



Global Sexual and Reproductive Health Service Package for

MEN AND ADOLESCENT BOYS



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Introduction, rationale and overview

Purpose of this service package

The *Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys* has been developed to support providers of sexual and reproductive health (SRH) services to increase the range and quality of services to meet the specific and diverse needs of men and adolescent boys. This package focuses specifically on the provision of such services integrated within clinical and non-clinical contexts and follows a gender-transformative approach. It covers men and adolescent boys in all their diversity and takes a positive approach to SRH, seeing this not just as the absence of disease, but the positive expression of one's gender, sex and sexuality. In doing so, this service package contributes to efforts to ensure universal access to sexual and reproductive health and rights (SRHR) as prioritized in the Sustainable Development Goals.¹ **This package is in no way intended to detract from the sexual and reproductive health and rights of women and adolescent girls, nor to divert resources, funding or attention from much-needed SRH services and programmes for women and adolescent girls.**

Why a service package for adolescent boys and men?

Men have substantial SRH needs for contraception, prevention and treatment of HIV and other sexually transmitted infections (STIs), sexual dysfunction, infertility and male cancers. Yet these SRH needs are often unmet due a combination of factors that include a lack of service availability, poor health-seeking behaviour among men, SRH facilities often not being seen as “male friendly spaces” and a lack of agreed standards for delivering SRH clinical and preventative services to men and adolescent boys.² Better meeting the diverse SRH needs of men and adolescent boys improves their own health. It also improves the SRH of their partners, and is an effective way to promote sexual and reproductive health and rights for all.

Ensuring that the SRH needs of men and adolescent boys are sufficiently addressed, along with those of women and girls, is also part of a comprehensive gender-transformative approach. Existing gender inequalities, in large part due to rigid gender norms and harmful perceptions of what it means to be a man, have far-reaching consequences on health and well-being. For example, in many contexts, women do not control decision making, including SRH choices, yet they bear a significant burden of contraceptive use and childbearing. Where men and adolescent boys are engaged in tackling gender inequality and promoting women's choices, the resulting outcomes are positive and men and women are able to enjoy equitable, healthy and happy relationships.³

The 1994 International Conference on Population and Development (ICPD) Programme of Action calls for governments to “promote gender equality in all spheres of life, including family and community life and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles”.⁴ The ICPD and a number of other international instruments provide states with a mandate to develop gender-transformative programmes and policies that include engaging men and boys in the context of family, reproductive health, violence and health equity. International commitments include the Programme of Action of the World Summit for Social Development (1995) and its review (2000)⁵, the Beijing Platform for Action (1995)⁶, the twenty-sixth special session of the General Assembly on HIV/AIDS (2001)⁷, the United Nations Commission on the Status of Women (CSW) (2004 and 2009), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Action Framework Addressing Women, Girls, Gender Equality and HIV (2009). Multiple other policy efforts, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)⁸, the Convention on the Rights of the Child (CRC), the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) also address this challenge.⁹ To be most effective, these international conventions and agreements need to be adapted at the national level into rights-based actions that will have an impact at many levels: policy, law, health systems and service delivery.¹⁰

Many organizations are committed to working with men and adolescent boys as SRH clients, partners and agents of change, regardless of age, social or health status, disability, sexual orientation or gender identity. The International Planned Parenthood Federation (IPPF) frames this commitment within a human rights approach as outlined in two policies, the 2014 Gender Equality Policy and the 2009 Men and Sexual and Reproductive Health Policy. For UNFPA, this dedication to protecting women’s and girls’ sexual and reproductive health and rights is detailed in their Gender Equality Strategy (forthcoming) and the 2013 Strategy on Adolescents and Youth (see Annex 6 for the full policies). These policies reflect the importance of addressing men’s SRHR, and the need to work with men and adolescent boys, together with women and girls, as equal partners in the provision of SRH services. These policies also highlight the need to create conditions for equitable relationships for individual health and the development of communities.

This service package supports IPPF, UNFPA, partner organizations and national health systems to address these challenges and increase the range and quality of SRH services that are tailored to men and adolescent boys. Importantly, the implementation and use of this service package should not lead to a reduction in the quality and quantity of services provided to women and girls. The approach of this package is that scaling-up services for men and adolescent boys will improve SRH for everyone. A key consideration in this work, explored further below, is that women’s sexual and reproductive health and rights and their access to services, continues to be at the forefront of our efforts.

This service package recognizes that men and adolescent boys are not a single, homogenous group but have diverse experiences and identities. Though each man has his own SRH needs, some groups have a distinct set of SRH needs due to particular risks and vulnerabilities. This needs to be highlighted to service providers. In this service package, specific health and service delivery considerations are outlined in relation to adolescence, sexual orientation and gender identity. For ease of communication, while this service package includes men in all their diversity, throughout the document the overall term men and adolescent boys is used.

Who is this service package written for?

The primary audience includes all levels of staff/service providers in clinical and non-clinical settings that offer, or would like to offer, SRH services for men, from adolescence through to adulthood. Programme managers, policy makers and advocates working in this area will also find it useful. The package can be used by organizations currently providing SRH services to men and adolescent boys to improve the range and quality of services, or by those intending to develop their work in this area. The contents are applicable to organizations across the globe, but will need to be adapted to local contexts (see section 6). This package supports those needing guidance for serving and engaging men and adolescent boys in SRH, and is not intended to shift attention away from women and girls.

How to use the service package

This service package provides an overview of the SRH services that need to be provided for men and adolescent boys and links to existing tools, service delivery guidelines and resources utilizing a gender-transformative approach.

The service package may be used in the following ways:

- To learn about the importance of addressing men's SRH and the principles for this work;
- To understand the components of an organized approach to providing a package of SRH services for men and adolescent boys;
- To determine what SRH services for men and adolescent boys should be provided by an organization or where existing services should be improved;
- To scale-up and strengthen SRH service provision and programming for men and adolescent boys, through key building blocks and strategies to operationalize this package;
- To advocate for a stronger focus on this issue within the work of an organization; and
- To gain insights from country case studies on the work of IPPF and UNFPA in providing SRH services for men and adolescent boys.

How this service package is organized

Section One of the package provides an overview of why it is important to use a gender-transformative approach to provide SRH services for men and adolescent boys, the history of this field, and the evolution of this area of work at global, regional and national levels. It also outlines the key principles important for work on men and SRH, and a conceptual framework to guide this work.

Section Two outlines seven building blocks critical to scaling-up work on men and SRH that should be considered prior to operationalizing the service package.

Section Three outlines the SRH package for men and adolescent boys, including an overview of the key service components.

Section Four outlines each of the elements of the SRH package in greater detail and provides links to relevant guidelines, tools and resources, including related clinical and commodity information.

Section Five looks at specific health and service delivery considerations related to adolescence, sexual orientation and gender identity.

Section Six provides key steps for operationalizing the framework, including assessing the current situation, building capacity and commitment, programme design, implementation, and monitoring and evaluation.

Section Seven provides a set of country case studies on the work of IPPF and UNFPA around the world engaging in innovative practices to address men's SRH needs.

Section Eight provides an extensive list of associated resources for additional information and guidance on scaling-up work on men's SRH.

The Annex provide a set of checklists, templates and further resources, linked to different sections within this publication.



1 Background and framing on men and SRH

Section 1:

Background and framing on men and SRH

Why SRH services for men and adolescent boys?

Men are husbands, partners, father, brothers and sons, and their lives are intertwined with women, children and other men.¹¹ Yet across the world, rigid gender norms and harmful perceptions of what it means to be a man have far-reaching consequences on health and well-being. These norms lead to gender inequalities that dramatically impact lives and choices and act as barriers to optimal health for women and men, adolescents, girls and boys. In many contexts, women do not control decision making, including on SRH choices, yet they bear a significant burden of contraceptive use and childbearing.¹² However, where men and adolescent boys are engaged in tackling gender inequality and promoting women's choices, the resulting outcomes are positive and men and women are able to enjoy equitable, healthy and happy relationships.¹³

Men and adolescent boys across the globe have substantial SRH needs, but adequate integration of SRH care for this group is often lacking. As a result, not only do men get sick unnecessarily, but their sexual partners, their families, their communities, and the health systems that serve them are also harmed. For instance, when men do not know their HIV positive status, they are less likely to practice safer sex and are thus much more likely to transmit HIV to their female and male partners. They are also less likely to access early treatment and therefore more likely to need ongoing care—both from loved ones (often women) and from the health system.¹⁴

To optimize public health outcomes and reduce the likelihood for long-term and costly interventions, where possible, prevention is favoured over treatment through a primary prevention approach. When prevention is also gender transformative, it can help avert the detrimental SRH outcomes that so disproportionately impact women and girls.

It is imperative for everyone's health and well-being to deconstruct harmful gender norms. Integrating gender-equitable norms in men and adolescent boys' SRH gives them the tools to take responsibility and protect their health while also being respectful, encouraging and supportive of women and girls protecting theirs.

Box 1: Years of life lost to SRH ill-health among men and boys

Global male disability-adjusted life years (DALYs)

HIV: 48 million (almost 44 million for females)

Sexually transmitted infections (other than HIV): close to 5 million (over 5 million for females)

Prostate cancer: almost 6 million

Infertility: almost 1 million

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

This service package focuses on meeting the SRH needs of men and adolescent boys in all their diversity using a gender-transformative approach. The benefits of this include:

1. Improving men’s and boys’ own sexual and reproductive health
2. Improving the SRH of women and girls
3. Challenging and transforming harmful male gender norms and promoting gender equality
4. Promoting sexual and reproductive health and rights (SRHR) for all

Box 2: What is sexual and reproductive health?

A working definition of sexual health is: “...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”¹⁵ Similarly, reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.¹⁶

Sexual and reproductive health programmes and policies relate to and include contraception and family planning, maternal and newborn health, prevention and treatment of HIV and other STIs, promotion of sexual health, prevention and management of gender-based violence, prevention of unsafe abortion and management of post-abortion care.¹⁷

Improving men's and boys' own sexual and reproductive health

Men have a variety of SRH needs such as contraception, prevention and treatment of HIV and other STIs, sexual dysfunction, infertility and male cancers. Yet these SRH needs are often unmet due to a combination of factors:

1. low utilization of SRH services due to services that are not seen as “male friendly” and also due to poor health-seeking behaviour among men.
2. policy- and structural-level factors, such as inclusive language in policies, access to and availability of services as well as addressing structural stigma so that men, regardless of sexual orientation, can be successfully reached;
3. a lack of focus on men and adolescent boys' sexual and reproductive health including: a limited articulation of what these services are, to whom they should be delivered and how to do so in a way that is inclusive of men in a meaningful way; and
4. insufficient evidence about large scale and implementable approaches to addressing the SRH needs of men, both as supportive partners as well as clients.

It is important to note that SRH provision for men and adolescent boys is not only about providing services within a clinical setting. Innovative service delivery methods are needed, for example, at workplaces, places of worship, sports gatherings and other community venues.

Box 3: What is gender?

