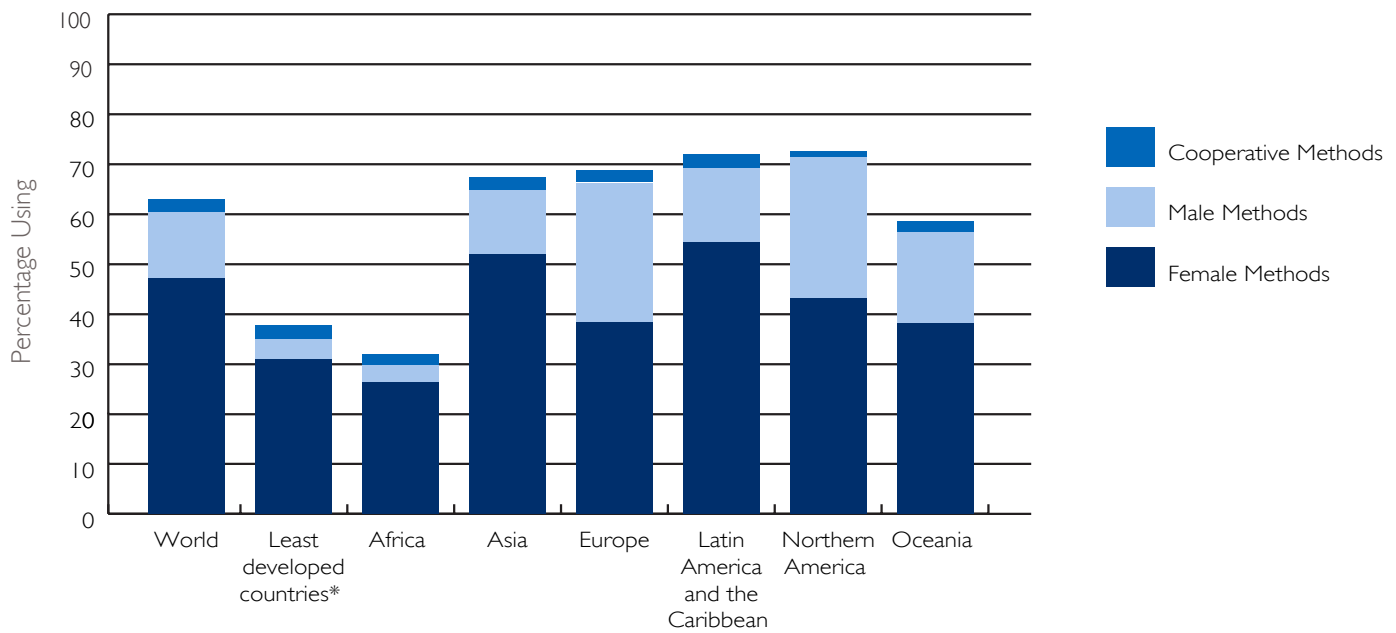
Box 2: Family Planning Method Types

Female-controlled FP methods require women's physical use and include the pill, injectable, implant, intrauterine devices, female sterilization, vaginal barrier methods, lactational amenorrhea and tubal ligation.

Male-controlled FP methods require men's physical use and include male condoms, vasectomy and withdrawal.

Cooperative contraceptive methods require participation and use by both partners (i.e., standard days method).

Table 1: Trends in Global Contraception Use



*The group of least developed countries encompasses 48 countries designated as such by the United Nations General Assembly, and defined as low-income countries suffering from structural impediments to sustainable development.

male-controlled methods is lower than modern female-controlled methods. For example, in Africa, the combined prevalence of vasectomy (0.0 percent) and male condom use (2.1 percent) is 2.1 percent compared to 26.4 percent for female-controlled methods. In Southern Asia, the combined prevalence of vasectomy (1.2 percent) and male condom use (6.4 percent) is 7.6 percent compared to 42.7 percent for female-controlled methods.⁶ These data highlight how increases in male use could address high unmet need when facilitating factors for men's support for and use of contraception outweigh the barriers.

BARRIERS TO MEN'S USE OF AND SUPPORT FOR CONTRACEPTION

Men's use of and support for women's use of contraception is shaped by a combination of factors, including differences in fertility desires between partners, attitudes toward contraception, communication, cultural and gender norms, limited availability of male-focused FP services and lack of attention to men in RH policies.

Men's use of family planning. Differences in female and male contraceptive use are not only due to the fact

that few male-controlled modern methods exists, for example, the use of vasectomy is lower than the use of tubal ligation, even where vasectomy is widely available.⁶ Gender-related barriers are among the demand-side barriers that limit the use of male-controlled methods. For example, concerns by both partners about the effect of vasectomy on masculinity (e.g., become physically weak and unable to work, unable to please his wife sexually, easier to have outside partners) may limit vasectomy uptake, even though it is safer and less costly than tubal ligation.⁷ Additionally, couples' male condom use is limited by a lack of experience and discomfort in discussing use with a partner and concerns about sexual pleasure and spontaneity, which in some contexts is considered a defining feature of masculine sexuality.⁸ Condom use is also often associated with disease prevention, infidelity and/or casual relationships, issues that couples have trouble discussing.⁸

Institutionally, the inclusion of male engagement into national RH policies is nascent.⁹ As of 2014, only 22 percent of countries that are signatories to the International Conference on Population and Development Programme of Action prioritized

“gender norms and male engagement” as a public policy priority.¹⁰ Additionally, analysis of Family Planning Costed Implementation Plans from five African countries suggests that most programming for men focuses on increasing their support for their partners’ use of contraception with little attention on increasing men’s own use of contraception.⁹ This lack of attention to men and boys in RH policies and guidelines contributes to limited access to male-friendly services. From the supply side, young men may face barriers to accessing FP/RH information, products, or services, due in part to insufficient availability of male-friendly services.⁹ Additionally, low rates of condom use are sometimes attributed to unreliable supply and distribution, and despite need, condom availability in many countries remains low.¹¹ Barriers to provision of vasectomies can include inadequate infrastructure, limited availability of services, negative provider attitudes and lack of accurate provider knowledge and skills about the procedure.^{12,13}

Men’s support for family planning. Gender-related barriers also limit men’s support for contraception. Although men’s ideal family size has declined in some countries in the past 10 years, men’s ideal family size—which influences women’s contraceptive use—was higher than replacement level in 18 countries.^{14,15,16} In contrast, women’s ideal family size was lower than replacement level in the same 18 countries.¹⁶ In many societies where men have greater decision-making authority in the home, they may act on their desire for more children by limiting women’s access to contraceptive services.¹⁷ Men and their partners also may not discuss FP and, as a result, may have an inaccurate understanding of each other’s fertility desires or views on FP methods and use.^{18,19} Additionally, prevailing definitions of masculinity suggest that in many contexts, men demonstrate their virility by having many children.²⁰ Men’s support for FP may be influenced by norms around reproductive responsibility and decision-making, perceived associations between female promiscuity and FP use, and comfort discussing FP and desired fertility with partners. For example, a study in Kenya found that men’s negative attitudes toward FP were influenced by their concerns about how FP

use impacted their identity as men and normative gender roles (e.g., suspicion of wives’ infidelity, fear of being “overpowered” by their wives).¹⁶ Furthermore, it is unclear how other dynamics such as intimate partner violence (IPV) impact men’s use and support of contraception. The impact of IPV on FP varies by country and context, and its effect on contraceptive use appears to be mixed. Some data show that those who experience IPV are more likely to use contraception. Conversely, other data suggest that women who experience IPV may not be able to negotiate contraceptive use with their partners.^{21,22,23}

FACILITATORS OF MEN’S USE OF AND SUPPORT FOR CONTRACEPTION

Fortunately, men’s support for contraceptive use has increased over time, particularly in sub-Saharan Africa.²⁴ Data further demonstrate that educated men, urban-dwelling men, and men who live in wealthier households are more likely to hold positive attitudes toward contraception.¹⁶ Men’s knowledge and support for contraceptive use is associated with increased contraceptive use among women.²⁵ Demographic Health Survey (DHS) data from 40 countries on men’s reproductive attitudes suggest that men who hold more equitable attitudes toward FP (e.g., believe that contraception is not just the woman’s responsibility) and about family roles and relationships (e.g., shared decision-making with women) are more likely to report using a female- or male-controlled method.^{2,16,26} Additionally, when it exists, open communication between couples about contraception helps facilitate men’s support for and women’s use of contraception.^{25,27,28,29}

ENGAGING BOYS AND MEN EARLY IN LIFE

Although the available data (as reported above) focus more on men (i.e., 25 years and older) than boys and young men (i.e., 24 years old and younger), gender-related issues play out across the life course. At all ages, boys and men are subject to social norms

around masculinity (e.g., boys are frequently teased and goaded into premarital sexual behaviors, boys and men are not sanctioned for having multiple partners and both boys and men often dictate the terms of sex, including condom use), but there are variations in their experiences and knowledge during different stages of their development.³⁰ Adult men's attitudes, values and behaviors related to relationships, gender roles, body literacy, responsibility for reproduction and other health-seeking behaviors are formed during adolescence.^{31,32} Biases or misconceptions from health care providers, peers, family members, teachers and other individuals who influence children's development can impact boys and young men's knowledge of and access to FP/RH products and services.³³

Throughout the life course, boys and young men's use and/or support for women's contraceptive use will evolve; this is frequently related to individuals' shifting relationship statuses. For example, younger unmarried males are unlikely to want to start a family, have more restricted access to services due to provider age biases

and may favor condoms or rely on their partners for contraceptive use. Married men and their partners face decisions about how many children to have, how to space pregnancies and when to limit children, and therefore may consider a wider range of contraceptive options, including permanent methods.

In sum, these patterns suggest that engaging men and boys in FP may improve FP outcomes for men, boys, women and girls, as well as challenge harmful forms of masculinity that prevent men from fully participating in their own RH.³⁴ Addressing gender dynamics has the potential to influence a host of factors that impact the health and well-being of men and women across the lifespan, including couple communication and decision-making about fertility desires and FP and shared responsibility for their family's health and well-being. *Fundamentally, reaching men and boys with age- and life-stage appropriate male engagement approaches also must be balanced with the need to safeguard rights and autonomy of women and girls.*

MALE ENGAGEMENT FRAMEWORK AND PROGRAMMATIC EXAMPLES

This section offers a programming framework for male engagement in FP as well as examples of effective male engagement activities and interventions. The framework positions the role of men and boys in FP as users, supportive partners and agents of change.³⁴ Activities and interventions may engage men and boys in one or more of these roles and **must** address gender inequalities and norms that act as barriers to men and boys' use and support of FP.

MEN AND BOYS AS FAMILY PLANNING USERS

To engage men and boys as users, or future users, programs must consider their unique needs at different life stages while addressing men's roles and male

Men and boys are FP **users** when they use male-controlled modern contraceptive methods (e.g., condoms and vasectomy) or a cooperative modern contraceptive method that requires active participation from both partners (e.g., the Standard Days Method).

sexuality. Male-friendly services, which train providers and staff on men's FP needs and adapt services to meet men and boys where they are, can engage men effectively as users.^{7,35} At a minimum, programs need to consider policy changes (e.g., availability of health budgets, services and products for men) and other factors that constrain men's use of services, including hours of operation (e.g., typically closed

when men are off work), sex of providers (e.g., men may be uncomfortable talking to female providers about sex) and perceptions that FP services are only for women. To reach younger men, programs should offer adolescent male-friendly services, community-based distribution of information and condoms (or condom outlets) and offer free or subsidized health care.^{36,37,38} Programs can engage young men and boys as they begin to forge relationships and transition through puberty, before they are FP users. Programs can work together with boys and young men, parents and teachers to improve communication about puberty and sexuality, increase knowledge and foster more equitable gender norms as well as a sense of shared responsibility for partnering, parenting and FP.³⁹

Programs also need to address method-specific barriers. Increasing uptake of male condoms may be achieved through attention to perceived advantages (e.g., privacy, cost, flexibility) and disadvantages (e.g., reduced sexual pleasure, stigma, loss of spontaneity) of condoms through social marketing, multi-group sessions and/or community group engagement.^{19,20,40,41,42,43} For youth and/or people living in areas with high rates of HIV and sexually transmitted infections, programs should consider promoting condoms as “dual protection” from unintended pregnancy, HIV and sexually transmitted infections.^{42,44,45} To increase uptake of vasectomy, programs should increase acceptability among men and women, address gender norms tied to contraceptive roles, generate demand and build staff capacity.⁷ Additionally, to increase men’s use of cooperative methods, programs should enhance men’s knowledge of body literacy and how to use these methods, as well as improve couple communication around FP.⁴⁶

Social and behavior change (SBC) interventions can improve knowledge of services, address negative attitudes and inequitable gender norms and encourage FP use. For example, SBC programs can work to improve boys’ and men’s reproductive knowledge and instill healthy attitudes and skills for communication, shared responsibility for reproduction, support for women’s access to and use of contraception and men’s

Box 3: Examples of Engaging Men as Users^{41,51}

To increase vasectomy uptake, the **Permanent Smile Campaign** project in Ghana trained providers on no-scalpel vasectomy and on male-friendly services. Each facility developed an action plan for community outreach, including ways to reach women and engage them in decision-making. Vasectomies increased by 350 percent over one year. The number of men in a panel study who reported they would consider a vasectomy also almost doubled from baseline to follow-up.

A social marketing program in Pakistan branded condoms **Touch** for an upscale market and used TV and radio spots that showed emotional closeness within a couple (thus the potential for communication) and men taking responsibility by purchasing condoms (rather than having the wife get condoms at the clinic). Exposure to the campaign was associated with increased use of condoms at last sex with wife (18.5 percent for unexposed men versus 22.0 percent for exposed men [$p < 0.0$]), and reduced embarrassment about purchasing condoms.

For additional information on these interventions and those in Boxes 4 and 5, please refer to Annex A.

use of male-controlled methods.⁴⁷ Mass media and other SBC approaches have been shown to increase men’s knowledge of condoms and ability to negotiate their use.⁴⁸ Similarly, research has shown that men’s attitudes toward FP can be influenced positively by sharing their experiences with other men and discussing FP with supportive and trusted influential people in their lives.⁴⁹ To promote positive attitudes and build skills for future healthy FP decision-making, programs can cultivate supportive behaviors among parents and caregivers. Interventions and activities for parents can promote gender equality for boys and girls, highlight puberty changes and children’s health and well-being, and build on parental skills for communicating with

and guiding children through adolescence.^{47,50} In order to work effectively, SBC and service delivery need to function in a harmonious and strategic ways to ensure that demand for services increase, gender-equitable attitudes and behaviors around health are reinforced, client-provider communication and service quality improves and appropriate follow-up care is conducted.

MEN AND BOYS AS SUPPORTIVE PARTNERS

Men and boys are **supportive partners** when they have a positive impact on their partners' FP choices and contraceptive use through increased couple communication and equitable, joint decision-making, resource provision for FP services and/or support for continued use.

Interventions that position men and boys as supportive partners also seek to improve their knowledge and attitudes toward FP and to increase and enhance partner communication, joint decision-making and shared responsibilities.^{52,53} Such interventions have resulted in improved FP attitudes, couple communication and joint decision-making skills and can be implemented within service delivery and/or SBC programs.^{46,51,53,54,55,56} For example, service delivery programs can engage men as supportive partners by ensuring facilities are welcoming to men and couples, in turn helping to dispel misconceptions that position FP services as solely for women; by providing couples counseling that includes comprehensive information on all methods; and by supporting men to be empathetic and respectful toward their partners' concerns as they engage in reproductive decision-making.

SBC activities and interventions can provide accurate information on fertility and contraception and address method-specific barriers to male- and female-controlled methods (e.g., concerns about return to fertility for hormonal methods, having an intrauterine device or implant inserted or the effect of condoms on sexual pleasure). In addition they should create

access to safe spaces where men, boys, women, girls or their parents (separately or in mixed groups) can identify, discuss and challenge inequitable gender norms and traditional notions of masculinity and femininity and learn and practice positive forms of communication and healthy relationship skills.³⁵ SBC efforts (e.g., service communication, group-based education and discussion, radio serial dramas and/or community group engagement) may be used alone or in combination with other SBC or service delivery approaches to promote gender equality and to encourage men and boy's support for FP.

Box 4: Examples of Engaging Men as Supportive Partners^{20,54}

The **Malawi Male Motivators** project relied on trusted men in the community (i.e., male motivators) to reach young men who (themselves or their partners) were not using contraception. Male motivators conducted five individual sessions in the men's homes, where they addressed FP knowledge and attitudes, conducted activities to challenge gender norms and improve couple communication and joint decision-making and provided referrals for FP methods. At endline, ease and frequency of communication between couples increased and 78.0 percent of men in the intervention (versus 59.0 percent of men in the control group) reported increased FP use (mostly the pill or the male condom).

A **Community Health Worker** program in Ethiopia employed male and female RH agents to provide FP information to couples in their homes, and promoted couple communication in home-based visits and monthly community meetings. Among people not using contraception at baseline, there was a positive association between participation in home-based counseling sessions and FP use (28.6 percent had started using contraceptives compared to 17.2 percent in the control group [$p=.014$]) and all men were more willing to be involved in FP.

MEN AND BOYS AS AGENTS OF CHANGE

Men and boys are **agents of change** when they use their social capital, status or power to take public action outside of their intimate sexual relationships to address barriers to FP and contraception, particularly those related to harmful gender norms and inequalities. Public action must take place in collaboration with women and women's groups, and may include discussion and advocacy to influence family and community members, peers and religious and policy leaders to promote gender equality.

FP programs that position men and boys as change agents within their families, social networks, communities and societies are needed to cultivate equitable gender norms and an enabling environment for FP use. Such programs engage with men and women to challenge rigid gender roles and norms and to advocate with institutional and government bodies for gender-equitable FP policies and programs.² What sets these programs apart from those that engage men as users and/or supportive partners is the nature of public action that men and boys might take as a result of the program. In addition to understanding and challenging restrictive gender norms in their own lives and families, becoming more supportive partners and sharing parenting and household responsibilities, men and boys as agents of change (including community or religious leaders) commit to sharing what they have learned with others (e.g., peers, extended family). They commit to using their social capital to propel positive change within the wider community. Programs that engage men and boys to work with women and women's groups for public action in support of FP are currently limited.

Men can hold positions as change agents that extend beyond the FP sphere. By addressing men's roles in

families and communities and encouraging their own and their partners' support, men can be engaged as mentors to cultivate positive fatherhood within communities, discourage IPV and physical punishment toward children, encourage behaviors that delay child marriage or mitigate its negative effects and improve women's economic empowerment and entrepreneurship opportunities.^{57,58,59} FP programs seeking to engage men as agents of change can learn from work that has been implemented in HIV prevention programs. For example, organizations like Sonke Gender Justice and Raising Voices have engaged with men and boys to take action alongside women's organizations to confront gender inequalities and mobilize for social change.^{60,61,62} While these specific efforts have focused on other health areas, they can be adapted to the FP context.

Box 5: Example of Engaging Men as Agents for Change⁶³

In Benin, **'Tékponon Jikagou' (TJ)** used social network approaches to generate discussion about gender equity and FP and connect individuals to services. TJ recruited men and women as volunteer "catalyzers" to facilitate discussion sessions about gender equity and FP-related issues and refer participants to health services. Qualitative research indicated that men reached by the volunteer catalyzers also raised awareness about FP among male peers in their networks and some took additional actions such as providing funds for women to access FP. Evaluation results revealed that men who were exposed to group discussions and influentials were 2.8 times more likely to visit a health center to obtain a FP method than those not reached by TJ. At least six months after catalyzers had finished their last structured information and discussion session, some were still meeting with their groups to discuss gender equity and FP.

APPROACHES TO GENDER INTEGRATION

Male engagement efforts must address gender inequalities and norms that act as barriers to men and boys' use and support of FP. To ensure that efforts are minimizing unintended negative consequences and addressing relevant gender dynamics effectively, program managers can use the Gender Integration Continuum,^b a framework for integrating gender into programs.⁶⁴ Along this continuum, activities and interventions are *gender-blind* when they do not take gender into account and are *gender-aware* when they recognize gender constructs. Gender-aware activities can be:

1. *Gender-exploitative*: These activities reinforce inequitable gender norms, roles, stereotypes and unequal power dynamics.
2. *Gender-accommodating*: These activities work around existing gender norms and inequalities.
3. *Gender-transformative*: These activities work to challenge and change inequitable gender-related factors.⁶⁵

Above all, activities must avoid being gender-exploitive (e.g., ads for contraception depicting men in stereotypically “macho” aggressive or promiscuous roles). Gender-accommodating activities (e.g., modifying hours of services so men can attend) are often a necessary first step on the path toward gender-transformative activities (e.g., encouraging couples who have reached their desired family size to participate

in couples counseling where they discuss gender roles and joint decision-making about permanent methods). Programs should work towards being gender transformative to achieve truly sustainable change.

Male engagement efforts should also be integrated into programs that reach women. They should be “*gender-synchronized*,” meaning that they engage men and women and girls and boys in complementary and mutually reinforcing ways.⁶⁶ These efforts can happen simultaneously or in sequence, as long as they intentionally work with males and females, together or separately, to move along a gender-transformative path. Gender-transformative and synchronized activities help programs avoid the “add men and stir” approach, which means simply including men as beneficiary populations with no articulated gender equity objective. They also safeguard against the possibility of reinforcing power imbalances or other negative outcomes for women and girls.

Annex A expands on the examples provided previously in Boxes 3, 4 and 5 by providing a more comprehensive compilation of programmatic approaches and interventions. All of these approaches engaged men and/or boys intentionally, used a gender-accommodating, -transformative and/or -synchronized approach, were rigorously evaluated and resulted in positive outcomes for FP use. This compilation can serve as a resource for programs aiming to increase FP outcomes among men and boys and/or women and girls.

^b For a full visual of the continuum, see Annex C.

PROGRAMMATIC CONSIDERATIONS FOR ENGAGING MEN AND BOYS

Integrating male engagement activities into FP programs can achieve gender-related outcomes, such as increased male responsibility for FP and more open communication between partners about FP. These outcomes can, in turn, increase the voluntary use of female-controlled, male-controlled and cooperative methods of contraception. Program managers and planners can integrate male engagement activities at any point in the life-cycle of a FP project and need not wait for a new project design in order to do so. When implemented effectively, multi-component interventions (i.e., interventions with a set of complementary activities designed to achieve program goals) can also lead to improved FP results.^c Ultimately, any effort to engage men and boys should always follow standard practices for developing and implementing quality activities, interventions and programs (i.e., gender analysis, sound program design and monitoring and evaluation). Most importantly, male engagement efforts should not diminish efforts to enhance women and girls' RH and agency. Additional information that outlines a strategic step-by-step process for effective investment in male engagement in FP is available online at <http://www.fphighimpactpractices.org/guides/engaging-men-and-boys-in-family-planning/>.