1. The socially constructed expectations and norms regarding appropriate roles, responsibilities and behaviours among men and women, known as masculinities and femininities;¹⁸ and
2. The “power relations between women and men, and structural contexts that reinforce and create these power relations.”¹⁹

Improving the SRH of women

As mentioned above, inequitable gender norms have a disproportionate impact on the SRH of women and adolescent girls. In many settings, due to social, political and cultural reasons, women, girls and other disempowered populations have little or no control over SRH decision-making, with male partners exercising autonomy over their use of contraception and the desired number and timing of pregnancies. When men take better care of their own SRH, which has a direct impact on the SRH of their partners, they are also more likely to support their partners and share power in decision making. The 2015 State of the World's Fathers report²⁰ highlighted a number of examples:

- When men partner with women to encourage and support prenatal and postnatal visits as well as a healthy pregnancy, women's maternal health outcomes improve greatly.
- Men's active involvement has significant benefits for their newborn's health and throughout the child's development and into adolescence, in addition to promoting gender-equitable views.

- When men participate in prenatal visits and receive maternal health education, they can provide life-saving support to their partners, such as noticing the danger signs during pregnancy or delivery and getting their partners the necessary emergency care.
- Men's involvement during and after pregnancy provides psychological and emotional support, and is associated with reducing the likelihood of developing post-partum depression.
- Fathers can improve child health by encouraging immunization, seeking care for childhood illnesses and supporting infant nutrition.
- Positive father involvement is associated with children's emotional and social development, such as empathy, lower rates of depression and behavioural and psychological problems, their cognitive and language development, better academic performance and protection from risky behaviours.

Challenging and transforming harmful male gender norms and promoting gender equality

Social and cultural norms around masculinity can have direct implications for men's own SRH and well-being, as well as that of their partners and families. For example, men who equate masculinity with risk-taking and sexual dominance have been found to be more likely to have multiple partners, have an STI and have negative attitudes towards condom use. Socio-cultural norms that hold family planning and childcare as women's responsibility limit men's willingness to get involved and provide support. The demand for toughness, and expectations of being stoic in the face of illness can make them hesitant to seek help for their own SRH needs or support their partners' needs. Therefore, engaging men as agents of change in SRH creates a space for challenging and overcoming harmful conceptions of masculinity, power dynamics and gender norms. This can be seen in the promotion of gender equitable fatherhood; advocacy against discriminatory laws and policies; and changing attitudes and behaviours that are causes and consequences of sexual and gender-based violence.

In addition, gender norms that value a heterosexual ideal place men at increased risk of poor SRH and HIV outcomes – notably gay and bisexual men and other men who have sex with men²¹, transgender people, and other individuals who do not conform to gender norms. They face many barriers to accessing SRH services and commodities due to a repressive legal environment, stigma, discrimination and violence as a result of their sexual orientation or gender identity.²² Additional guidance has been developed for implementing comprehensive HIV and STI programmes with men who have sex with men and transgender people.²³

Effectively promoting sexual and reproductive health and rights for all

Finally, there is clear evidence that well-implemented gender-transformative approaches at the community level with men can bring about significant changes in their attitudes and practices related to gender, SRH and HIV, improving the well-being of women and girls, and of men and adolescent boys themselves.²⁴ This evidence is supported by governmental commitments at national, regional and global levels to strengthen work with men and adolescent boys (see box 4). While the provision of some SRH services may be challenging given resource constraints in low- and middle-income settings as well as prevailing harmful gender norms, evidence from such contexts demonstrates that it is possible and beneficial for the health development of women, newborns and children when men are engaged positively. It is therefore essential to

scale-up work on men's SRH within current provision, in order to build effective clinical and preventive services for all people, and to promote more healthy and equitable relationships in both homes and communities.²⁵

Box 4: Brazil's policy for men's health, fatherhood and gender equality*

Between 2007 and 2009, the Government of Brazil developed a policy to address a gap in existing national health policies, which overlooked the specific health needs of men. The core motivations for the Brazilian National Policy of Integral Health Attention to Men (PNAISH) are as follows:

- Recognition that health indicators and data demonstrate that male mortality rates are considerably higher compared with female mortality rates throughout the ages in the life cycle;
- Recognition of the necessity of organizing a health care network that guarantees men's integral health care;
- Considering the need to support actions and health promotion activities to facilitate and expand access to health services for this population; and
- Considering the need to support the qualification of health professionals to meet the specific health needs of the male population.

Since the policy's launch, an understanding has developed within the Brazilian Ministry of Health that when men are healthier, women and children probably will be healthier and that men's presence at health services can also be a golden opportunity to strengthen gender equity. Also, the implementation of the policy has reduced the overall cost to the health services. The primary health system is focused on preventative care, including through earlier diagnosis. Given late diagnosis, men are more likely to use the more expensive specialized services or emergency and urgent care.

Fatherhood presents a unique opportunity. There has been the greatest success in introducing men to primary health services and the arena of care, health and gender equity around fatherhood. In Brazil, four out of every five men are, or will become, fathers and this will make them gravitate, at some point, towards primary healthcare facilities when accompanying their partners for a pregnancy test or prenatal consultation. This moment presents an opportunity to work with men and help them understand that this space is also for men.

* Adapted from: Chakora E. et al (2014). A Brazilian Governmental Policy for Men's Health, Fatherhood and Care and Gender Equity. Available from www.menengagedilli2014.net/uploads/2/4/5/3/24534141/daniel_lima_mens_health_-_brazilian_ministry_of_health.pdf

A brief historical perspective to work on men's SRH

Focusing on men and adolescent boys within the context of SRH is not a new phenomenon. In 1994, the International Conference on Population and Development (ICPD) Programme of Action highlighted the importance of encouraging and enabling men “to take responsibility for their sexual and reproductive behaviour”.²⁶ This was followed by other intergovernmental declarations, particularly the Beijing Platform for Action (1995)²⁷ and the 48th session of the Commission on the Status of Women (2004).²⁸ Together, these provided a clear mandate for work on men's SRH, within a human rights framework. These developments took place alongside an increasing recognition of reproductive rights (and more recently sexual rights) for women and girls, following the work of many activists and organizations calling for women to have greater agency over their bodies and choice over reproductive decisions. Many of these feminist activists and organizations called for greater male involvement in SRH. Despite this international mandate for work on men's SRH, the programmatic response has been limited, except for a focus on the involvement of men to support the SRH outcomes of women and children. This approach has been slowly broadened over time, reflecting in particular the necessity of addressing men's own specific SRH needs. More recently, the framework in which work on men's SRH is undertaken promotes an integrated approach. Today, men are engaged as clients of SRH services in their own right, as partners in supporting the SRH of others, and as agents of change for SRH in their communities (see “Conceptual framework” below for further details).

For men who have sex with men, policy instruments were broadly silent until the 2011 Political Declaration of Commitment on HIV/AIDS, which was the first to specifically mention men who have sex with men. This represents an important step, but remains limited in scope, focusing only on the inclusion of men who have sex with men in national prevention strategies. Other entities, such as the Global Commission on HIV and the Law, show repressive laws and high levels of stigma and discrimination that create barriers to access SRH and HIV services. For example, same-sex sexual activity remains criminalized in 73 countries; in 13 countries (or parts of) the death penalty might be applied.²⁹

Box 5: Evolution of IPPF work on men and SRH

Since its inception, the International Planned Parenthood Federation has been undertaking pioneering work on engaging men and adolescent boys in gender equality, addressing their SRH needs, and working with them as partners in supporting and promoting the needs and rights of other men, women and children.³⁰ This has included work across the organization’s six geographical regions and in support of its strategic plan. Much of the initial work on engaging men with SRH was initiated by Member Associations (MAs), such as the Young Men as Equal Partners project in Africa, a similar initiative in South Asia, and work on machismo in Latin America.

In 2009, the Federation adopted the *IPPF Men and Sexual and Reproductive Health Policy* (see Annex 6). This replaced a previous policy on male involvement. This new policy is also complemented by the Gender Equality policy, a revised version of which was adopted in 2014 (also see Annex 6). These policies have provided the organizational framework and mandate for work on men and SRH within the Federation.

Several IPPF publications and toolkits have been developed to support this work, and IPPF Secretariat and MAs have undertaken a range of research studies, mappings, programmes and projects, workshops and initiatives related to this issue. IPPF has also partnered with other organizations, including joining the MenEngage Alliance, where it is now one of the inaugural board members.³¹

Despite these important developments, work on men’s SRH remains small-scale and the Federation continues to face challenges in reaching out to a sufficient number of men and adolescent boys. Global service statistics show that in 2014, a range of SRH and HIV services were provided to up to 14.1 million men and adolescent boys through IPPF Member Associations out of a total of 61.9 million clients.³² The aim is to find ways to build on this number, while not affecting the quality of care and level of uptake among women. This service package seeks to support this aspiration, and directly build on IPPF work to date.

Guiding principles

Several overarching principles guide the work within this SRH service package. It is framed within a rights-based, client-centred, stigma-free, and gender-sensitive and gender-transformative approach (see box 6). A detailed breakdown of these principles is provided in Annex 1.

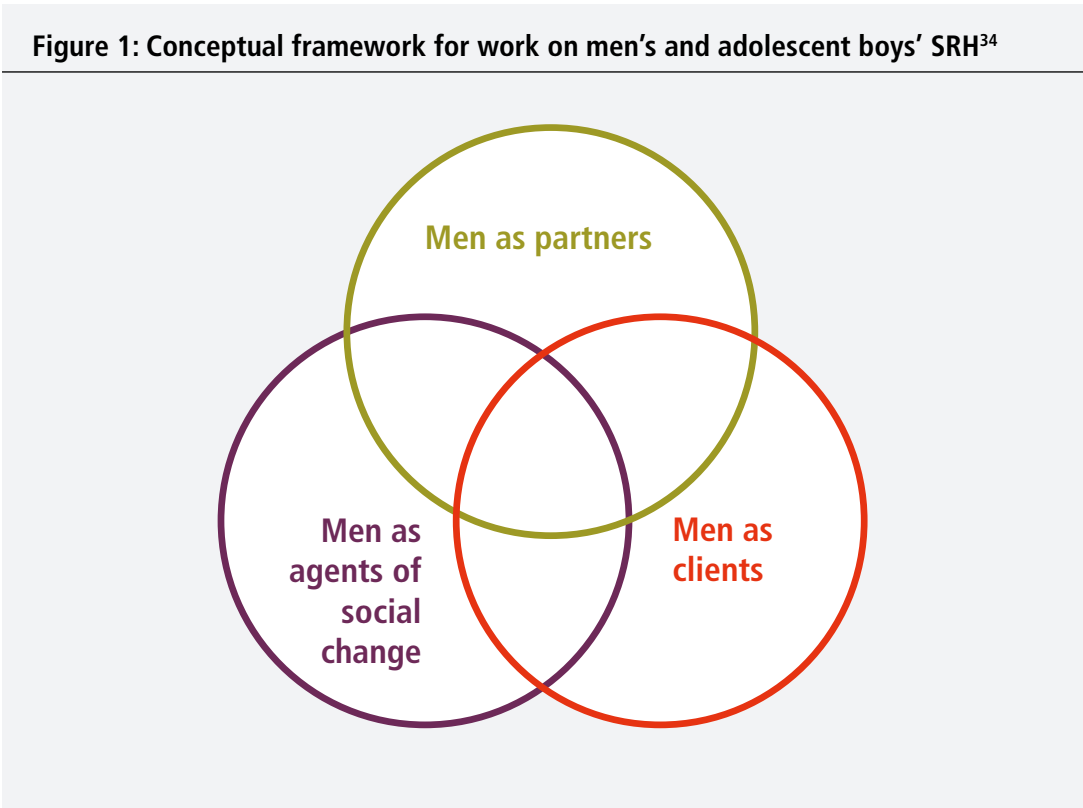
Box 6: Guiding principles for work on men and SRH

- | | |
|--|--|
| • Rights-based and client-centred | • Transformative and positive approach |
| • Evidence-informed | • Supportive and respectful to women’s rights and autonomy |
| • Respectful of sexual diversity | • Acknowledging men’s vulnerabilities |
| • Non-discriminatory and stigma-free | • Integrated, decentralized and cost-effective |
| • Supportive of a broad conception of gender and masculinities | • Collaboration and community participation |

Many SRH organizations³³ use a conceptual framework for their work that includes three components:

- **Men as clients/users of SRH clinical services**, in increasing their access to, and utilisation of, SRH clinical services. This is the primary focus of this service package.
- **Men as partners**, in supporting the SRH of partners and families, and in the promotion of sexual and reproductive health and rights.
- **Men as agents of change**, through their advocacy for sexual and reproductive health and rights and in challenging gender inequalities and harmful masculinities.