GENDER ANALYSIS^d

Gender analysis of existing and/or new data provide an in-depth understanding of gender issues that influence FP outcomes in particular contexts. Analyses should address factors such as gender roles and power dynamics within families and communities; differences in opportunities for education and employment, access to services, control over resources and participation in public life; and norms associated with sexual behavior,

relationship formation, marriage, couple communication and decision making and shared responsibilities within the family. It is important to remember that men and boys do not constitute homogenous groups; rather, they represent varied experiences, concerns and attitudes toward gender and FP as well as diverse aspirations and priorities. Understanding this diversity through gender analyses and other formative research is crucial to designing quality interventions.

PLANNING AND IMPLEMENTATION

Programs can and should integrate male engagement activities into new and ongoing efforts, including policy, service delivery and SBC interventions. For men and boys to fully engage in their own RH, to support their partners and to advocate for positive change in their communities, these efforts should seek to increase:

- Men and boys' knowledge about body literacy, RH and FP.
- Positive attitudes about FP, contraceptive methods, shared responsibility and well-being.
- Respectful communication between partners about desired fertility, FP and joint decision-making.
- Access to FP products and services.
- Understanding of how gender dynamics influence FP and how to promote more equitable gender norms that support men's use of and support for contraception.

Similarly, programs that effectively engage young men and boys must understand the vulnerabilities they face as well as the unique and diverse needs of subpopulations of boys and young men, and tailor their interventions accordingly.^{33,67}

^c See Annex A for a full table of effective interventions.

^d See Annex C for tools and additional resources on how to conduct a gender analysis.

Since attitudes and behaviors are often formed during adolescence, reaching boys earlier is an opportune time to shape more equitable attitudes and values related to relationships, gender roles, body literacy, shared responsibility for reproduction and women and girls' RH needs.³¹

Ideally, efforts should be linked across the spectrum of FP programming. For example, policy changes that support men and boys' access to FP services should be linked with provider training on men and boys' RH needs and male-friendly services should be linked with demand creation activities designed to address norms, increase contraceptive knowledge and promote voluntary FP. In addition, while reaching men and boys with these approaches, engaging women and girls in discussions that provide

Box 6: Strategies to Effectively Engage Men and Boys in FP Programming

- Implement gender-transformative programmatic approaches.
- Use a gender-synchronized approach by working with men, women or couples in mutually reinforcing ways.
- Ensure that programs are age-appropriate and tailored to youth and adolescent-specific needs, cultural contexts and life stages.
- Include multiple, complementary components to maximize effectiveness.
- Create safe spaces for critical discourse and reflection for program participants.
- Promote shared responsibility for RH and contraception and provide opportunities for men and boys to build empathy for women and girls' challenges and issues.
- Mobilize communities through outreach and engagement with community members and community influencers to create an enabling environment for FP use and promotion.

opportunity for reflection on existing norms and behaviors can improve program effectiveness.

These and other cross-cutting strategies and programmatic principles for male engagement should focus on gender-transformative and -synchronized approaches (see Box 6). For example, the activities in Boxes 3 and 4 engaged boys and girls in community dialogue and targeted individuals and/or couples with programming that integrated messaging on gender inequalities. Community outreach or community group engagement may be particularly important for challenging and changing inequitable gender norms. For example, reflective dialogue among men and women and girls and boys provides a space to identify and reshape notions of masculinities and femininities that may help develop men and boys' consciousness around gender equity and equality, an essential first step to becoming agents of change.

ENGENDERING SUPPORTIVE POLICIES

Crucial to ensuring sustainable integration of male engagement in FP programs is its inclusion in national FP and RH strategies and policies. This requires strategic planning, financing and the support of policymakers who appreciate the importance and benefits of engaging men and boys in the FP space. Efforts are needed to generate political and programmatic will to implement policies that support male-friendly FP services and address normative and demand-side barriers to men's engagement with FP services. There is a need for activities that promote national policies and financing for FP/RH agendas that include a focus on men, boys and couples. This means that male-controlled contraceptive methods (vasectomy and male condoms) and incremental costs associated with engaging men in services (e.g., the costs of having condoms and trained vasectomy providers readily available) are included in national-level costing for commodities, services, implementation of FP programming, as well as in national FP

guidelines. Additionally, policies should require that the FP needs of men and boys are included in RH curricula for healthcare providers.⁷ Integrating male engagement into FP policies and financing structures (e.g., Costed Implementation Plans) would help drive the paradigm shift needed to enhance support for FP use, men's FP use and ultimately achieve improved RH and well-being of men and their families.

MONITORING AND EVALUATION

Monitoring and evaluation for both gender and FP outcomes are necessary to improve the quality of programs and to advocate for the importance of

this work. Indicators (e.g., service use, contraceptive use) that are age- and sex-disaggregated should be used to better understand outcomes for men, boys, women and girls and to enhance future programming. Indicators to assess changes in gender norms are needed as well. Measures such as the Gender Equitable Men (GEM) scale and indicators from the DHS on household decision-making or women's empowerment can be used to assess pre- and post-intervention changes in gender norms. Annex C lists additional resources to help FP/RH programs integrate gender into their monitoring and evaluation activities, measures and reporting.

CONCLUSION

Engaging men and boys in FP without sacrificing the needs and agency of women and girls is essential to improving health outcomes for all people. Although FP programs have focused primarily on women as beneficiaries, a paradigm shift is needed to increase and enhance the role of men and boys not only as supportive partners, but also as users and future users of FP as well as champions of equitable FP and RH behaviors. Within this new paradigm, it is essential to start early by reaching adolescent boys, young men and their influencers (i.e., parents) with health programming to cultivate equitable attitudes, norms and behaviors that serve as foundational resources for men as they pass through different life stages. Programs can engage boys and men individually, as part of a couple, or in group and community events. Intentionally coordinating these programs with women- and girl-centered efforts is recommended for attaining optimal long-term impact.

Engaging men and boys as users, supportive partners and agents of change can also play a key role in accelerating global FP goals such as Family Planning 2020 by sharing the responsibility for voluntary FP more evenly among men and women and adding new contraceptive users. Most importantly, any efforts to engage men and boys must be designed

with an understanding of the needs of women and girls and must safeguard their autonomy and rights.

Outside of improved FP outcomes, the process of involving boys and men in FP programming may have a positive spillover effect into other health and non-health contexts. Addressing dynamics such as improved couple communication, healthy decision-making, more equitable attitudes toward health and more supportive father-child relationships may contribute to improved outcomes in other development areas (e.g., eliminating gender-based violence (GBV), improving education outcomes). The programmatic approaches and recommendations in this document provide a roadmap for how to engage men and boys effectively in FP. These essential considerations will help USAID mission and headquarters staff design, implement and evaluate FP activities that will contribute to the evidence base for engaging men and boys in FP using SBC, service delivery and other strategies. As a result, programs will develop more nuanced and meaningful activities that address the gendered complexities of men and women's reproductive realities and increase better health outcomes for all.

ANNEXES

ANNEX A: EFFECTIVE PROGRAMMATIC APPROACHES

PROGRAMMATIC APPROACHES TO ENGAGING MEN AND BOYS IN FP^e

Service Delivery & Service Communication				
Program Name	Country/ Target Population	Details of the Approach	Evaluation & Intermediate Outcomes	Reference
Male-Centered Clinical- or Facility-Based Services				
The ACQUIRE Project's "Permanent Smile"	Ghana/ Providers and men 35+ years old/Urban settings	<p>Objective: Increase provider knowledge and generate demand for no-scalpel vasectomy (NSV).</p> <p>Intervention: Physicians and staff trained in NSV and on providing male-friendly services. After the training each facility staff developed an action plan for community outreach. NSV information was provided through nationally televised ads to reach men and women.</p>	<p>Evaluation Client-provider communication was assessed via mystery client study (n=6). Knowledge and acceptance of NSV among potential clients was assessed with baseline and follow-up surveys (n=200) in 2003-2004 and with three follow-up panel surveys in 2008 (n=240 each survey).</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> NSV procedures increased from 2003 (n=26) to 2004 (n=83) and 2007 (n=18) to 2008 (n=53). <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> Improved attitudes and knowledge around NSV by trained health staff, with mystery clients reporting they received accurate and nonjudgmental NSV counseling. Increased awareness of NSV and the proportion of men who would consider NSV. 	Subramanian, et al., 2010 ⁵¹

^e With the exception of The GREAT Project and Tékponon Jikaugou below, there is limited specific information about costing to design male engagement activities/interventions or integrate male engagement into activities/interventions. For intervention-specific costing information, please refer to the respective intervention's reference, or email the USAID contacts provided on page 2.

Healthy Images of Manhood	Tanzania/Men aged 18+/Urban settings	<p>Objective: Increase use of health services and increase safer sexual behaviors (in the context of high-HIV prevalence).</p> <p>Intervention: Tea estate provided free medical care to employees and dependents (hospital, two HIV/AIDS clinics and dispensaries), integrated gender, RH and FP education and services into existing HIV/AIDS prevention and treatment services, provided clinical staff training on gender, RH, and FP and male public health educators/role models made household visits to conduct couples counseling, distribute male and female condoms and make referrals to services.</p>	<p>Evaluation Quantitative and qualitative data were collected. Monthly output data were collected on the number of counseling sessions, number of referrals, and number of male and female condoms distributed. Service statistics from health facilities were collected quarterly and structured interviews and focus group discussions (n=300) were conducted.</p> <p>FP Outcome</p> <ul style="list-style-type: none"> • Number of FP visits increased by 28 percent (from 1,036 to 1,443) from 2008-2009. <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> • Men increased their use of clinical services, including HIV testing. • Reported improved changes in gender relations between men and women, developing positive male views on changes in relationships among men and women in the workplace. • Men were more likely to engage with services for families. • Men reported being viewed as change agents. 	ESD, 2010 ⁶⁸
---------------------------	--------------------------------------	--	--	-------------------------

Community Health Workers

CHARM	India/Married men 18–30 years old and their wives/Rural setting	<p>Objective: Engage men in FP and gender equity to increase contraceptive use, couple communication on FP and to reduce IPV.</p> <p>Intervention: Conducted three gender, culture and contextually-tailored counseling sessions on FP and gender equity, including discussions of FP options, barriers to FP, the importance of healthy couple communication on FP and gender equity issues (including son preference) and the provision of free male condoms and oral contraception. The sessions were delivered by trained male village health workers in a clinical setting or near or in the participant's home. Married men received the first two sessions alone and the third session was for the married couple.</p>	<p>Evaluation Two-arm cluster randomized controlled trial with young married couples (n=1,081 couples, men aged 18-30 years old) that were recruited from 50 geographic clusters (25 clusters randomized to CHARM, 25 clusters randomized to control condition). Baseline survey and follow-ups at 9- and 18-months.</p> <p>FP Outcome</p> <ul style="list-style-type: none"> • Women in the intervention versus the control group were more likely to report modern contraceptive use at the 9- and 18-month follow-ups (50 percent more likely at 18-month follow up). <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> • Women in the intervention group versus the control group were less likely to report sexual IPV at 18-month follow-up. • Women in the intervention group were more likely to report couple communication on contraception at the 9-month follow-up. • Men in the intervention group versus the control group were less likely to report accepting attitudes of sexual IPV at the 9- and 18-month follow-ups and attitudes of physical IPV at 18-month follow-up. 	Raj, et al., 2016 ⁵⁵
-------	---	---	---	---------------------------------