Each of these components (see figure 1), while separately important, should not be implemented alone: all three are essential to ensure successful and equitable SRH outcomes. Using a gender-transformative approach to meet the varied SRH needs of men and adolescent boys, organizations need to think about men not only as clients, but also as partners to support the SRH of others, potential agents of positive change in their own relationships, as well as allies and advocates for gender equality and improving SRH for all. It also requires gender equality to be centrally placed as a critical and non-negotiable element of improving sexual and reproductive health for both men and women. As such, while the first component – men as clients/users of SRH clinical services – is the primary focus of this service package, the second and third components are also addressed.



2 Building blocks to working on men's SRH



Section 2:

Building blocks to working on men's SRH

This package proposes seven essential and interlinked building blocks to support the efforts of organizations to operationalize a greater focus on men's SRH:

1. Using a gender-transformative approach
2. Delivering quality gender-sensitive SRH clinical services
3. Meeting men's diverse SRH needs often requires a different approach
4. Including a focus on young men and couples
5. Adapting to the context and local needs among men
6. Building a committed organization and workforce
7. Taking a primary prevention and integrated approach



1. Using a gender-transformative approach

Increasing service provision for men and adolescent boys should not just seek to increase men's and boy's access to care. This process also provides opportunities to reflect on and challenge unequal power relations and negative gender and sexuality norms, and support and encourage men to develop relevant skills related to communication with partners, health-seeking behaviour, condom use, and parenting if applicable. This will encourage men to be more caring and equitable, and to be more involved in the sexual and reproductive health of their partners and families.³⁵ This is known as a gender-transformative approach, and should be central to scaling-up SRH service delivery for men and adolescent boys (see box 7).

Box 7: Gender-transformative approaches

Gender-transformative approaches actively strive to examine, question and change rigid gender norms and imbalances of power as a means of reaching health as well as gender equity objectives. Gender-transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers and traditional leaders.³⁶

An invaluable tool developed to support organizations to move towards gender-transformative approaches within their work is the Gender Integration Continuum.³⁷ This continuum can help organizations increasing their focus on men's SRH to assess how their programme design and implementation can better incorporate a gender approach in order to ensure the greatest impact. The framework highlights the difference between approaches that are "gender blind" – where programmes have been designed without any consideration for gender-related outcomes and factors – and "gender aware" – where programmes have deliberately examined and addressed these gender-related issues. Once programmes are gender aware, they must, however, seek to "do no harm", though not intentionally or unintentionally reinforcing or taking advantage of gender inequalities. These programmes must also seek to go beyond simply accommodating gender differences, but aim to transform gender relations.

In the context of men's SRH, therefore, while increasing men's access to contraceptive and other family planning services, for example, it is also important to integrate information that it is not only important for men to be taking responsibility for their own SRH but to be supportive and respectful of their partner's SRH as well. This approach would apply both to the provision of services, such as during counselling sessions, client-provider interactions and skills building, as well as during awareness raising activities such as marketing. Further information on applying the Gender Integration Continuum can be found in Annex 2.

2. Delivering quality gender-sensitive SRH clinical services

Provision of quality SRH clinical services is paramount to all populations served, including to women, men and adolescent girls and boys. Providing quality of care to men and adolescent boys should not affect or undermine the quality of care provided to women and adolescent girls. In other words, work with men should not affect or undermine the quality of existing services for women and girls.

Within a quality assurance and quality improvement approach, the following dimensions are highlighted for achieving high-quality health care:

- care must be safe, effective and reliable, acceptable/client-centred, timely, efficient and equitable³⁸;
- services must be available, accessible and acceptable³⁹;
- clients have the right to information, choice, privacy and confidentiality, dignity and comfort, and continuity of services and consistent professional medical opinion⁴⁰;
- the needs of service providers must be met to fulfil clients' needs.⁴¹

The focus here should be on providing male-friendly SRH services (see box 8), within a context of high-quality health care for everyone. This includes moving away from siloed services for men and adolescent boys, and exploring successful ways to integrate within existing service provision. This is particularly important within resource poor contexts where there is already significant pressure on existing health systems to address women and children's health, which is still under-resourced and challenged in many settings.

Many lessons have been learned from providing quality SRH services to women and girls that should be built upon as part of improving SRH provision for men and adolescent boys. Such lessons include ensuring confidentiality and quality of care, appropriately training service providers, building organizational commitment and strengthening community-based health service delivery. A key part of building on these lessons is also a focus on primary prevention and integration as part of the approach to men's SRH.

Box 8: What are male-friendly SRH services?

SRH health services and programmes should better reflect the health needs of men and adolescent boys and encourage their appropriate use of services. Such services should encompass coordinated and multidisciplinary SRH care, addressing both primary prevention and disease management. Services should be provided to men by qualified staff in line with agreed quality of care standards. The range of barriers that men face when accessing and engaging with SRH services should also be appropriately considered, including whether the infrastructure of the health facility is male-friendly, i.e. bathrooms for men and neutral decor. Section 6 supports the operationalization of this service package in a male-friendly manner.⁴²

3. Meeting men's diverse SRH needs often requires a different approach

a. Meeting men's needs often requires a different approach and understanding

Dealing with men's SRH is different from providing services for women (as is the case vice-versa). This often requires a different way of speaking to men. For example, some men may present with symptoms of an STI but begin by talking to a service provider about their "headache". Only within time will these men disclose their actual STI concern. Given existing sex differences in health-care utilization, where many men do not access services, men's knowledge of SRH issues may also be low and they may feel embarrassed being seen at a health centre or discussing concerns about sex and sexuality. In addition, men may decide not to seek diagnosis and treatment for SRH conditions for other reasons, including a feeling of shame or fear of rejection from their partner, family, community and employer. There also may be pressures to provide financial support for one's family or stress relating to their economic situation where men are the "bread winners" and feel inadequate – so health-seeking may not be seen as the best use of one's time compared to seeking paid work.⁴³

These barriers among men themselves can be reinforced by a bad experience in the health system, such as through encountering unskilled staff, learning of the unavailability of treatment or experiencing a breach of confidentiality/privacy. This will not only lead to inadequate diagnosis and treatment of men's SRH illnesses and dysfunctions, but may further

discourage them from accessing services in the future. It is important that these issues are acknowledged and addressed as part of the approach to increasing a focus on men's SRH. This is explored further in section 6, including ensuring that staff and providers are sufficiently trained and confident, and that services and interventions are more responsive and appealing to men and adolescent boys seeking support.

b. Not all men have the same SRH needs

There are many SRH issues concerning men globally, and many similarities in sexual and reproductive ill-health among men throughout the world. However, the spread of those health concerns is not even. The prevalence of diseases differ, for example, according to place of residence, age, marital status, disability and sexual practices. Health care providers need to be trained to accommodate diverse needs and ensure access to stigma-free services. Furthermore, various groups of have additional or slightly different sexual and reproductive health issues and needs, e.g. young men and adolescent boys, gay and bisexual men and other men who have sex with men, men and adolescent boys living with HIV, men who sell sex, men who inject drugs, and transgender people identifying as men. In section 5 of this service package, specific health and service delivery considerations are outlined related to adolescence, sexual orientation and gender identity. Men's health-seeking behaviour also intersects with a range of other issues, including poverty and inequality. Therefore, understanding and programming for these differences when reaching out to men – such as through offering a wide range of services for diverse populations and being able to refer clients to related health services where needed – will lead to more effective SRH responses. In addition, this knowledge will inform strategies for successfully addressing men's SRH needs.⁴⁴

4. Including a focus on young men and couples

a. Targeting adolescents and young men

Adolescence is an age where gender and sexual norms are usually established and can dictate the context of sexual relations in decades to come. Adolescent boys and young men face a number of specific sexual and reproductive health needs. While this is an age that many men become sexually active, it is also a time often marked by a lack of knowledge about their own and the female body, and concerns about sex, masturbation and sexual dysfunction issues. These young men may fear accessing services due to embarrassment and to stigma from their community or peers, and too often when they do access such services and information they face prejudice from service providers. This can be compounded by religious and cultural beliefs and practices, which may disapprove of young people's sexuality, thus creating silence or fear around their behaviour. At the same time, these young men and adolescent boys may be keen to express their manhood and are influenced by social and cultural norms regarding appropriate behaviour, and this can lead to risk-taking.⁴⁵

Given these concerns, it is critical that the specific needs of adolescents and young men are taken into consideration within SRH service provision and that this group is specifically targeted. Adolescence is a period of development where behaviours and attitudes can be shaped for life, which provides a unique and important opportunity. For example, providing accurate SRH information to young men can help them adopt safer sexual practices, and more openly discuss their feelings and concerns. It can also help this group approach sexual

relationships in a more healthy, supportive and respectful manner. As part of this approach, improving parent-child communication around SRH issues is also very important (see Sections 5 and 6).

b. Importance of a couples approach

Working with couples can be a key entry point to reaching men (of any sexual orientation), particularly given men's lower engagement with the health system. For instance, research shows that engaging couples around contraceptive decision-making can have a significant positive impact on improving uptake of contraceptive methods.⁴⁶ However, it is important that service providers are adequately trained to take into consideration and address power dynamics during the counselling so *both* voices are equally heard. In contexts where women too often bear the burden of responsibility for accessing SRH services and the maintenance of SRH within their families, a couples approach also provides opportunities to challenge this gender inequality.

It is important, therefore, to consider what it means to work with couples within service delivery. For heterosexual couples, given that most contraceptive methods are female-only methods that generally require support of their male partner, this requires creating safe spaces where men and women can be provided with services and information together. Extending current service provision to offer couple counselling on contraception is a critical intervention in that regard. For same-sex couples, it is important that these same safe spaces are non-judgemental and stigma-free so that these couples can openly discuss their sexual health issues. Ultimately, it is about creating opportunities to effectively engage men and adolescent boys together with their male or female partners (see Section 5).

5. Adapting to the context and local needs among men

Organizations providing SRH services, including IPPF Member Associations, operate across many different contexts. Within these contexts, some have small community clinics, and others have larger facilities. It is important not to begin work on men's SRH by thinking of ways in which new structures can be created as this can be costly and often unsustainable. The starting point should be to explore ways to adapt existing facilities and to do so in a context-appropriate way. As such, beginning with a small number of new or improved services that address men's SRH and providing them to a high standard may be more advisable, with referrals given for the other SRH services outlined in the service package (see Section 3).

In order to focus on men's SRH, however, the target group(s) and their needs must be identified. Important questions to consider include:

- What are barriers in the community to men accessing SRH services?
- Which national and local laws and policies advance men and adolescent boys' SRH? Which national and local laws and policies hinder men and adolescent boys' SRH (e.g. criminalized relationships)?
- How and where is best to reach men?
- Among the components of this service package, what are best-suited to men's needs within your context (given the need for services will vary by age and population, etc.)?

To understand the context and local needs, it will be necessary to conduct formative research in which men and adolescent boys are meaningfully involved to articulate their SRH needs, in order to obtain input directly from the target group(s). The assessment within the operationalization section (Section 6) provides further details on formative research.

6. Building a committed organization and workforce

Before embarking on a scale-up of SRH services for men and adolescent boys, organizations should, where possible, ensure that they have a clear organizational mandate for this work, such as a policy on men and SRH. The IPPF policy on men and SRH provides a useful template (see Annex 6). There are important steps to follow in developing such a policy, including understanding the context, reviewing existing policies, working with stakeholders and implementation of the policy. The IPPF Men-streaming Toolkit⁴⁷ provides a helpful step by step guide to this process.

It is also of vital importance to ensure that all health providers and staff are aware of men's sexual and reproductive health issues, have the skills and confidence to deal with these issues, and are committed to doing so. This is particularly important in relation to issues of confidentiality and anonymity. Specialist training to make staff feel more comfortable providing SRH services to men in all their diversity, building their understanding of the common SRH issues that men have (as identified through the assessment), and empowering them to provide non-judgemental services, is a critical part of this. These issues are explored further within Sections 5 and 6.

7. Taking a primary prevention and integrated approach

A final important consideration is how to increase knowledge around SRH and encourage men's access to healthcare – including preventative services – through a primary prevention approach. This approach is one that focuses on addressing the upstream cases of SRH ill-health and requires engaging men, together with their partners, in local and clinic-based services not only when they are sick, but also encouraging a culture of men accessing SRH services preventatively. Men often access SRH services, particularly HIV, very late (by which time infection is advanced) and have been found to display significant knowledge gaps around SRH. A preventative approach would increase men's knowledge at an earlier stage, and change the harmful norm of low health-seeking behaviour, to instil a greater culture of engagement with the health system. In contexts where the existing health system is overburdened, these kinds of strategies can be very effective. Steps to adopt a primary prevention approach include exploring models to decentralize health services and provide community-based responses, including with volunteers.

Organizations should also seek to use an integrated approach, and in particular ensure sufficient linkages between SRH and HIV service provision, as well as ensuring strong referrals to different levels of the health system so men can be effectively referred and followed up. The international community has adopted several commitments to intensifying such SRH and HIV linkages,⁴⁸ given that the majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding, and that SRH and HIV ill-health also share similar root causes.⁴⁹ An integrated approach also means that any new work on the SRH of men and adolescent boys is incorporated into existing provision rather than becoming a stand-alone approach (as reflected in building block five above on being context-appropriate in one's implementation). Referral mapping and strengthening referral systems will help to improve follow up.

Taking an integrated approach is particularly important for some men's SRH issues. For example, benign prostatic hyperplasia, reproductive cancers and male infertility are challenging to treat since access to diagnostics, surgery and medical/surgical and radiation oncology are expensive. However, if a culture of engaging with the health-care system is encouraged among and adopted by men, for example, via outreach by community health workers, and they know where and how to access quality services, then they will be more likely to visit a health care professional who can provide a diagnosis and begin treatment early or be referred to the correct level of the health system where treatment can be accessed. As mentioned previously, gender-transformative approaches to men's and boys' SRH are key to primary prevention since women and adolescent girls as well as men and adolescent boys, will be empowered to protect their SRH and will not face the barriers to good health that unequal gender norms impose.

3

SRH service package for men and adolescent boys



Section 3:

SRH service package for men and adolescent boys

A combination of SRH services are required to respond effectively to the needs of men and adolescent boys in all their diversity. Recommended components are grouped within 12 categories of clinical services, which seek to reflect common understandings.⁵⁰ Figure 2 shows the component headings plus three non-clinical supportive strategies, and Tables 1 and 2 provide additional detail. Section 4 describes each component. Section 5 outlines specific health and service delivery considerations for adolescent boys and about recognizing diversity in sexual orientation and gender identity. Section 5 provides further information on how to operationalize the service package.

There is no expectation that every service in the list below should be provided in a single facility or a single client encounter. The service mix needs to be based on the expertise and resources available in the clinic and an understanding of the needs of the community which the clinic serves. For the healthcare providers, taking a detailed history of a new client is particularly important. The provider then offers the required services based on current national standards or refers as necessary, either within the facility or to another facility. For services that are not provided, effective referrals systems should be set up that include mechanisms to ensure a client receives the service referred for and any necessary follow up.

For each of the services in the table, the location of service delivery is highlighted as well as whether it should form part of a minimum package using the following key:

- Ⓒ Services relevant at the community level
- ① Services relevant at the clinic or first-level health facility

Why these service/facility levels?

This service package has been developed based on the standard set-up of SRH services, particularly within developing country settings; these tend to include both a static “first level” clinic and outreach SRH services to communities. The package does not seek to provide guidance for other settings, though much of the content may be applicable.

It is important to note that the client has the right to refuse any service offered (except in the case of being suicidal and/or homicidal, which can be grounds for detainment in accordance with the law/medical practice).

Figure 2: SRH services for men and adolescent boys

SRH clinical services

- 1 Assessment questions on male client history
- 2 Physical exam of male client
- 3 Contraception
- 4 Sexually transmitted infections
- 5 HIV and AIDS
- 6 Disorders of the male reproductive system, including sexual dysfunction
- 7 Male cancers
- 8 Fertility and infertility
- 9 Supporting prenatal and postnatal care, including safe motherhood
- 10 Supporting safe abortion care
- 11 Sexual and gender-based violence support
- 12 Information and counselling

SRH non-clinical supportive programmes

- 1 Information, education and communication materials
- 2 Skills building and support
- 3 Advocacy issues in which to engage men and adolescent boys

Table 1: Clinical SRH services and components

SRH clinical services for men and adolescent boys	Components*	Service level checklist	
		Community-based	1st level clinic
1. Assessment questions on male client history ⁵¹	a. Take a standard medical history	Ⓒ	1
	b. Take a detailed sexual health assessment (including sexual function and satisfaction)	Ⓒ	1
	c. Assess for fertility intentions	Ⓒ	1
	d. Take a cancer evaluation (as appropriate)	Ⓒ	1
	e. Assess for experience of sexual and gender-based violence, including intimate partner violence (initial assessment questions)	Ⓒ	1
	f. Assess for alcohol, tobacco and other substance use	Ⓒ	1
	g. Assess for mental health including depression	Ⓒ	1
	h. Assess for nutrition, food availability, diet and exercise	Ⓒ	1
	i. Assess for immunizations/vaccinations	Ⓒ	1
2. Physical exam of male client ⁵²	a. Measure height and weight, and calculate Body-Mass Index (BMI)	Ⓒ	1
	b. Measure blood pressure	Ⓒ	1
	c. Conduct external genital and perianal exam	Ⓒ	1
	d. Conduct other physical exam relevant from history using clinical judgement		1
3. Contraception	a. Counsel client (if not undertaking couple counselling) and provide information on all available contraceptive options, his role in this, and how to be supportive and communicate with his partner in choosing the contraceptive option that works for them both	Ⓒ	1
	b. Counsel a couple (if partner agrees) and provide information on all available methods of contraception, including promotion of dual protection through use of condoms	Ⓒ	1
	c. Provide condoms and condom-compatible lubricant, and other contraceptive methods, including emergency contraception	Ⓒ	1
	d. Provide vasectomy services (or referral)		1

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

SRH clinical services for men and adolescent boys	Components*	Service level checklist	
		Community-based	1st level clinic
4. Sexually transmitted infections (STIs)	a. Counsel client and provide information on STIs, including couple counselling (if partner agrees)	C	1
	b. Conduct external genital and perianal exam (as part of syndromic management)	C	1
	c. Provide etiological diagnosis of STIs (diagnostic testing), i.e. laboratory and microscopy		1
	d. Treat STIs following syndromic management or etiological diagnosis	C	1
	e. Counsel client and provide support for partner notification for STIs and facilitated treatment (where applicable)	C	1
	f. Provide condoms and condom-compatible lubricant	C	1
	g. Provide HPV and Hepatitis B vaccinations		1
	h. Provide viral hepatitis services including prevention, screening and treatment		1
5. HIV and AIDS	a. Provide HIV testing services (including information and counselling)	C	1
	b. Provide condom and condom-compatible lubricant	C	1
	c. Provide antiretroviral treatment for HIV (or referral) including initiation, monitoring and adherence support	C	1
	d. Provide pre-exposure prophylaxis (PrEP) for HIV	C	1
	e. Provide post-exposure prophylaxis (PEP) for HIV		1
	f. Provide voluntary medical male circumcision (VMMC)		1
	g. Counsel client on how to support partner in preventing mother-to-child transmission of HIV (if partner wants)	C	1
	h. Diagnose, manage and prevent HIV-related coinfections and co-morbidities		1
	i. Provide care and support for men and adolescent boys living with HIV	C	1
6. Disorders of the male reproductive system, including sexual dysfunction	a. Diagnose and counsel client on sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation), and provide referral		1
	b. Treat (or refer) for sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation)		1
	c. Treat (or refer) for other disorders of the male reproductive system (warts, varicoceles, urological disease, etc.)		1
	d. Screen and treat urinary tract infections (or refer)		1
7. Male cancers	a. Counsel client on sexual and reproductive-related male cancers (prostate, testicular, penile, anal, breast)	C	1
	b. Take a history for sexual and reproductive-related male cancers		1
	c. Refer for further investigation and management as necessary		1

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

SRH clinical services for men and adolescent boys	Components*	Service level checklist	
		Community-based	1st level clinic
8. Fertility and infertility	a. Counsel client on basic fertility awareness including pre-conception health	●	1
	b. Counsel couples for conception (if the partner agrees)	●	1
	c. Counsel client on infertility		1
	d. Provide basic infertility care for men, including semen analysis		1
	e. Provide vasectomy reversal (recanalisation) services (or refer)		1
	f. Treat for infertility/provide assisted reproduction (or refer)		1
	g. Counsel client (and partner) on adoption (or refer)		1
9. Supporting prenatal and postnatal care, including safe motherhood	a. Counsel client on preconception, support during pre-and post-natal period and care-giving	●	1
	b. Provide links to a support group for expectant and new fathers / classes on parenting/ fatherhood skills		1
10. Supporting safe abortion care[§]	a. Counsel clients who are partners in safe abortion care on the role they can play as a source of support		1
	b. Support client to be a supportive partner and to participate in pre- and post-abortion care counselling sessions (if the partner wants)		1
11. Sexual and gender-based violence (SGBV) support	a. Screen for experience of SGBV, including intimate partner violence	●	1
	b. Counsel and support clients affected by violence and refer for clinical, psychosocial and protection services	●	1
	c. Refer clients who have a history of perpetrating violence against women to a relevant programme/support group		1
12. Information and counselling [Note: specific information and counselling also included in above sections] Within clinic settings, if the counselling is not directly provided by the healthcare provider it can be provided by a member of the healthcare team.	a. Provide information and counsel client on sex, sexuality and sexual health, including pleasure (for man and partner)	●	1
	b. Provide information and counsel client on self-confidence and self-esteem	●	1
	c. Provide information and counsel client on relationships and non-violent communication and negotiation	●	1
	d. Provide information on comprehensive sexuality education (CSE), values and gender equality, with specific focus on role of men, to reach in-school and out-of-school youth	●	1
	e. Provide information on genital/anal health and hygiene	●	1
	f. Counsel client and provide information on stigma reduction, particularly in the context of HIV and other STIs	●	1