<p>Couple-Based FP Education and Counseling</p>	<p>Ethiopia/Women aged 15-49 and their husbands/Rural setting</p>	<p>Objective: Encourage couple communication to increase FP use.</p> <p>Intervention: Activities included FP education—through print media and face-to-face discussions, at the household level and at monthly community meetings—and promotion of couple communication on FP. Trained male and female community agents administered these FP educational activities during household visits.</p>	<p>Evaluation Quasi-experimental design of married couples with an intervention and control group. Baseline (n=1,622 individuals) and endline (n=1,546 individuals) surveys administered to both groups.</p> <p>FP Outcome</p> <ul style="list-style-type: none"> • There was a positive association between participation in the intervention and FP use for those participants in the intervention group who were not using an FP method at baseline because of a reported lack of FP knowledge, versus the control group (28.6 percent had started using contraceptives compared to 17.2 percent in the control group). <p>Intermediate Outcome</p> <ul style="list-style-type: none"> • Post-intervention, men in the intervention group had a significantly higher level ($p < .01$) of reported willingness to be actively involved in FP than those in the control group. 	<p>Tilahun, et al., 2015⁵⁴</p>
---	---	---	--	---

Social & Behavior Change

Program Name	Country/ Target Population	Details of the Approach	Evaluation & Intermediate Outcomes	Reference
Peer Education				
Male Motivators Project	Malawi/Men aged 18+/ Rural settings	<p>Objective: Engage men in FP using male motivators who were ≥30-years-old, married and enthusiastic about modern contraception as peer outreach workers.</p> <p>Intervention: Male motivators conducted five home visits and provided information on modern FP options and local facilities where they were accessible. Men that requested male condoms or oral contraception were provided with those methods the next day. For other FP methods, male motivators referred men to local hospitals and clinics with the male motivators facilitating the appointment. The male motivators targeted “men with messages focused on the financial and health-related benefits of FP, information about contraceptive methods and activities to challenge gender norms and improve spousal communication.” Male motivators emphasized the importance of joint FP decision-making for couples.</p>	<p>Evaluation Randomized study design (n=397). Baseline and post-intervention survey for intervention and control groups of men who reported not using any contraception method. The intervention arm received five visits from a motivator over six-months and the control arm participants received the post-intervention survey. One-year post-intervention in-depth interviews were conducted with some men in the intervention group and with female partners (n=30).</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • 78 percent of the intervention arm and 59 percent of the comparison arm reported that they were using FP methods with their wives. • Of the men in the intervention group that reported contraceptive uptake, 56 percent reported using male condoms, 41 percent reported their partner using injectables and 14 percent reported their partner using oral contraception. <p>Intermediate Outcome</p> <ul style="list-style-type: none"> • Qualitative data showed that men find financial arguments for FP to be persuasive and several participants linked the financial benefits of using FP with the health outcomes of their wives and children. 	Shattuck, et al., 2011 ²⁰

Multi-Session Group Meetings

<p>Group Education with Men</p>	<p>Nigeria/Men aged 18–73/Urban settings</p>	<p>Objective: Lower risk of HIV/STI infection and unintended pregnancies.</p> <p>Intervention: Groups of men met for two five-hour workshops and a monthly two-hour check-in session. The sessions emphasized communication, assertiveness and negotiation skills needed for practicing safer sex as well as developing more gender-equitable attitudes. Workshop topics included HIV-related stigma, HIV/STI risks and prevention, pregnancy risks and FP options, sexual negotiation, GBV and setting personal risk-reduction goals to reduce unintended pregnancies. Methods included didactic and interactive teaching, small-group discussion and role-playing, proverbs, songs, stories and games.</p>	<p>Evaluation Quasi-experimental, with intervention group (n=149) and control group (n=132). Baseline survey and then a survey three-months post-intervention.</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • Men in the intervention group were four times more likely than those men in the control group to report having used a male condom at last sex (p<.001). • Men in the intervention group reported greater safer sex self-efficacy, more equal power dynamics in their primary relationships, more positive expectations of male condom use and more intent to use male condoms consistently moving forward. 	<p>Exner, et al., 2009⁴²</p>
---------------------------------	--	--	--	---

<p>Emanzis: Male Engagement Intervention FP/HIV Integration Project</p>	<p>Uganda/Men aged 18+/ Rural settings</p>	<p>Objective: Engage men in sexual health and RH as users, supportive partners and agents of change.</p> <p>Intervention: Ten-session curriculum engaged men in discourse on gender norms and in FP and HIV services. The interventions included male role models leading the groups and acting as peer educators, as well as community outreach to faith-based organizations.</p>	<p>Evaluation Cross-sectional surveys conducted pre- (n=1,251) and post-intervention (1,122). The Gender Equitable Men (GEM) Scale was applied to look at impact on attitudes about gender.</p> <p>FP Outcome</p> <ul style="list-style-type: none"> Increased male condom use with main partner from 13.9 percent pre-intervention to 32.8 percent post-intervention. <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> There were improvements in men utilizing HIV testing and health facility visits. 	<p>Ghanotakis, et al., 2016⁶⁹</p>
---	--	--	--	--

Mass Media Campaigns

<p>Urban Reproductive Health Initiatives (URHI)</p>	<p>India, Nigeria, Kenya, Senegal/Men and women aged 15–49/ Urban settings</p>	<p>Objective: Generate demand for FP and increase the use of modern contraceptive methods, particularly in low socioeconomic populations.</p> <p>Intervention: All four countries utilized mass media (including radio programs and spots, television spots and print media) and community group engagement strategies. Country-specific components to the program were:</p> <ul style="list-style-type: none"> • India's program included home visits by community health workers to provide FP counseling and referrals for men and women, and promote long-term and permanent methods to women who had recently become pregnant. • Nigeria, Kenya and Senegal all conducted outreach with community and religious leaders. • Nigeria and Kenya programs both included improvements to service delivery models. • Kenya implemented youth groups to address social norms and barriers to FP use. 	<p>Evaluation (Illustrative) Longitudinal household surveys were administered to women in all four countries, with data collected at baseline and endline. Senegal also conducted a cross-sectional study.</p> <p>FP Outcomes (Illustrative) Some evidence of increased contraceptive use in some groups and cities in all countries.</p> <ul style="list-style-type: none"> • Nigeria: Propensity score matching showed increased contraceptive use in the four cities that was attributable to exposure to the intervention was 9.9 percentage points. • Kenya: Contraceptive use increased by 20.5 percent for the poorest wealth quintile from baseline to endline, and 21.5 percent for the poor wealth quintile over that same period. • Kenya and Senegal: Significant increase in use of long-acting reversible contraception. 	<p>Achyut, et al., 2016⁷⁰</p> <p>Krenn, et al., 2014⁷¹</p> <p>Muthamia, et al., 2016⁷²</p> <p>Senegal tech working paper, 2015⁷³</p>
---	--	--	---	--

Social Marketing

<p>Male Condom Social Marketing</p>	<p>Pakistan/Men and women aged 15–49/ Urban and rural settings (national campaign)</p>	<p>Objective: Impact contraceptive use at the population level.</p> <p>Intervention: The two-phase, three-month male condom advertising campaign was a part of a larger social marketing program. It included television and radio spots targeting young middle- and upper-middle-class couples that had recently had a child. The campaign integrated male condom messaging with healthy timing and spacing of pregnancies.</p>	<p>Evaluation A nationally representative Advertising Impact Survey administered at baseline (n=806) and endline (n=617) to married men with wives of reproductive age (15–49).</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • Ever use of male condoms increased from 49 percent to 55 percent (p< 0.01). • Use of male condoms at last sex with wife increased from 18.5 percent to 22 percent (p< 0.05). • Consistent use of male condoms with wife increased from 12.5 percent to 16 percent (p< 0.05). <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> • Men with confirmed exposure to the campaign reported increased perceived availability of male condoms, discussion of FP, approval of FP and male condom procurement. 	<p>Agha and Meekers, 2010⁴¹</p>
-------------------------------------	--	--	---	--

Community Group Engagement

<p>CARE: Family Planning Results Initiative</p>	<p>Kenya/Married men aged 20–49 and women aged 18–45/Rural settings</p>	<p>Objective: Increase the acceptability and demand for FP among men and women, and challenge and change gender norms and inequitable power relations.</p> <p>Intervention: Based on CARE's Social Analysis and Action approach, the intervention held ongoing dialogues on social and gender norms in community meetings, with community groups, women's groups and village savings and loans groups. It also included community drama programs on gender, sexuality and FP and on increasing the availability of contraceptives at the community level. The project supported religious leaders to provide clear messages normalizing FP. Role model couples shared FP stories with the community and male community leaders engaged with men.</p>	<p>Evaluation Quantitative and qualitative. County-representative, cross-sectional household surveys at baseline in 2009 (n=650 women/305 men) and endline in 2012 (n=617 women/317 men). In-depth interviews with 10 couples.</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • Men and women's FP use increased significantly from baseline to endline. • Male condom use rose from 18.5 percent to 27.2 percent. • Men reported their partners' use of injectables (from 4.7 percent to 18.3 percent) and oral contraceptives (from 3.7 percent to 10.4 percent) rose from baseline to endline. <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> • Couple communication was significantly associated with exposure to the intervention. • For women, couple communication and self-efficacy were positively associated with exposure to the intervention, but women's increased participation in household decision-making was not a significant predictor of FP use. 	<p>Wegs, et al., 2016⁵³</p>
---	---	--	---	--

<p>Program H (Youth)</p>	<p>Brazil/Young men and boys aged 14–25/Urban settings</p>	<p>Objective: Work with men and boys to change gender norms around masculinity and “machismo” and their related effects on sexual and reproductive health.</p> <p>Intervention: Included interactive education for young men led by adult male facilitators or education sessions and/or a community-level social marketing campaign to promote male condom use through gender-equitable messaging that reinforced ideas promoted in the education sessions. One intervention site, Maré, focused on group education; the other intervention site, Bangu, combined group education with social marketing.</p>	<p>Evaluation Cohorts in three sites with two intervention sites and one control site. Baseline (n=780), six-month midline (n=622) and twelve-month endline (n=407, control group not included in endline surveys as a delayed intervention followed the control period).</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • At midline and endline there was a statistically significant increase in reported male condom use at last sex with a primary partner in Bangu ($p < 0.05$). • Male condom use at last sex with a primary partner increased in Maré at midline and baseline, but it was not a significant increase. <p>Intermediate Outcome</p> <ul style="list-style-type: none"> • Statistically significant decrease in attitudes supporting inequitable gender norms in the intervention areas. 	<p>Pulerwitz & Barker, 2006³⁰</p>
------------------------------	--	---	--	--

<p>PRACHAR (Youth)</p>	<p>India/Married and unmarried youth, boys and girls, aged 15–24/Rural settings</p>	<p>Objective: Use communications-based interventions to increase voluntary contraceptive use, healthy timing and spacing of pregnancies and shift norms and behaviors around early marriage and childbearing.</p> <p>Intervention: The intervention worked with communities to build socially enabling environments and to increase information and access to RH and FP services. Activities engaged individuals, couples, groups and communities. During household visits, male change agents encouraged male involvement and couples' joint decision-making, while female change agents visited young married women. Parents and mothers-in-laws were reached through community meetings and the broader community was reached through wall paintings, puppet shows and street theater. Rural health practitioners were trained on FP and RH.</p>	<p>Evaluation Quasi-experiment, cluster sampling was used to interview women at baseline in 2001 (n=1,995 women) and endline (n=2,080 women) in 2005.</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • Contraceptive use rose in both the intervention and control areas, but adjusted odds of use in intervention areas were 3.8 times higher than in control areas. • Contraceptive use was low at baseline for the intervention and control areas (2–6 percent); contraceptive demand increased from 25 percent to 40 percent in intervention areas, and was unchanged in control areas. 	<p>Daniel et al., 2008⁵⁶</p>
----------------------------	---	---	--	---