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

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

Table 2: Non-clinical SRH supportive programmes and components

SRH non-clinical supportive programmes for men and adolescent boys	Components*
1. Information, education and communication (IEC) materials for men and adolescent boys	a. Basic sex and SRH education, including sexuality and sexual orientation, pleasure and anatomy, libido, masturbation and related myths
	b. Genital health and penile hygiene (e.g. smegma reduction)
	c. Contraception choices and mens’ supportive role in making a contraceptive choice with their partner
	d. Infertility
	e. Prevention and treatment of STIs and HIV
	f. Supportive involvement in prenatal and postnatal care, materials on fatherhood/men’s role as a parent
	g. Mental health and psychosocial support
	h. Stigma reduction, particularly for HIV and other STIs
	i. Awareness and prevention of SRH-related male cancers
	j. Drug and alcohol dependence or overuse
	k. Tobacco dependence
2. Skills building and group support for men and adolescent boys	a. Pregnancy and STI prevention (including HIV)
	b. Fatherhood and maternal health, newborn and child health and development skills
	c. Non-violent communication and negotiation in relationships (between couples/other caregivers, on shared caregiving and domestic responsibilities, and with children)
	d. Awareness of risk-taking behaviour and the effect this can have on their own and their partners sexual and reproductive health
	e. Engaging men in SGBV prevention
	f. Comprehensive sexuality education, values and gender equality, support for women and girls’ rights including reproductive rights, with specific focus on role of men and to provide positive images of more gender-equitable men
	g. Support groups for men (such as groups for men living with HIV)
3. Advocacy issues in which to engage men and adolescent boys	a. Greater focus on men and adolescent boys within national SRH & HIV laws and policies
	b. Safe abortion services and stigma-free environment
	c. Increasing and promoting shared parental leave
	d. Engaging men in SGBV prevention
	e. Engaging men as partners in supporting prenatal and postnatal care, including safe motherhood
	f. Creating an enabling policy environment that addresses discrimination and violence against men, for example men who have sex with men, and transgender men and other gender-nonconforming individuals, male sex workers, men who inject drugs, male prisoners
	g. Acceptance of adolescent sexuality and SRH and creating an enabling policy and legal environment that aims to dismantle barriers to adolescent SRH

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

4 Detailed summary of SRH clinical service components



Section 4:

Detailed summary of SRH clinical service components

This section describes the 12 clinical service components introduced in the previous section. Specifically, further explanation and key activities for each component are listed, as well as resources to consult for additional information (for example, on considerations of commodities and medical equipment).

Please note that the implementation of these services should be in line with national guidelines and protocols, and determined based on the local contexts and client needs and situation. This includes, for example, the frequency or age range at which such components should be provided to male clients. Where there is specific global evidence on the optimum frequency or age range for a specific component, this has been noted below. Many of these services also require specialist training of health providers before being rolled out (see section 2 and 5 for further details).

A number of these service components are already required to be provided to men as part of existing national guidelines, and organizations should ensure their compliance with such commitments. In addition, many of these service components are also relevant for women and are currently being provided to women within many service provision contexts; therefore they should continue to be provided to women, and extended to men, where that is not currently the case.

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
1. Assessment questions on male client history ⁵³		
a. Take a standard medical history	Assess for medical and surgical history, current medical conditions and medications and allergies reason for visit, and current/impending fatherhood status	Preventive male sexual and reproductive health care: Recommendations for clinical practice. Male Training Center for Family Planning and Reproductive Health, 2014. Available at: http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC_White_Paper_2014_V2.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Take a detailed sexual health assessment (including sexual function and satisfaction)	Ask the male client about their sexual history including: 1) Sexual practices/behaviour 2) Sexual partners, current and recent 3) Sexual function and satisfaction, including level of interest in sex, change in libido, regularity, erectile dysfunction, any difficulties during sexual intercourse, and level of satisfaction. Refer to category 6 for further details. 4) Current and future pregnancy prevention/family planning as appropriate 5) Current use of SRH and HIV medicines and commodities 6) STI/HIV protection 7) Past STI/HIV history Ask if the client has any questions about sex. Note that it is particularly important to ask men about sex, given stigma in such areas.	Young men and HIV prevention: A toolkit for action. UNFPA and Promundo, 2007. Available at: http://menengage.org/resources/toolkit-action-young-men-hiv-prevention/ Men’s reproductive health curriculum: Management of men’s reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf UK national guideline for consultations requiring sexual history taking. British Association for Sexual Health and HIV, 2013. Available at: http://www.bashh.org/documents/Sexual%20History%20Guidelines%202013%20final.pdf
c. Assess for fertility intentions	Determine fertility intentions and whether there are any known difficulties with fertility. If the intention is not to have children at present – ensure there is knowledge about contraceptive options available. Refer to category 3 for more details.	As above
d. Take a cancer evaluation (as appropriate)	Ask about family history of prostate, testicular and breast cancer. Depending on the age of the client, assess whether the client has ever had a prostate exam, or conducted a self-testicular exam. Provide age-appropriate follow-up testing and treatment for cancer, as needed.⁵⁴ Note that there is no internationally-agreed standard or routine screening method for prostate and testicular cancer. In the US, routine examination of the testicles for testicular cancer is not recommended in asymptomatic adolescent and adult men, and advice differs on the use of prostate-specific antigen (PSA)-based screening for prostate cancer.⁵⁵ However, it is important that clinicians and health providers are aware of its signs and symptoms, and can provide appropriate information to clients, where applicable. Moreover, the male genital examination still remains an important part of the male physical examination (beyond the need to screen for testicular cancer). See category 7 below, and resources for further information.	Men’s reproductive health curriculum: Introduction to men’s reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf Early detection of prostate cancer: AUA guideline. American Urological Association, 2013. Available at: http://www.auanet.org/documents/education/clinical-guidance/Prostate-Cancer-Detection.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
e. Assess for experience of sexual and gender-based violence including intimate partner violence (initial assessment questions)	Conduct initial assessment for history of incidences of all forms of violence and abuse, physical, emotional/mental, including sexual violence and domestic violence. It is important to remember that some men may be apprehensive about discussing violence, such as rape and partner abuse. This should include assessing both experience and perpetration of violence, as well as a history of exposure to childhood family violence (given links between childhood experience of violence and future perpetration in men). ⁵⁶ If there is an indicator of any of the above conduct a fuller assessment and provide counselling and referrals, as appropriate, as outlined in category 11.	Preventive male sexual and reproductive health care: Recommendations for clinical practice. Male Training Center for Family Planning and Reproductive Health, 2014. Available at: http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC_White_Paper_2014_V2.pdf Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. WHO, 2013. Available at: http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf
f. Assess for alcohol, tobacco and other substance use	Assess for alcohol use, other substance use and smoking habits/use of other tobacco products, and whether use is having deleterious consequences for the client or others. Counselling should then be provided based on assessment, with referral to behavioural interventions to reduce alcohol/other substance use and smoking cessation, as appropriate, acceptable and available.	Preventive male sexual and reproductive health care: Recommendations for clinical practice. Male Training Center for Family Planning and Reproductive Health, 2014. Available at: http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC_White_Paper_2014_V2.pdf
g. Assess for mental health including depression	Assess for signs of depression, anxiety, stress and other mental health issues, including risk of suicide, homicide and other forms of violence. This is important given the high reported global rates of male depression and links to SRH and HIV, risk-taking behaviour specific for SRHR, as well as high levels of male suicide. ⁵⁷ If positive findings, probe in accordance with relevant national standards and refer as appropriate.	As above Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5). American Psychiatric Association, 2013. Available at: http://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596
h. Assess for nutrition, food availability, diet and exercise	Assess nutritional status, food availability, diet and level of exercise. This is important given benefits of a healthy diet and regular exercise, and links between poor diet/insufficient exercise and male SRH problems, such as decreased fertility and libido. Provide counselling and referrals as appropriate.	As above

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
i. Assess for immunizations/ vaccinations	Assess past receipt of SRH immunizations or care. Offer (or refer) all clients for: • Human Papillomavirus (HPV) vaccination for all early adolescent boys and young men aged 11-26 years, where applicable. Routine vaccination recommended for at risk men and adolescent boys, particularly MSM and those living with HIV.⁵⁸ • Hepatitis B (HBV) vaccination among boys aged below 19 years and for all at risk men, particularly MSM, people who inject drugs, and people living with HIV. HBV vaccination is recommended as standard during infant immunization. • Hepatitis A, recommended for MSM (in some contexts).	As above
2. Physical exam of male client ⁵⁹		
a. Measure height and weight, and calculate Body-Mass Index (BMI)	Assess all men and adolescent boys for obesity, including measuring their weight, height and calculating body mass index (BMI). Obese men should be referred for counselling and behavioural interventions.	Preventive male sexual and reproductive health care: Recommendations for clinical practice. Male Training Center for Family Planning and Reproductive Health, 2014. Available at: http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC_White_Paper_2014_V2.pdf
b. Measure blood pressure	Measure blood pressure. This should be every two years if normal (blood pressure <120/80), every year for young people, and every year for those with pre-hypertension (blood pressure 120-139/80-89).	As above
c. Conduct external genital and perianal exam	Perform examination of the external genital and perianal (around the anus, the opening of the rectum). Document developmental stage, and other genital findings including discharge, phimosis, lesions/ulcers, etc. Examine skin and hair, inguinal nodes, scrotal contents, penis and the perianal area. In addition, a physical examination should be conducted as part of an evaluation for male infertility with particular focus given to: 1) examination of the penis, including the location of the urethral meatus 2) palpation of the testes and measurement of their size 3) presence and consistency of both the vas deferens and epididymis 4) presence of a varicocele and hydroceles 5) secondary sex characteristics 6) a digital rectal exam (DRA) 7) Proctoscopy (when required)⁶⁰	As above Men’s reproductive health curriculum: Management of men’s reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf
d. Conduct other physical exam(s) relevant from history using clinical judgement	Based on the history information provided in section 1, any other physical exam should be provided following standard medical practice and clinical judgement.	As above

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3. Contraception		
a. Counsel client (if not undertaking couple counselling) and provide information on all available contraceptive options, his role in this, and how to be supportive and communicate with his partner in choosing the right contraceptive option that works for them both	In addition to the above, provide information on the role men can play in supporting, and being involved in, pregnancy prevention/family planning. This can include men doing the following:⁶¹ • Use male contraceptive methods, such as condoms and vasectomy. • If female controlled method, help with this method if female partner so desires (e.g. by helping insert the spermicide, if needed, or reminding her when to use it), and if the partner is not using a female condom, then consider also simultaneously using a male condom for dual method use as a back-up and to prevent HIV and other STIs. • Support by using an alternative method (such as withdrawal or condoms) in case the female partner forgets to use or has an unexpected problem with her chosen method. • Provide financial support (e.g. by helping his partner pay for the method). • Provide emotional support (e.g., by accompanying his partner to the clinic, discussing the reasons for choosing one method over another, and/or supporting her choice of method). See resources section for strategies on involving men in family planning.	Men's reproductive health curriculum: Introduction to men's reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf Men's reproductive health curriculum: Counselling and communicating with men. EngenderHealth, 2003. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-2/participant/mrh_2p.pdf Guide for Promoting Sexual and Reproductive Health Products and Services for Men. Health Communication Capacity Collaborative, 2017. Available at: https://healthcommcapacity.org/hc3resources/guide-promoting-sexual-reproductive-health-products-services-men/
b. Counsel a couple (if partner agrees) and provide information on contraception including promotion of dual protection	Offer couple counselling to male and female partners during family planning visits and provide only if female partner consents to this. Provide information (individually or with couples) on the various types of contraceptive methods, and their effectiveness, merits, and side effects, and help the couple/individual client choose a method and explain its use. As most methods are female-controlled, encouraging couple communication around family planning, and that men provide support to their partners in this area, is essential (including the lactational amenorrhea method (LAM) and fertility awareness methods) and the man's role in supporting his partner in effectively following these methods. Highlight the importance of triple protection from HIV, other STIs, and unintended pregnancy, and that family planning can help women and men plan and space births and prevent unintended pregnancy. Couple counselling should ideally be linked to the provision of skills development on equitable and safe negotiation around sex (see resources section).	Counselling for effective use of family planning. EngenderHealth, 2008. Available at: http://www.engenderhealth.org/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2_resources/fp_curric_ph_main_text.pdf Ensuring human rights within contraceptive service delivery: Implementation guide. UNFPA and WHO, 2013. Available at: http://www.who.int/reproductivehealth/publications/family_planning/hr-contraceptive-service-delivery/en/ Engaging men in sexual and reproductive health and rights, including family planning. EngenderHealth and UNFPA, 2017. Available at: https://www.engenderhealth.org/pubs/gender/gender-toolkit/ Men's reproductive health curriculum: Counselling and communicating with men. EngenderHealth, 2003. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-2/participant/mrh_2p.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
c. Provide condoms and condom-compatible lubricant, and other contraceptive methods, including emergency contraception	Condoms (male and female) should be readily available for men women, and widely distributed to men in various community settings. Provide condoms along with instructions about correct and consistent use as well as condom-compatible lubricant. Other contraceptive methods, particularly emergency contraception, should be made available to men on behalf of their partners.	Men’s reproductive health curriculum: Introduction to men’s reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf
d. Provide vasectomy services (or referral)	Vasectomy is one of the few male-only methods of contraception, and clients should be informed about and given access to the procedure along with the entire range of contraception available. It is a male sterilization procedure that prevents the passage of sperm into the ejaculation fluid by blocking the spermatic cords (vasa deferentia). Men can either receive conventional (incisional) vasectomy or no-scalpel vasectomy (NSV). NSV has a number of advantages. Provide pre-vasectomy counselling. Inform men about the effectiveness of vasectomy, potential side effects/complications, and degree of permanency. Highlight that this method does not provide protection from HIV and other STIs. Undertake the procedure. Undertake a post-vasectomy semen analysis.	No-scalpel vasectomy: Curriculum, second edition. Engenderhealth, 2007. Available at: http://www.engenderhealth.org/files/pubs/family-planning/nsv_curric_participant_final.pdf No-scalpel vasectomy: An illustrative guide for surgeons, third edition. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/family-planning/no-scalpel.pdf Instruments and supplies needed to provide clinical methods of family planning. EngenderHealth, 2013. Available at: http://www.engenderhealth.org/pubs/family-planning/vasectomy.php Guidelines on vasectomy. European Association of Urology, 2012. Available at: https://www.ncbi.nlm.nih.gov/pubmed/22033172
4. Sexually transmitted infections (STIs)		
a. Counsel client and provide information on STIs, including couple counselling (if partner agrees)	Provide information on the various types of STIs, including transmission, symptoms, and prevention techniques for all STIs, including HIV (see category 5 below), and how STIs can be detected and treated. Emphasize harm reduction, safer sex and dual protection. Following a positive diagnosis, recommend that the client notify their sexual partners, so that they, too, can be tested and treated. See category 4c below. Counselling should ideally be linked to the provision of skills development, including how to correctly and consistently use condoms, and equitable and safe negotiation around sex (see resources section).	See national guidelines for the diagnosis and treatment of STIs (if applicable) Guidelines for management of sexually transmitted infections. WHO, 2004. Available at: http://www.who.int/hiv/pub/sti/pub6/en/ Men’s reproductive health curriculum: Management of men’s reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Conduct external genital and perianal exam (as part of syndromic management)	The specific approach to syndromic management for STIs for men should be based on national guidelines for the diagnosis and treatment of STIs and local/national prevalence. The general approach is outlined below. STIs are often easier to detect with men rather than women, as men as it is easier to detect specific signs and symptoms such as urethral discharge and genital ulcers. As such, syndromic management of STIs (treatment of STIs based on signs and symptoms) can be very effective with men. By performing genital and anorectal examination, it is possible to look for symptoms of STIs, including urethral discharge (often gonococcal or chlamydial infection) and genital ulcers (often syphilis, chancroid or genital herpes). It may also be important to look for anorectal infections, as ulcers can also appear in this area, as well as anorectal discharge (often gonococcal or chlamydial infection). Other syndromes can also be managed, but it is important to recognize the limitations of syndromic management.	As above Training modules for the syndromic management of sexually transmitted infections. WHO, 2007. Available at: http://www.who.int/reproductivehealth/publications/rtis/9789241593407/index/en/index.html
c. Provide etiological diagnosis of STIs (diagnostic testing), i.e. laboratory and microscopy	The specific approach to etiological diagnosis of STIs for men should be based on national guidelines for the diagnosis and treatment of STIs and local/national prevalence. The general approach is outlined below. Serological tests are available for the laboratory diagnosis of syphilis, Hepatitis B and Hepatitis C. Similar to HIV, rapid point-of-care diagnostic tests are available for serological syphilis diagnosis. Diagnosis of chlamydia and gonorrhoea requires laboratory diagnosis through microscopy or NAAT/PCR (Nucleic Acid Amplification Test/ Polymerase Chain Reaction) of either a urine sample or urethral/ anorectal/pharyngeal swab. Etiological diagnosis of STIs (or diagnostic testing) is problematic in many settings due to the length of time it takes, the need for trained laboratory staff, resources required and costs.	As above Laboratory diagnosis of sexually transmitted infections, including human immunodeficiency virus. WHO, 2013. Available at: http://www.who.int/reproductivehealth/publications/rtis/9789241505840/en/ Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. WHO, 2015. Available at: http://www.who.int/hepatitis/publications/hepatitis-b-guidelines/en/ Guidelines for the screening, care and treatment of persons with hepatitis C infection. WHO, 2014. Available at: http://www.who.int/hepatitis/publications/hepatitis-c-guidelines/en/
d. Treat STIs following syndromic management or etiological diagnosis	The specific approach to STI treatment for men should be based on national guidelines for the diagnosis and treatment of STIs. The general approach includes providing treatment for STIs based on syndromic management or etiological diagnosis. Where treatment is not available, clients must be referred.	As above Guidelines for the treatment of sexually transmitted infections (including gonorrhea, chlamydia, syphilis, herpes simplex virus). WHO, 2016. Available at: http://www.who.int/reproductivehealth/publications/rtis/en/

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e. Counsel client and provide support for partner notification for STIs and facilitated treatment (where applicable)	Partner notification for STIs is encouraged, where possible. Notification can be active (where the facility makes contact with the partner) or passive (where the facility asks the clients to inform or bring their partners). This should be discussed with the client during post-test counselling, and support provided. The specific approach should be based on national guidelines for the diagnosis and treatment of STIs.	As above 2012 BASHH statement on partner notification for sexually transmissible infections. International Journal of STD & AIDS, 2013. Available at: http://www.bashh.org/documents/2012%20Partner%20Notification%20Statement.pdf
f. Provide condoms and condom-compatible lubricant	Consistent and correct use of male condoms reduces sexual transmission of many STIs, including HIV. Condoms (male and female) should be readily available, affordable, accessible and of quality (AAAQ), and widely distributed to men in various community settings. Condom-compatible lubricants (i.e. water- or silicone-based) should also be available, as can decrease risk of condom failure, especially for anal intercourse.	Men’s reproductive health curriculum: Management of men’s reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf Ensuring human rights within contraceptive service delivery: Implementation guide. UNFPA and WHO, 2013. Available at: http://www.who.int/reproductivehealth/publications/family_planning/hr-contraceptive-service-delivery/en/
g. Provide HPV and Hepatitis B vaccinations	HPV is mainly transmitted through sexual contact and can lead to cancers of anus and penis in men. Non-cancerous types (6 and 11) can cause genital warts, which are very common and infectious, and respiratory papillomatosis. HPV vaccines have been approved in many countries and are recommended for boys before the onset of sexual activity to prevent genital cancers and genital warts. ⁶² Hepatitis B attacks the liver, which can cause acute and chronic disease, such as cirrhosis of liver or liver cancer and is spread by blood, semen and other bodily fluids. Hepatitis B vaccine is recommended for infants to prevent infection.	Human papillomavirus (HPV) and cervical cancer, factsheet 380. WHO, 2015. Available at: http://www.who.int/mediacentre/factsheets/fs380/en/ Human papillomavirus vaccines: WHO position paper. WHO, 2014. Available at: http://www.who.int/wer/2014/wer8943.pdf?ua=1 Hepatitis B, factsheet 204. WHO, 2014. Available at: http://www.who.int/mediacentre/factsheets/fs204/en/ The immunological basis for immunization series, module 22: Hepatitis B. WHO, 2011. Available at: http://apps.who.int/iris/handle/10665/77755

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
h. Provide viral hepatitis services including prevention, screening and treatment	Hepatitis B and C are bloodborne viruses and hepatitis B is also spread by semen and other body fluids. It is recommended that screening be offered to individuals belonging to a population with high HCV prevalence or risk/exposure behaviour, in particular, injecting drug use through the sharing of injection equipment. Hepatitis B attacks the liver, which can cause acute and chronic disease, such as cirrhosis of liver or liver cancer. Hepatitis B cannot be diagnosed in a clinic, so laboratory confirmation is needed using blood tests. Oral treatments are recommended (tenofovir, entecavir) since they are the most potent at suppressing the hepatitis B virus. Hepatitis C infection is diagnosed by screening for anti-HCV antibodies with a serological test. If they test positive for anti-HCV antibodies, a nucleic acid test for HCV RNA is needed to confirm chronic HCV infection (around 15–45% of people infected with HCV have a strong immune response, clearing the infection without the need for treatment). After diagnosis, an assessment of the degree of liver damage is necessary. Antiviral drugs, called direct antiviral agents (DAA) are the newest, more effective therapies. There is no vaccine for hepatitis C.	Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. WHO, 2015. Available at: http://www.who.int/hiv/pub/hepatitis/hepatitis-b-guidelines/en/ Guidelines for the screening, care and treatment of persons with hepatitis C infection. WHO, 2014. Available at: http://apps.who.int/iris/bitstream/10665/111747/1/9789241548755_eng.pdf New recommendations in the updated guidelines for the screening, care and treatment of persons with chronic hepatitis C infection. WHO, 2016. Available at: http://apps.who.int/iris/bitstream/10665/204452/1/WHO_HIV_2016.01_eng.pdf?ua=1 Hepatitis: fact sheets. WHO, 2015. Available at: http://www.who.int/topics/hepatitis/factsheets/en/