<p>The GREAT Project (Youth)</p>	<p>Uganda/ Youth, boys and girls 10–19 years old and their communities/ Rural settings</p>	<p>Objective: Identify and prioritize adolescent sexual and reproductive health issues and engage community and government leaders.</p> <p>Intervention: GREAT first implemented the Community Action Cycle by establishing nine-member community action groups (CAGs). These CAGs conducted awareness raising meetings and reflective community dialogue sessions that engaged participants in a process of advocacy and collective action on gender equality, FP and violence. The CAGs also worked with families and youth groups on integrating GREAT teachings into daily behavior. Local community-based organization staff mapped existing community groups, school-based clubs and health services. They then chose three groups in each village to receive the GREAT tool kit during a half-day orientation. The radio and village health team dramas were then launched, with parallel engagement of adults through the radio broadcasts and CAG and youth group activities.</p>	<p>Evaluation Stratified two-stage cluster sampling methodology. Household and school-based baseline survey and an endline survey conducted at the end of the 22-month pilot. Four intervention sub-counties compared to two control sub-counties. In-depth interviews with adolescents conducted every six months in the intervention and control areas to look at norms change.</p> <p>FP Outcome Among newly married or parenting adolescents exposed to GREAT:</p> <ul style="list-style-type: none"> • Current FP use increased from 33 percent to 43 percent from baseline to endline. <p>Intermediate Outcomes Among newly married or parenting adolescents exposed to GREAT:</p> <ul style="list-style-type: none"> • Reported they believed men and women are equal (48 percent vs. control group 37 percent). • Reported fewer experiences touching/being touched without permission in the past three months (4 percent vs. control group 12 percent). • Had more gender-equitable attitudes toward education (56 percent vs. control group 36 percent). • Husbands exposed to GREAT were more likely to be involved in household work and child care (65 percent vs. control group 53 percent). 	<p>IRH, 2016³³</p>
----------------------------------	--	--	---	-------------------------------

<p>Tékponon Jikaugou</p>	<p>Benin/Men and women of married age/Rural settings</p>	<p>Objective: Address gender and social factors that hinder dialogue on FP.</p> <p>Intervention: Used a social network analysis approach to FP, which was designed to mobilize communities and individuals. The intervention package included engaging communities in social mapping, supporting influential groups in reflective dialogue, encouraging influential individuals to act and using radio broadcasts of stories on gender roles and cultural norms of fertility to create an enabling environment for discussion and to link FP providers and members of influential groups.</p>	<p>Evaluation In-depth baseline, two mid-intervention (at six months intervals) and at the endline of the intervention (n=50). Household survey comparing the experimental (n=2,000) and control (n=2,000) groups at baseline and endline.</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • Increased reported use of modern contraception methods. <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> • Increased reported couple communication. • Increased perceived FP use (which included visits to a health facilities to obtain a method and talking to a partner about how to obtain a method). • Increased FP approval and discussions about FP increased within social networks for both men and women. 	<p>IRH, 2014⁶³</p>
------------------------------	--	---	--	-------------------------------

<p>Somos Diferentes, Somos Iguales (We're Different, We're Equal) (Youth)</p>	<p>Nicaragua/Youth, boys and girls 13–24 years old/Urban settings</p>	<p>Objective: Empower young men and women and address sociocultural issues impeding HIV prevention.</p> <p>Intervention: The project focused on challenging machismo and used the weekly drama TV series Sexto Sentido (Sixth Sense), and the accompanying call-in radio program to promote gender-transformative messaging on sexual and reproductive health (SRH). The program included 80 local service providers and 200 collaborating organizations to increase access to SRH services for young women and men. Interventions included a weekly national educational program (telenovela), a daily call-in radio show, community-based activities, school visits, training camps for youth and informational materials.</p>	<p>Evaluation Quantitative and qualitative. Household surveys, in-depth interviews and focus group discussions with participants, non-participants and key stakeholders. Longitudinal panel study consisting of three surveys administered in 2003, 2004 and 2005 to the same cohort of young people (n=3,099, age 13-24).</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • Men with greater exposure had a 56 percent greater probability of male condom use with casual partners over the last six months. • Men and women with greater exposure had a 44 percent greater probability of having used a male condom during last sex with a casual partner. • Men and women with greater exposure combined had a 42 percent greater probability of having consistently used a male condom with a casual partner over the past six months. 	<p>Solorzano, et al., 2008⁷⁴</p>
---	---	--	---	---

<p>Planning Together</p>	<p>El Salvador/Men and women aged 15–49/ Rural setting</p>	<p>Objective: Integrate FP messages into an ongoing water, sanitation and hygiene (WASH) education project with the goal of reaching men through community outreach.</p> <p>Intervention: FP messages were included in ongoing educational activities for a WASH construction project in the community. There were two home visits (with the man or the couple) that included discussions on the relationship between natural resources, family health and gender equity, RH, choosing a FP method (including the Standard Days Method), contraceptive referrals and couple communication. The intervention also distributed condoms at the community level.</p>	<p>Evaluation Non-experimental baseline (n=151 men and n=190 women) and endline (n=175 men and n=189 women) surveys.</p> <p>FP Outcomes</p> <ul style="list-style-type: none"> • Men's reported contraceptive use increased from 44 percent at baseline to 63 percent at endline. <p>Intermediate Outcomes</p> <ul style="list-style-type: none"> • Contraceptive knowledge increased for men and women. • Men and women reported they were more likely to have discussed FP with their partner at endline and an increase in discussions of men's role in FP. • Knowledge of different forms of contraception increased from baseline to endline for both men and women. 	<p>Lundgren, et al., 2005⁵²</p>
--------------------------	--	--	--	--

ANNEX B: KEY TERMS

Body literacy explores what we are, how we came to be and how our bodies function, in order to lead healthier lives. Body literacy includes an understanding of puberty and body changes, fertility and reproduction. It enables an individual to recognize how his/her sexual and RH are influenced by gender and social norms, roles and power relations.⁷⁵

Community group engagement engages and mobilizes communities in group dialogue and action to promote health and other development issues. Community group engagement interventions work with and through community groups to influence individual behaviors and/or social norms rather than shifting behavior by targeting individuals alone.⁷⁶

Community health workers are individuals who provide health education, referral and follow-up, case management and basic preventative health care and home visiting services to specific communities. They provide support and assistance to individuals and families in navigating the health and social services system. Involving community health workers is a proven service delivery practice in FP.⁷⁷

Empowerment is the expansion of people's capacity to make and act upon decisions affecting all aspects of their lives—including health-related decisions—by proactively addressing socioeconomic and other power inequalities in a context where this ability was previously denied. Programmatic interventions often focus specifically on empowering women due to inequalities in their socioeconomic status.⁷⁸

Fertility awareness refers to actionable information about fertility throughout the life course and the ability to apply this knowledge to one's own circumstances and needs. It includes basic information about the menstrual cycle, when and how pregnancy occurs, the likelihood of pregnancy from unprotected intercourse at different times during the cycle and at different life stages, and the role of male fertility.

This can also include information on how specific FP methods work, how they affect fertility and how to use them and it can create the basis of understanding, communicating about and correctly using FP.⁷⁹

Gender refers to the culturally defined set of economic, social and political roles, responsibilities, rights entitlements and obligations associated with being female or male, as well as the power relations between and among women and men and between and among boys and girls. The definition and expectations of what it means to be a woman or girl and a man or boy, and sanctions for not adhering to those expectations, vary across cultures and over time, and often intersect with other factors such as race, class, age and sexual orientation.⁷⁸

Gender-based violence (GBV) is an umbrella term for any harmful threat or act directed at an individual or group based on actual or perceived biological sex, gender identity and/or expression, sexual orientation and/or lack of adherence to varying socially constructed norms around masculinity and femininity. It is rooted in structural gender inequalities, patriarchy and power imbalances. GBV is typically characterized by the use or threat of physical, psychological, sexual, economic, legal, political, social and other forms of control and/or abuse. GBV impacts individuals across the life course and has direct and indirect costs to families, communities, economies, global public health and development. Although women and girls are most at risk of and disproportionately affected by GBV. It is experienced by individuals across the spectrum of gender identities and gender expression. Men and boys also experience GBV. GBV is a global problem: it occurs in every country and society.⁸⁰

Gender integration means taking into account both the differences and the inequalities between women and men in program planning, implementation and assessment. The roles and power relationships between women and men affect who does what in carrying out an activity and who benefits. Taking into account these inequalities and designing programs

to reduce them should contribute not only to more effective development programs, but also to greater social equity/equality. Experience has shown that sustainable changes are not realized through activities focused on either women or men alone.⁸¹

Gender equality is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people.⁷⁸

Gender equity is the process of being fair to women and men, boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social and political disadvantages that prevent women and men, boys and girls from operating on a level playing field.⁷⁸

Gender mainstreaming is the process of incorporating a gender perspective into organizational policies, strategies and administrative functions, as well as into the institutional culture of an organization. This process at the organizational level ideally results in meaningful gender integration as outlined above.⁷⁸

Gender norms are societal expectations for how men, boys, women, and girls should behave.⁸⁰

Gender synchronization is an approach to gender integration that promotes working with men and women and girls and boys in an intentional and mutually reinforcing manner. By doing this, health and development programs can overcome inequalities, promote gender-equitable attitudes and behaviors and promote positive FP and RH outcomes. USAID promotes this approach to gender integration.⁶⁶

Gender-transformative interventions seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by: 1) fostering critical examination of inequalities and gender roles, norms

and dynamics, 2) recognizing and strengthening positive norms that support equality and an enabling environment, 3) promoting the relative position of women, girls and marginalized groups and transforming the underlying social structures, policies and broadly held social norms that perpetuate gender inequalities.⁶⁴

Male-centered clinic- or facility-based services are health services that target and strive to meet the specific health needs of men and boys. These services could include male-only clinic days, separate entrances for men or extended clinic hours to after-work hours.²

Multi-session group meetings can include education, training or counseling on FP that have the same group of people attend for a required number of meetings to complete the sessions.⁷⁶

Peer education is an approach in which community peers, drawn from a population targeted for the education, provide guidance and support for behavior change. Because of their sociocultural similarity to a program's intended audience, peers are empathetic and credible and better able to draw on local knowledge, to tailor information to audience needs, to build rapport, to interact more effectively and to serve as role models for behavior change.⁸²

Service communication is the use of social and behavior change communication (SBCC) processes and techniques to motivate health service-related behaviors among intended audiences across the continuum of care—before, during and after services. By integrating SBCC—or the use of communication strategies to influence individual and collective health behaviors—into service delivery programming, projects can get more clients to health facilities, improve client-provider interactions and increase the adoption and maintenance of healthy behaviors.⁸²

Service delivery for health refers to the coordinated provision of essential, safe, and quality health products, information and services to clients at the facility and community level. Health service delivery should

respond to the different needs of women, men, boys and girls. This helps increase service access, coverage, quality and safety, which in turn contributes to improved health, a more responsive and efficient health system, and social and financial risk protection.^{83,84}

Social behavior change (SBC) is a process that draws on communication, structural, environmental and/or other approaches—such as mass and social media, community-level activities, interpersonal communication, advocacy, behavioral economics and human-centered design—to influence individual and collective behaviors pertaining to health. SBC is an essential element of effective health programming, as it shapes not only demand for and correct use of products and services, but practice of behaviors like contraceptive use, increased age of marriage, reduced number of sexual partners and many other behaviors that protect and maintain health. It also molds client-provider communication, couples' communication and engagement of community leaders and other influencers. Ultimately, SBC has the power to catalyze shifts in cultural and gender norms and support sustained changes in collective and individual behaviors.⁸²

Social behavior change communication refers to the use of communication strategies—mass media, “new” and social media, community-level activities and interpersonal communication—to influence individual and collective behaviors pertaining to health.⁸²

Social capital refers to features of social organization such as networks (who people know), norms, and social trust that facilitate coordination and cooperation for mutual benefit (“norms of reciprocity”).⁸⁵

Social marketing in FP programs is an approach that makes contraceptive products accessible and affordable through private sector outlets, such as pharmacies and shops, while using commercial marketing techniques to achieve specific behavioral goals. Social marketers combine product, price, place (distribution) and

promotion—often referred to as the “4Ps” or the “marketing mix”—to maximize use of specific health products among priority population groups.⁸⁶

ANNEX C: RESOURCES

PROGRAMMATIC RESOURCES

FP High Impact Practices (HIPs): Strategic Planning Guide for Engaging Men and Boys in Family Planning. This guide is intended to lead program managers, planners and decision-makers through a strategic process to identify effective investments for engaging men in efforts to improve sexual and RH. Building on reviews of male engagement strategies for FP, the guide provides illustrated steps to help identify relevant gaps and issues and offers programming approaches to consider. The guide includes examples of HIPs in SBC and service delivery that can be designed to foster male engagement. To view and download the guide, visit http://www.fphighimpactpractices.org/guides/engaging-men-and-boys-in-family-planning/?utm_source=HIPNetListserv&utm_medium=Email&utm_campaign=MaleEngagementPromtion.

Gender Equitable Men (GEM) Scale. This scale aids in identifying appropriate gender-related measures important for developing and evaluating interventions that aim to promote positive health outcomes by addressing gender-related normative barriers to health. The objective of the GEM Scale is to measure attitudes toward gender norms in intimate relationships or differing social expectations for men and women. For additional information, visit <https://www.c-changeprogram.org/content/gender-scales-compendium/gem.html>.

Guide for Promoting Sexual and Reproductive Health (SRH) Products and Services for Men. The guide, developed by the Health Communication Capacity Collaborative (HC3), focuses on engaging men meaningfully in SRH and creating an enabling environment to increase men's use of SRH products

and services. This tool provides guidance, resources and examples of approaches that have increased men's use of SRH products and services in a variety of settings and highlights key considerations for developing social and behavior change strategies and activities for increasing men's SRH. Visit <https://healthcommcapacity.org/hc3resources/guide-promoting-sexual-reproductive-health-products-services-men/> for additional information.

Gender Analysis and Integration Training

Toolkit. These are a specific set of frameworks and methods for participants to use in order to integrate gender components into their projects and programs. The Programmatic Guidance presentations and tools assist participants with the 'what,' while the Gender Analysis and Integration activities will help participants with the 'how.' For additional information, visit <https://www.igwg.org/training/gender-analysis-and-integration/>.

The Gender Integration Continuum Training

Session User's Guide. The Gender Integration Continuum (see Figure 1 on the following page) is a conceptual framework that illustrates different approaches to gender integration and their potential consequences. The Continuum categorizes approaches by how they treat gender norms and inequities in program and policy design, implementation and evaluation. Designers and implementers can also use the continuum to plan how to integrate gender into programs/policies. The Training Session User's Guide is a tool that enables new and experienced gender trainers to plan, prepare for and facilitate the Gender Integration Continuum training session. It includes a heavily scripted facilitator guide and helpful processing questions, suggestions and trainer notes to ensure attainment of training objectives. To access the guide, visit <https://www.igwg.org/2017/11/updates-made-to-gender-integration-continuum-users-guide/>.

Gender and Social and Behavior Change Communication (SBCC) Implementation Kit.

This kit provides a step-by-step approach to integrate

gender into an existing SBCC strategy or marketing plan. The I-Kit is designed to help users understand gender concepts, theories and frameworks. Users will also learn to assess the current level of gender integration in a project and use a series of tools to uncover new information that can be applied to an existing SBCC strategy or marketing plan. To access the kit, visit <https://sbccimplementationkits.org/gender/courses/gender-and-social-and-behavior-change-communication/>.

Male Engagement in Family Planning Indicator

Brief. Rigorous monitoring and evaluation (M&E) using consistent and effective indicators is essential to the success of male engagement in FP programs. This brief outlines 15 key indicators that ministries of health and organizations can use to inform the M&E of programs that encourage male engagement in FP. Each indicator featured contains its definition, suggested disaggregations, and, if applicable, calculation. To access the brief, visit <https://www.measureevaluation.org/resources/publications/fs-18-284>.

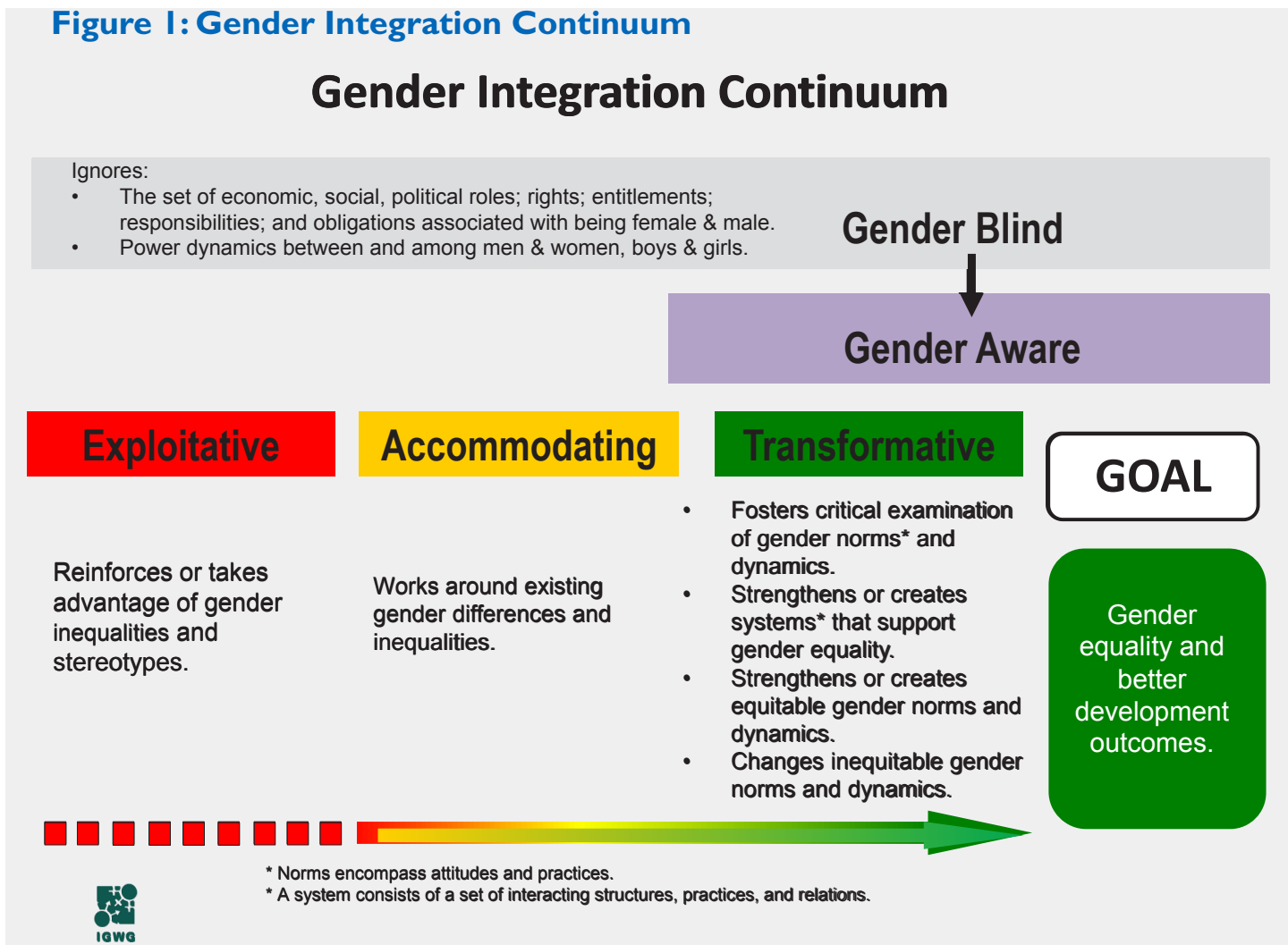
Promoting Evidence-based Vasectomy

Programming Resources. This set of resources provides policymakers, advocates, program managers and service providers with evidence-based recommendations for improving vasectomy programming. Briefs included in the set of resources give information about creating successful vasectomy programs, experiences and lessons learned from vasectomy programming in low-resource settings and country-specific recommendations for Ethiopia, Haiti, Kenya, Malawi, the Philippines, Rwanda and Uganda. To access the resources, visit <https://www.fhi360.org/resource/promoting-evidence-based-vasectomy-programming>.

Toolkit for Integrating Gender in the Monitoring and Evaluation of Health Programs.

This toolkit helps FP/RH and other health programs integrate a gender perspective in their monitoring and evaluation activities, measures and reporting. The toolkit is designed for use by program staff working in

Figure 1: Gender Integration Continuum



HIV, malaria, reproductive, maternal, newborn and child health and tuberculosis, and for various health agencies and initiatives. Visit <https://www.measureevaluation.org/resources/tools/gender/toolkit-for-integrating-gender-in-the-monitoring-and-evaluation-of-health-programs/toolkit-for-integrating-gender-in-the-monitoring-and-evaluation-of-health-programs> to access the kit.

USAID PROJECTS AND INTERVENTIONS

Breakthrough ACTION (2017–2022). As USAID’s global SBC flagship project, Breakthrough ACTION builds upon current USAID investments in SBC research and programming, including both global and bilateral projects, to simultaneously guide new learning and drive broader application of proven practices and tools in SBC. The project works to fulfill a global leadership function within SBC, working through a number of new and existing platforms to create

opportunities for technical agenda-setting, learning and collaboration; designing and implementing innovative and strategic SBC programs in USAID-supported countries and promoting agreed-upon priorities through its own programs and knowledge management efforts.

Breakthrough RESEARCH (2017–2022). In collaboration with its sister project Breakthrough ACTION, Breakthrough RESEARCH convenes and engages a broad range of health and development stakeholders, supporting them in developing, promoting and operationalizing visionary, consensus-driven agendas for SBC research that contribute to measurable global health impact. In addition to designing and implementing high-priority SBC studies, Breakthrough RESEARCH may conduct performance and impact evaluations of Breakthrough ACTION activities and USAID bilateral SBC mechanisms.

Fertility Awareness for Community Transformation (FACT) Project (2013–2018).

FACT is a research, intervention and technical assistance project that tests whether improved fertility awareness among women and men increases the use of FP and whether expanding the availability of fertility awareness methods (FAM) increases FP uptake. FACT aims to foster an environment where women and men can take actions to protect their RH throughout the life course and test strategies to increase fertility awareness and expand FAM at the community level. For additional information, visit http://irh.org/projects/fact_project/.

PASSAGES Project (2015–2020). PASSAGES aims to address the root causes of SRH challenges like GBV, child marriage and unintended pregnancy by transforming social norms. PASSAGES fosters normative environments that enable young people to use modern FP and achieve healthy timing of first and subsequent pregnancies through scalable progress. For additional information, visit: <http://irh.org/projects/passages/>.