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
5. HIV and AIDS		
a. Provide HIV testing services (including information and counselling)	HIV testing services (HTS) are key for men to know their status. It must always be voluntary and free from coercion. The HIV testing process should be guided by the WHO’s “5 Cs” of HTS: Consent; Confidentiality; Counselling; Correct results; and linkage to Care.⁶³ Provide male clients who test positive with HIV prevention, treatment and care services. Those clients who test negative should be provided with prevention programmes and encouraged to undertake retesting at a later stage. HTS must be part of a comprehensive programme, with clear links between testing and HIV prevention, treatment and care services. Counselling remains an essential component of HIV testing services with pre-test information and post-test counselling. Pre-test information can be provided in a group setting, but everyone should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. Post-test counselling offers a valuable opportunity to provide accurate information about safer sex and harm reduction that is relevant to the person being tested, as well as other SRH-related care. Provide couples HTS, where possible and there is no risk of resulting violence. This will support couples to test together and mutually disclose their HIV status, and make informed decisions about HIV prevention and offer each other support for obtaining and adhering to ART. HTS for couples or partners should be offered to anyone, regardless of how they define their relationships. Provide alternative HIV testing methods such as through mobile clinics, workplace testing, door-to-door testing and self-testing, including the use of rapid, point-of-care HIV diagnostic tests. Further details on HTS are provided in the resources section.	Consolidated guidelines on HIV testing services. WHO, 2015. Available at: http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/ Engaging men in HIV and AIDS at the service delivery level: A manual for service providers. The ACQUIRE Project/ EngenderHealth and Promundo, 2008. Available at: http://www.acquireproject.org/archive/html/7-engage-men/tools.html Service delivery approaches to HIV testing and counselling (HTC): A strategic HTC policy framework. WHO, 2012. Available at: http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877_eng.pdf Guidance on provider-initiated HIV testing and counselling in health facilities. WHO, 2007. Available at: http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in sero-discordant couples: Recommendations for a public health approach. WHO, 2012. Available at: http://whqlibdoc.who.int/publications/2012/9789241501972_eng.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Provide condoms and condom-compatible lubricant NB: also under contraceptives & STIs	Consistent and correct use of male condoms prevents sexual transmission of many STIs, including HIV. Condoms (male and female) should be readily and cheaply available for men and widely distributed to men in various community settings. Condom-compatible lubricants (i.e. water- or silicone-based) should also be available, as can decrease risk of condom failure, especially for anal intercourse. The provision of condom and condom-compatible lubricant should therefore be a key part of HIV prevention strategies.	Engaging men in HIV and AIDS at the service delivery level: A manual for service providers. The ACQUIRE Project/ EngenderHealth and Promundo, 2008. Available at: http://www.acquireproject.org/archive/html/7-engage-men/tools.html Condom programming for HIV prevention: An operations manual for programme managers. UNFPA, 2005. Available at: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2005/condom_prog2.pdf Use and procurement of additional lubricants for male and female condoms: Advisory note. WHO, 2012. Available at: http://apps.who.int/iris/bitstream/10665/76580/1/WHO_RHR_12.33_eng.pdf
c. Provide antiretroviral treatment for HIV (or referral) including initiation, monitoring and adherence support	Evidence highlighting the potential of HIV antiretroviral treatment (ART) to reduce HIV transmission by suppression of viral load, supports the early initiation of ART. It is important to also be aware of the current lower rates of ART access among men compared to women, especially in sub-Saharan Africa, men's challenges associated with ART adherence, and men's greater likelihood to be lost to follow-up or to die while on ART.⁶⁴ Provide ART to those testing positive with a CD4 count of ≤ 500 cells/mm³, or refer the client to another ART provider. ART should be used in combination with other interventions, such as the provision of condoms. Current WHO guidelines recommend initiation of ART regardless of CD4 count for the HIV-positive partner in serodiscordant couples for HIV prevention.⁶⁵ Early ART initiation is also recommended for clinical reasons for people co-infected with HIV and hepatitis B virus with severe hepatic disease and/or active TB.⁶⁶ Provide follow-up support for drug adherence among men initiated on to ART.	Engaging men in HIV and AIDS at the service delivery level: A manual for service providers. The ACQUIRE Project/ EngenderHealth and Promundo, 2008. Available at: http://www.acquireproject.org/archive/html/7-engage-men/tools.html Consolidated guidelines on general HIV care and the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach, second edition. WHO, 2016. Available at: http://www.who.int/hiv/pub/arv/arv-2016/en/ Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. WHO, 2016. Available at: http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
d. Provide pre-exposure prophylaxis (PrEP) for HIV	Oral pre-exposure prophylaxis (PrEP) of HIV is the use of ARV drugs by people who are not living with HIV to prevent the acquisition of HIV. Studies have demonstrated the effectiveness of PrEP in reducing HIV transmission among serodiscordant heterosexual couples and MSM, among others. ⁶⁷ Where serodiscordant couples can be identified and where additional HIV prevention choices for them are required, particularly among MSM, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.	Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach, second edition. WHO, 2016. Available at: http://www.who.int/hiv/pub/arv/arv-2016/en/ Technical update on pre-exposure prophylaxis (PrEP). WHO, 2015. Available at: http://www.who.int/hiv/pub/prep/prep-technical-update-2015/en/
e. Provide post-exposure prophylaxis (PEP) for HIV	Post-exposure prophylaxis (PEP) is given to reduce the likelihood of acquiring HIV infection after possible exposure. PEP is currently the only way to reduce the risk of HIV infection in an individual who has been exposed to HIV, such as through sexual assault, possible sexual exposure or medical exposure. As such, it is widely considered an integral part of an overall HIV prevention strategy. ⁶⁸ The current recommended duration of PEP is 28 days; the first dose should be taken as soon as possible and within 72 hours after exposure.	Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach, second edition. WHO, 2016. Available at: http://www.who.int/hiv/pub/arv/arv-2016/en/
f. Provide voluntary medical male circumcision (VMMC)	Voluntary medical male circumcision (VMMC) is recommended as an important strategy for the prevention of heterosexually acquired HIV infection in men in countries with a high HIV prevalence and low levels of male circumcision.⁶⁹ Where provided, VMMC should be a part of a comprehensive prevention package, and seen as an opportunity to provide a broader range of SRH/HIV services to men and adolescent boys. This is particularly important given the lack of engagement with health systems among men and adolescent boys, and the opportunity that VMMC provides to bring this group into that system. As such, VMMC should never be set-up as a stand-alone intervention. VMMC should be complemented with HIV testing and counselling services, screening and treatment for STIs, the promotion of safer sex practices, and the provision of family planning services and male and female condoms. Evidence is lacking in terms of effectiveness of VMMC during anal intercourse. VMMC must be performed by well-trained health practitioners in hygienic settings. Free and informed consent must be obtained from the client, and confidential and risk-reduction counselling should be provided. Information should be provided on both the possible benefits and harms of VMMC. Where possible, related health messages within the context of VMMC should address both men and women.	A framework for voluntary medical male circumcision: Effective HIV prevention and a gateway to improved adolescent boys’ & men’s health in eastern and southern Africa by 2021. UNAIDS and WHO, 2016. Available at: http://www.who.int/hiv/pub/malecircumcision/vmmc-policy-2016/en/ Clearing house on male circumcision for HIV prevention. FHI360, 2014. Available at: http://www.malecircumcision.org/

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g, Counsel client on how to support partner in preventing vertical transmission of HIV (if partner wants)	Men’s involvement in preventing vertical transmission of HIV – sometimes referred to as Prevention of Mother-to-Child Transmission of HIV (PMTCT), or Prevention of Parent-to-Child Transmission (PPTCT) – can have an important beneficial effect on improving health outcomes for both the mother and the baby.⁷⁰ Provide men with information on the prevention of vertical transmission process, such as through invitation letters for male partners. Provide HIV couple counselling and testing to men (see category 5a above), within a family-centred approach. Acknowledge and address men’s associated needs, such as to access HIV treatment if they test positive. Men’s involvement should also be encouraged within the context of Option B+ (Option B+ recommends providing lifelong ART to all pregnant and breastfeeding women living with HIV regardless of CD4 count or WHO clinical stage). This would include acknowledging and addressing men’s associated needs, such as to access HIV treatment if they test positive.	Male involvement in the prevention of mother-to-child transmission of HIV. WHO, 2012. Available at: http://www.who.int/reproductivehealth/publications/rtis/9789241503679/en/ Engaging men in HIV and AIDS at the service delivery level: A manual for service providers. The ACQUIRE Project/ EngenderHealth and Promundo, 2008. Available at: http://www.acquireproject.org/archive/html/7-engage-men/tools.html Preventing HIV and unintended pregnancies: Strategic framework. Inter-agency Task Team for Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and their Children, 2013. Available at: http://srhhivlinkages.org/wp-content/uploads/2013/04/pmtct1_2_en.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
h. Diagnose, manage and prevent HIV-related coinfections and co-morbidities	For men living with HIV an essential part of HIV treatment and care is the management of opportunistic infections such as pneumonia, tuberculosis, viral hepatitis, persistent diarrhoea, oral thrush and skin infections. Addressing HIV effectively also requires addressing other co-morbidities such as other sexually transmitted bloodborne infections and mental health disorders. The medical history will provide initial indicators for possible opportunity infections that need to be screened for. Prophylaxis and treatment should be provided (or referred for) as appropriate. Co-trimoxazole preventive therapy (CPT) should be implemented as an integral component of a package of HIV-related services. Existing recommendations cover initiation of CPT among adults, adolescents, pregnant women and children for prevention of Pneumocystis pneumonia, toxoplasmosis and bacterial infections, as well as benefits for malaria prophylaxis and discontinuation of CPT. Among people living with HIV, TB is the most frequent life-threatening opportunistic infection and a leading cause of death. ART should be provided to all people with HIV with active TB disease. HIV care settings should implement the WHO Three I’s strategy: intensified TB case-finding, isoniazid preventive therapy (IPT) and infection control at all clinical encounters. Cryptococcal meningitis is one of the most important opportunistic infections and a major contributor to high mortality before and after ART is initiated. WHO 2011 Rapid Advice covers diagnosis, screening and prevention of cryptococcal infection, induction, consolidation and maintenance regimens, monitoring and managing toxicities, timing of ART and discontinuing maintenance regimens. People living with HIV are at increased risk of developing a range of noncommunicable diseases (NCDs), including cardiovascular disease, diabetes, chronic lung disease and some types of cancer. Chronic HIV care provides the opportunity for screening, monitoring and managing NCDs, especially through primary care. Integrating interventions such as nutrition assessment, dietary counselling and support, smoking cessation, promoting exercise, monitoring blood pressure and where available cholesterol as part of HIV care provide opportunities for reducing the risks of NCDs among people living with HIV. For further information see WHO’s Package of Essential Noncommunicable (PEN) disease interventions for primary health care in low-resource settings.	Consolidated guidelines on general HIV care and the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach, second edition. WHO, 2016. Available at: http://www.who.int/hiv/pub/arv/arv-2016/en/ Rapid implementation of the Xpert MTB/RIF diagnostic test: Technical and operational “how-to” practical considerations. WHO, 2011. Available at: http://apps.who.int/iris/bitstream/10665/44593/1/9789241501569_eng.pdf Intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained setting. WHO, 2011. Available at: http://www.who.int/hiv/pub/tb/9789241500708/en/ Treatment of tuberculosis: Guidelines for national programmes, 4th edition. WHO, 2010. Available at: http://apps.who.int/iris/bitstream/10665/44165/1/9789241547833_eng.pdf Rapid advice: Diagnosis, prevention and management of cryptococcal disease in HIV-infected adults, adolescents and children. WHO, 2011. Available at: http://www.who.int/hiv/pub/cryptococcal_disease2011 Package of Essential Noncommunicable (PEN) disease interventions for primary health care in low-resource settings. WHO, 2010. Available at: http://www.who.int/cardiovascular_diseases/publications/pen2010/en/