Smart Client, Smart Couple Digital Health Tools. The HC3 Project (2012–2017) created this set of digital health tools, aimed at increasing the number of FP clients who are informed, empowered and confident. “Smart Client” is designed for women of reproductive age, and “Smart Couple” is designed for both men and women. The tools use an entertainment-education approach delivered

through interactive voice response and SMS, including messaging and role modeling around couple communication about FP and gender norms that impact reproductive decision-making. For additional information, visit <http://healthcommcapacity.org/>.

Youth Power Implementation and Youth Power Evidence and Evaluation (2015–2020).

These two projects work to achieve a vision of healthy, productive and engaged youth with the goal of improved ability of youth to navigate adolescence and young adulthood successfully. The sister projects collaborate to strengthen local, national and global youth systems and programs to achieve sustainable, positive youth outcomes across sectors and to improve evaluation, research and knowledge management related to youth programming. This includes improved quality and use of youth services and opportunities and a greater emphasis on youth engagement in development efforts and in other policy and decision-making processes in their communities. Youth Power also generates and disseminates knowledge about the implementation and impact of positive youth development and cross sectoral approaches and provides evidence and evaluation support to USAID missions for youth assessments, evaluations, research, training, strategy and program design and other technical assistance through field support buy-in options. For additional information, visit <http://www.youthpower.org/youthpower-our-approach>.

ANNEX D: REFERENCES

1. International Conference on Population and Development. United Nations Population Fund. <http://www.un.org/popin/icpd/conference/offeng/poa.html>. Published 1994. Accessed October 17, 2016.

2. Edstrom J, Hassink A, Shahrokh T, Stern E. Engendering Men: A Collaborative Review of Evidence on Men and Boys in Social Change and Gender Equality, Evidence Report. <http://promundoglobal.org/wp-content/uploads/2015/09/EMERGE-Engendering-Men-Evidence-Review.pdf>. Published 2015. Accessed July 18, 2016.

3. Family Planning 2020. Family Planning 2020. <http://www.familyplanning2020.org/>. Accessed August 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 July 18, 2016.

5. Acting on the Call 2017. USAID. https://www.usaid.gov/sites/default/files/documents/1864/USAID_2017_AOTC_final.pdf. Published 2017. Accessed August 2017.

6. Trends in Contraceptive Use Worldwide. United Nations, Department of Economic and Social Affairs, Population Division. <http://www.un.org/en/development/desa/population/publications/pdf/family/trendsContraceptiveUse2015Report.pdf>. Published 2015. Accessed October 19, 2016.

7. Pery B, Packer C, Chin Quee D, Zan T, Dulli L, Shattuck D. Recent Experiences and Lessons Learned in Vasectomy Programming in Low-Resource Setting: A Document Review. FHI 360, the Population Council and the Evidence Project. <https://www.fhi360.org/sites/default/files/media/documents/resource-vasectomy-lit-review-final.pdf>. Published 2016. Accessed October 19, 2016.
8. Hoga L, Rodolpho J, Sato P, Nunes M and Borges A. Adult men's beliefs, values, attitudes and experiences regarding contraceptives: a systematic review of qualitative. *Journal of Clinical Nursing*. 2014; 23(7-8):927-39. Doi: 10.1111/jocn.12262.
9. Hardee K, Croce-Galis M, Gay J. Are men well served by family planning programs? *Reproductive Health*. 2017;14:14. Doi:10.1186/s12978-017-0278-5.
10. Framework of Actions. Report of the Secretary-General. United Nations Populations Fund. https://www.unfpa.org/sites/default/files/pub-pdf/ICPD_beyond2014_EN.pdf. Published February 12, 2014. Accessed October 10, 2017.
11. Programming for Prevention in Various Stages of an HIV/AIDS Epidemic. HIV Prevention Now: Programme Briefs. No. 8. UNFPA. Published 2002.
12. Shattuck D, Pery B, Packer C, Chin Quee D. A Review of 10 Years of Vasectomy Programming and Research in Low-Resource Settings. *Global Health: Science and Practice*. 2016;4(4):647-660. Doi:10.9745/GHSP-D-16-00235.
13. Ross J, Stover J. The Family Planning Program Effort Index: 1999 Cycle. *International Family Planning Perspectives*. 2001;27(3):119. Doi:10.2307/2673833.
14. Roy T, Nangia P, Ram F and Khan N. Can Women's Childbearing and Contraceptive Intentions Predict Contraceptive Demand? Findings from a Longitudinal Study in Central India. *International Family Planning Perspectives*. 2003;29(1):25-31. Doi: 10.1363/IFPP.29.025.03.
15. Tiruneh F, Chuang KY, Ntenda P, Chuang YC. Factors associated with contraceptive use and intention to use contraceptives among married women in Ethiopia. *Women & Health*. 2016;56(1):1-22. Doi:10.1080/03630242.2015.1074640.
16. MacQuarrie K, Edmeades J, Steinhaus M, Head S. Men and Contraception: Trends in Attitudes and Use. DHS Analytical Studies No. 49. ICF International. <http://dhsprogram.com/pubs/pdf/AS49/AS49.pdf>. Published 2015. Accessed 2016.
17. Withers M, Dworkin SL, Onono M, et al. Men's Perspectives on Their Role in Family Planning in Nyanza Province, Kenya. *Studies in Family Planning*. 2015;46(2):201-215. Doi:10.1111/j.1728-4465.2015.00024.x.
18. Tumlinson K, Speizer I, Davis J, Fotso J, Kuria P, Archer L. Partner communication, discordant fertility goals, and contraceptive use in urban Kenya. *African Journal of Reproductive Health*. 2013;17(3):79-90.
19. Sonfield A. Rounding Out the Contraceptive Coverage Guarantee: Why "Male" Contraceptive Methods Matter for Everyone. Guttmacher Institute. 2015;18(2). www.guttmacher.org/about/gpr/2015/06/rounding-out-contraceptive-coverage-guarantee-why-male-contraceptive-methods. Accessed October 25, 2016.
20. Shattuck D, Kemer B, Gilles K, Hartmann M, Ng'ombe T, Guest G. Encouraging Contraceptive Uptake by Motivating Men to Communicate About Family Planning: The Malawi Male Motivator Project. *Am J Public Health*. 2011;101(6):1089-1095. Doi:10.2105/AJPH.2010.300091.
21. MacQuarrie K, Mallick L, Kishor S. Intimate Partner Violence and Interruption to Contraceptive Use. DHS Analytical Studies No. 57. ICF International. <https://www.dhsprogram.com/pubs/pdf/AS57/AS57.pdf>. Published 2016. Accessed October 2017.
22. Stephenson R, Koenig M, Ahmed S. Domestic violence and contraceptive adoption in Uttar Pradesh, India. *Studies in Family Planning*. 2006;37(2):75-86.
23. Adjwanou V, N'Bouke A. Exploring the Paradox of Intimate Partner Violence and Increased Contraceptive Use in sub-Saharan Africa. *Studies in Family Planning*. 2015;46:127-142. Doi:10.1111/j.1728-4465.2015.00020.
24. Men as Contraceptive Users and Family Planning Clients. Population Reference Bureau. http://thepaceproject.org/ce/multimedia/men_as_fp_clients/. Published 2016. Accessed October 19, 2016.
25. Echezona E, Ezeanolue J, Iwelunmor I, Asaolu M, et al. Impact of male partner's awareness and support for contraceptives on female intent to use contraceptives in southeast Nigeria. *BMC Public Health*. 2015;15(1):1.
26. Johnson K and Gu Y. Men's Reproductive Health: Findings from Demographic and Health Surveys. DHS Comparative Reports No. 17. ICF Macro. <https://dhsprogram.com/pubs/pdf/CRI7/CRI7.pdf>. Published 2009. Accessed October 2017.

27. Ajong A, Njotang P, Yakum M, et al. Determinants of unmet need for family planning among women in Urban Cameroon: a cross sectional survey in the Biyem-Assi Health District, Yaoundé. *BMC Women's Health*. 2016;16:4.
28. Wulifan J, Brenner S, Jahn A, et al. A Scoping Review on Determinants of Unmet Need for Family Planning among Women of Reproductive Age in Low and Middle Income Countries. *BMC Women's Health*. 2016;16:2. doi:10.1186/S12905-015-0281-3.
29. Baldé M, Diallo B, Compaoré R, et al. Men's behavior surrounding use of contraceptives in Guinea. *International Journal of Gynecology & Obstetrics*. 2016;135:16–19. Doi:10.1016/j.ijgo.2016.08.007.
30. Pulerwitz J, Barker G. Measuring attitudes toward gender norms among young men in Brazil: development and psychometric evaluation of the gEm scale. *Men and Masculinities*. 2007;10(3):322-338. Doi:10.1177/1097184X06298778.
31. What about boys? A literature review on the health and development of adolescent boys. Geneva, Switzerland: WHO. http://apps.who.int/iris/bitstream/10665/66487/1/WHO_FCH_CAH_00.7.pdf. Published 2000.
32. Kågesten A, Gibbs S, Blum RW, Moreau C, Chandra-Mouli V, et al. Understanding Factors that Shape Gender Attitudes in Early Adolescence Globally: A Mixed-Methods Systematic Review. *PLOS ONE*. 2016. 11(6), <https://doi.org/10.1371/journal.pone.0157805>
33. A Review of Adolescent Gender and Sexual and Reproductive Health Projects: Findings and Recommendations. Institute for Reproductive Health and Pathfinder International. <https://www.pathfinder.org/wp-content/uploads/2016/11/GREAT-Project-Review-of-Adolescent-Gender-and-SRH-Projects.pdf>. Published October 2011. Accessed October 20, 2017.
34. Greene M, Mehta M, Pulerwitz J, Wulf D, Bankole A, Singh S. *Involving Men in Reproductive Health: Contributions to Development*. Geneva: United Nations Millennium Project. Accessed August 5, 2016.
35. Hardee K, Croce-Galis M, Gay J. *Men as Contraceptive Users: Programs, Outcomes and Recommendations*. The Evidence Project and Population Council. http://evidenceproject.popcouncil.org/wp-content/uploads/2016/09/Men-as-FP-Users_September-2016.pdf. Published 2016.
36. High-Impact Practices in Family Planning (HIPs). Adolescent-friendly contraceptive services: mainstreaming adolescent-friendly elements into existing contraceptive services. USAID. <https://www.fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services>. Published 2015. Accessed December 6, 2017.
37. Glinski A, Sexton M, Petroni S. *Adolescents and Family Planning: What the Evidence Shows*. International Center for Research on Women. <https://www.icrw.org/publications/adolescents-and-family-planning-what-the-evidence-shows-synthesis/>. Published 2014. Accessed October 19, 2016.
38. *Adolescent Sexual and Reproductive Health*. United Nations Population Fund. <http://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health>. Published 2014.
39. *Growing Up Great Brief*. Institute of Reproductive Health. http://irh.org/wp-content/uploads/2017/04/Growing_Up_GREAT_brief.pdf. Published 2017. Accessed April 16, 2018.
40. Kamran I, Arif M, Vassos K. Concordance and discordance of couples living in a rural Pakistani village: Perspectives on contraception and abortion – a qualitative study. *Glob Public Health*. 2011;6(sup1):S38-S51. Doi:10.1080/17441692.2011.590814
41. Agha S, Meekers D. Impact of an advertising campaign on condom use in urban Pakistan. *Stud Fam Plann*. 2010;41(4):277-290.
42. Exner T, Mantell J, Adeokun L, et al. Mobilizing Men as Partners: The Results of an Intervention to Increase Dual Protection Among Nigerian Men. *Health Education Research*. 2009;24(5):846-854. Doi:10.1093/her/cyp021.
43. Pulerwitz J, Barker G, Segundo M, Nascimento M. Promoting More Gender-Equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy: Horizons Program. Population Council. http://pdf.usaid.gov/pdf_docs/Pnadf883.pdf. Published 2006. Accessed October 19, 2016.
44. Cates W, Steiner M. Dual protection against unintended pregnancy and sexually transmitted infections: what is the best contraceptive approach? *Sexually Transmitted Diseases*. 2002;29(3):168-174.
45. Improving Dual Protection Counseling for Adolescents in Dar es Salaam, Tanzania. FHI Briefs. FHI 360. <https://www.fhi360.org/sites/default/files/media/documents/1dualprotectionTanzaniabrief.pdf>. Published 2010. Accessed October 20, 2017.
46. Lundgren R, Cachan J, Jennings V. Engaging men in family planning services delivery: experiences introducing the Standard Days Method® in four countries. *World Health Population*. 2012;14(1):44-51.
47. *Growing Up Smart Endline Study Report*. Institute for Reproductive Health. <http://irh.org/resource-library/growup-smart-endline-study-report/>. Published 2015. Accessed January 20, 2018.

48. Health Communication Capacity Collaborative. Guide for Promoting Sexual and Reproductive Health Products and Services for Men. http://healthcommcapacity.org/wp-content/uploads/2017/06/Promoting20Male20SRH20Guide_final-4.pdf. Published June 2017. Accessed December 14, 2017.
49. Male Engagement: Reducing Unmet Need for Family Planning. Institute for Reproductive Health. <http://irh.org/resource-library/male-engagement-family-planning-reducing-unmet-need-family-planning-addressing-gender-norms/>. 2014. Accessed August 5, 2016.
50. Lundgren R, Beckman M, Chaurasiya SP, Subhedi B, Kemer B. Whose turn to do the dishes? Transforming gender attitudes and behaviours among very young adolescents in Nepal. *Gender and Development*. 2013;21(1):206-222. Doi: 10.1080/13552074.2013.767520.
51. Subramanian L, Cisek C, Kanlisi N, Pile JM. The Ghana vasectomy initiative: facilitating client-provider communication on no-scalpel vasectomy. *Patient Education and Counseling*. 2010;81(3):374-380. Doi:10.1016/j.pec.2010.05.008.
52. Lundgren R, Gribble J, Greene M, Emrick G, de Monroy M. Cultivating Men's Interest in Family Planning in Rural El Salvador. *Studies in Family Planning*. 2005;36(3):173-188. Doi:10.1111/j.1728-4465.2005.00060.x.
53. Wegs C, Creanga AA, Galavotti C, Wamalwa E. Community Dialogue to Shift Social Norms and Enable Family Planning: An Evaluation of the Family Planning Results Initiative in Kenya. *PLOS ONE*. 2016;11(4):e0153907. doi:10.1371/journal.pone.0153907.
54. Tilahun T, Coene G, Temmerman M, Degomme O. Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. *BMC Public Health*. 2015;15:682. Doi:10.1186/s12889-015-2057-y.
55. Raj A, Ghule M, Ritter J, et al. Cluster Randomized Controlled Trial Evaluation of a Gender Equity and Family Planning Intervention for Married Men and Couples in Rural India. *PLOS ONE*. 2016;11(5):e0153190. Doi:10.1371/journal.pone.0153190.
56. Daniel E, Masilamani R, Rahman M. The Effect of Community-Based Reproductive Health Communication Interventions on Contraceptive Use Among Young Married Couples in Bihar, India. *International Family Planning Perspectives*. 2008;34(4):189-197. doi:10.1363/iffp.34.189.08.
57. Ashburn K, Kemer B, Ojamuge D, Lundgren R. Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on Physical Child Punishment and Intimate Partner Violence in Northern Uganda. *Prevention Science*. 2017;18(7):854-864. Doi:10.1007/s1121-016-0713-9.
58. Engaging Men in Women's Economic Empowerment and Entrepreneurship Development Interventions. International Labor Organization. http://www.ilo.org/wcmsp5/groups/public/-ed_emp/-emp_ent/-ifp_seed/documents/briefingnote/wcms_430936.pdf. 2014. Accessed February 2, 2018.
59. Greene M, Perlson S, Taylor A, Lauro G. Engaging Men and Boys to Address the Practice of Child Marriage. *GreeneWorks*. <https://promundoglobal.org/wp-content/uploads/2015/04/Engaging-Men-and-Boys-to-End-the-Practice-of-Child-Marriage1.pdf>. Published 2015. Accessed February 2, 2018.
60. Sonke Gender Justice. <http://www.genderjustice.org.za/>. Accessed October 24, 2016.
61. SASA! Raising Voices. <http://raisingvoices.org/sasa/>. Accessed October 24, 2016.
62. One Man Can. Sonke Gender Justice. <http://www.genderjustice.org.za/community-education-mobilisation/one-man-can/>. Accessed December 14, 2017.
63. Tékonon Jikagou project brief. Institute of Reproductive Health. http://irh.org/projects/tekonon_jikagou/. Accessed July 18, 2016.
64. The Gender Integration Continuum Training Session User's Guide. Pace Project and Population Reference Bureau. https://www.igwg.org/wp-content/uploads/2017/12/17-418-GenderContTraining-2017-12-12-1633_FINAL.pdf. Published 2017. Accessed February 20, 2018.
65. Kraft J, Wilkins K, Morales G, Widyono M, Middlestadt S. An evidence review of gender-integrated interventions in reproductive and maternal-child health. *Journal of Community Health*. 2014;19 Suppl 1:122-141. Doi:10.1080/10810730.2014.918216.
66. Greene M, Levack A. Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations. Population Reference Bureau. http://www.prb.org/igwg_media/synchronizing-gender-strategies.pdf. Published 2010. Accessed August 6, 2016.
67. Kato-Wallace J, Barker G, Sharafi I, Mora I, Lauro G. Adolescent boys and young men: Engaging them as supporters of gender equality and health and understanding their vulnerabilities. *Promundo-US and UNFPA*. <http://promundoglobal.org/wp-content/uploads/2016/03/Adolescent-Boys-and-Young-Men-final-web.pdf>. Published 2016. Accessed October 20, 2017.

68. Healthy Images of Manhood: A Male Engagement Approach for Workplaces and Community Programs Integrating Gender Family Planning and HIV/AIDS. Extending Service Delivery Project. Pathfinder. https://www.intrahealth.org/sites/ihweb/files/attachment-files/ESD_legacy_HIM_6_24_10.pdf. Published 2010. Accessed July 22, 2016.
69. Ghanotakis E, Hoke T, Wilcher R, et al. Evaluation of a male engagement intervention to transform gender norms and improve family planning and HIV service uptake in Kabale, Uganda. *Global Public*. 2016;0(0):1-18. Doi:10.1080/17441692.2016.1168863.
70. Achyut P, Benson A, Calhoun L, et al. Impact evaluation of the Urban Health Initiative in urban Uttar Pradesh, India. *Contraception*. 2016;93(6):519-525. doi:10.1016/j.contraception.2016.02.031.
71. Krenn S, Cobb L, Babalola S, Odeku M, Kusemiju B. Using Behavior Change Communication to Lead a Comprehensive Family Planning Program: The Nigerian Urban Reproductive Health Initiative. *Glob Health Sci Pract*. 2014;2(4):427-443. Doi:10.9745/GHSP-D-14-00009.
72. Muthamia M, Owino K, Nyachae P, et al. The Tupange Project in Kenya: A Multifaceted Approach to Increasing Use of Long-Acting Reversible Contraceptives. *Glob Health Sci Pract*. 2016;4(Supplement 2):S44-S59. Doi:10.9745/GHSP-D-15-00306.
73. Senegal Technical Working Paper, Senegal 2015 Endline Survey Executive Summary. Urban Reproductive Health Initiative. <https://www.intrahealth.org/projects/the-urban-reproductive-health-initiative-in-senegal>. Published 2016.
74. Solorzano I, Bank A, Pena R, Espinoza H, Ellsberg M, Pulerwitz J. Catalyzing Individual and Social Change Around Gender, Sexuality, and HIV: Impact Evaluation of Puntos de Encuentro's Communication Strategy in Nicaragua. Horizons Final Report. http://www.endvawnow.org/uploads/browser/files/sextos_sentido_impact_evaluation_english.pdf. Published 2008. Accessed October 19, 2016.
75. My changing body. Puberty and fertility awareness for young people. Institute for Reproductive Health. http://irh.org/wp-content/uploads/2013/04/My_Changing_Body-Eng_FEB_2012.pdf. Published 2011. Accessed January 22, 2018.
76. High-Impact Practices in Family Planning (HIPs). Community engagement: changing norms to improve sexual and reproductive health. USAID. <http://www.fphighimpactpractices.org/briefs/community-group-engagement>. Published 2016. Accessed January 22, 2018.
77. International Standard Classification of Occupations, 2008 Revision. International Labor Organization. <http://www.ilo.org/public/english/bureau/stat/isco/docs/gdstruct08.doc>. Published 2008. Accessed October 24, 2016.
78. Gender-related Terms and Definitions. Interagency Gender Working Group. <https://www.igwg.org/wp-content/uploads/2017/05/HandoutGenderTerms.pdf>. Accessed January 19, 2018.
79. Fertility Awareness across the Life Course: A comprehensive literature review. Institute for Reproductive Health. http://irh.org/wp-content/uploads/2014/01/Literature_Review_Fertility_Awareness_FINAL_Jan.2014.pdf. Published 2013. Accessed January 22, 2018.
80. ADS 205. Integrating Gender Equality and Women's Empowerment in USAID's Program Cycle. USAID. <https://www.usaid.gov/sites/default/files/documents/1870/205.pdf>. Published 2017. Accessed January 23, 2018.
81. Guide to Gender Integration and Analysis. Additional Help for ADS Chapters 201 and 203. USAID. http://pdf.usaid.gov/pdf_docs/Pdacp506.pdf. Published 2010. Accessed January 19, 2018.
82. Storey D, Lee K, Blake C, et al. Social & Behavior Change Interventions Landscaping Study: A Global Review. Center for Communication Programs Johns Hopkins Bloomberg School of Public Health. https://www.researchgate.net/profile/Nicole_DePasquale/publication/271706961_Social_and_Behavior_Change_Interventions_Landscaping_Study_A_Global_Review/links/54d049f70cf298d656665d83/Social-and-Behavior-Change-Interventions-Landscaping-Study-A-Global-Review.pdf. Published 2011. Accessed February 2, 2017.
83. USAID's Vision for Health Systems Strengthening. USAID. <https://www.usaid.gov/sites/default/files/documents/1864/HSS-Vision.pdf>. Published 2015. Accessed February 20, 2018.
84. Gender and Health Systems Strengthening. Global Health Learning Center. <https://www.globalhealthlearning.org/course/gender-and-health-systems-strengthening>. Published 2014. Accessed February 20, 2018.
85. Putnam R. Bowling alone: America's declining social capital. *Journal of Democracy*. 1995;6:65-78.
86. High-Impact Practices in Family Planning (HIPs). Social Marketing: Leveraging the private sector to improve contraceptive access, choice, and use. USAID. <https://www.fphighimpactpractices.org/briefs/social-marketing/>. Published 2013. Accessed January 22, 2018.