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
i. Provide care and support for men and adolescent boys living with HIV	Address the SRH and positive health, dignity and prevention (see note below) needs of men living with HIV, their partners and family members, including providing support for men in sero-discordant relationships. Provide referrals to support groups for men living with HIV, where necessary and feasible. Role models of men living with HIV can play an important role in encouraging other men and adolescent boys to get tested for HIV, to access treatment and to take protective measures, such as going for VMMC and using condoms. Note that positive health, dignity and prevention for and with people living with HIV, encompasses a set of actions that help people living with HIV protect their sexual health, prevent other STIs, delay HIV disease progression, and avoid transmitting HIV infection to others. People living with HIV play an essential role in preventing new HIV infections. Strategies include individual health promotion, scaling-up of HIV and SRH services, community participation, and advocacy and policy change.⁷¹	Engaging men in HIV and AIDS at the service delivery level: A manual for service providers. The ACQUIRE Project/ EngenderHealth and Promundo, 2008. Available at: http://www.acquireproject.org/archive/html/7-engage-men/tools.html Positive health, dignity, and prevention: Operational guidelines. GNP+ and UNAIDS, 2013. Available at: http://www.gnpplus.net/assets/wbb_file_updown/3250/English.pdf Advancing the sexual and reproductive health and human rights of men who have sex with men living with HIV. GNP+ and MSMGF, 2010. Available at: http://srhhivlinkages.org/wp-content/uploads/2013/04/srhr-msm_2010_en.pdf Advancing the sexual and reproductive health and rights of people living with HIV: A guidance package. GNP+, 2009. Available at: http://srhhivlinkages.org/wp-content/uploads/2013/04/advancingsexual_reproductivehealthhumanrightshiv_2009_en.pdf
6. Disorders of the male reproductive system, including sexual dysfunction		
a. Diagnose and counsel client on sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation), and provide referral	Ask about concerns men may have on sexual dysfunction. Provide counselling for low sexual desire, erectile dysfunction (impotence), delayed ejaculation, premature ejaculation and pain during sexual activity. See resources section for further information. Provide referrals to address the psychological aspects of these issues, where necessary.	Men's reproductive health curriculum: Management of men's reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf Men's reproductive health curriculum: Introduction to men's reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf Guidelines for the management of sexual problems in men. British Society for Sexual Medicine, 2010. Available at: http://www.bashh.org/documents/3116.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Treat (or refer) for sexual dysfunctions (erectile dysfunction, delayed ejaculation, premature ejaculation)	After assessment, provide treatment or referral for: • Erectile dysfunction (impotence) • Premature ejaculation • Delayed ejaculation • Problems with libido See resources section for further information.	As above
c. Treat (or refer) for other disorders of the male reproductive system (warts, varicoceles, urological disease, etc.)	After assessment, provide treatment or referral for disorders such as: • Acne and skin lesions of the genital tract (including colposcopy for warts) • Hernias • Varicoceles • Urological disease (e.g. benign prostate hyperplasia) • Pain during sexual activity See resources section for further information.	As above
d. Screen and treat urinary tract infections (or refer)	Urinary tract infections (UTIs) are rare among adult men but are more common if a man has an abnormal genitourinary tract. It is important to consider STIs that may have symptoms similar to a UTI and should be considered in the differential diagnosis. UTIs may be addressed through the syndromic management approach in category 4a above. Nevertheless, awareness of UTIs is important. UTIs can involve the urethra (urethritis), bladder (cystitis), or kidneys (pyelonephritis). When the kidneys are involved, UTIs can be life threatening. Where possible, diagnose the UTI using a urine specimen/sample. Treat the UTI with antibiotics, or refer the client where testing and treatment are not available.	Men’s reproductive health curriculum: Management of men’s reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
7. Male cancers		
a. Counsel client on sexual and reproductive health-related male cancers (prostate, testicular, penile, anal, breast)	SRH-related male cancers include prostate, testicular, penile, anal and breast cancers. While it is not expected that a primary healthcare clinic will provide cancer treatment, it is important that clinicians and health providers are aware of the signs and symptoms and can provide appropriate information to clients, where applicable. This includes information how the client can conduct a self-exam to identify male genital structures (e.g. penis, testicles, epididymis, spermatic cord, vessels) and understand what’s normal or not.	Men’s reproductive health curriculum: Introduction to men’s reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf Men’s reproductive health curriculum: Management of men’s reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf Anal cancer: ESMO-ESSO-ESTRO clinical practice guidelines for diagnosis, treatment and follow-up. Annals of Oncology, 2014. Available at: http://annonc.oxfordjournals.org/content/early/2014/07/06/annonc.mdu159.full.pdf Male breast cancer treatment. National Cancer Institute at the National Institute of Health, 2017. Available at: https://www.cancer.gov/types/breast/hp/male-breast-treatment-pdq

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Take a history for sexual and reproductive-related male cancers	It is important to note that there are no internationally-agreed standard for routine screening methods for most sexual and reproductive-related male cancers. However, an assessment of each of the cancers is possible and should be based on the signs and symptoms highlighted in the client’s medical history. Prostate cancer: Prostate cancer is an adenocarcinoma (malignant tumour) of the prostate gland. Its incidence rises steadily with age - prostate cancer is rare in men under 40 years. As such, screening is advised mainly for men aged 40 years and over. Undertake a digital rectal examination and check whether the client is showing signs and symptoms (including pain in pelvic area, and urinary retention). Diagnosis is assisted by a needle biopsy of the prostate gland, a trans-rectal ultrasound and an elevated prostate-specific antigen (PSA). Testicular cancer: Testicular cancer is a malignant tumour of the testicle. This cancer is rare, but is one of the most common cancers in men under 30. It is most commonly misdiagnosed as epididymitis. Undertake a physical examination, particularly of the testicle, and check whether the client is showing signs and symptoms (scrotal pain, pain during sleep, etc). Penile cancer: Penile cancer, also known as squamous cell carcinoma of the penis, while rare, is mostly seen in older uncircumcised men, and is associated with poor hygiene. Most penile cancers originate near the corona of the glands. Undertake a physical examination, and check whether the client is showing signs and symptoms (such as prolonged painful erections). This cancer can often have a wart-like appearance. Penile cancer has a low mortality rate if diagnosed quickly, and a high mortality rate if not.⁷² Anal cancer: Anal cancer, cancer of the anus, is rare, with anal cancer being slightly more common in women. Anal cancer is typically an anal squamous cell carcinoma, and is often linked to human papillomavirus (HPV) infection. Take anal pap smears (similar to those used in cervical cancer screening) only when anal colposcopy is available, for early detection of anal cancer in high-risk individuals. Symptoms of anal cancer can include pain or pressure in the anus or rectum, a change in bowel habits, a lump near the anus, rectal bleeding, itching or discharge. Breast cancer: Men with breast cancer typically have lumps detectable by touch. Clinical breast exams are used to detect and diagnose it and, if found, a biopsy is necessary to check for signs of cancer. Ultrasounds and MRIs can also be used to detect breast cancer. Radiation exposure, high estrogen levels and family history increase men’s risk of breast cancer.	As above

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
c. Refer for further investigation and management as necessary	For all the cancers refer the client for further investigation, management or treatment as necessary.	As above
8. Fertility and infertility		
a. Counsel client on basic fertility awareness for men including pre-conception health	Provide information to men and women on how to have children when they are desired. This information should include helping couples identify the days of the month when the female partner is most likely to get pregnant and pre-conception information such as the importance of folic acid to prevent neural tube and other defects.	Men's reproductive health curriculum: Management of men's reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf
b. Counsel couples for conception (if the partner agrees)	Involve men in pre-conception counselling and partner's pregnancy testing and counselling services, offered as part of family planning services, where appropriate. Such services should be provided in accordance with national family planning guidelines. It is of fundamental importance that any approach to working with male partners within the context of pregnancy testing is underpinned by support for a women's right to choose, including whether or not to involve her partner. Such male engagement should never produce unnecessary barriers to women accessing pregnancy testing and counselling services.	As above
c. Counsel client on infertility	Provide counselling guided by the information elicited from the client during the medical and history and physical exam findings (categories 1 and 2 above). Where there is no apparent cause of infertility, the client should be educated about how to maximize fertility. Attention should be paid to the emotional and educational needs of the client, with referrals for appropriate support, where necessary. ⁷³	As above
d. Provide basic infertility care for men, including semen analysis	Infertility is commonly defined as the failure of a couple to achieve pregnancy after 12 months or longer of regular unprotected intercourse. ⁷⁴ An earlier evaluation may be warranted where known risk factors/questions of male infertility are present. ⁷⁵ It is recommended that an infertility evaluation of both partners is undertaken simultaneously. ⁷⁶ Refer to results on screening and history (see category 1 above). The physical examination (category 2c above) should be conducted. Male clients concerned about their fertility should have a semen analysis. The semen analysis is the first and most simple way to screen for male fertility. If this test is abnormal, they should be referred for further diagnosis (i.e. second semen analysis, endocrine evaluation, post-ejaculate urinalysis or others deemed necessary) and treatment (category 8f). Referral to specialist care following the result of the infertility evaluation, if necessary.	As above The optimal evaluation of the infertile male: AUA best practice statement. American Urological Association, 2010. Available at: http://www.auanet.org/documents/education/clinical-guidance/Male-Infertility-d.pdf

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
e. Provide vasectomy reversal (recanalisation) services (or refer)	It should be clear that vasectomy is a permanent method. Reversal can be expensive to provide and may not be successfully reversible. Where a male client requests vasectomy reversal, these services should be provided or appropriate referrals made.	Instruments and supplies needed to provide clinical methods of family planning. EngenderHealth, 2013. Available at: http://www.engenderhealth.org/pubs/family-planning/vasectomy.php Guidelines on vasectomy. European Association of Urology, 2012. Available at: https://www.ncbi.nlm.nih.gov/pubmed/22033172
f. Treat for infertility/ provide assisted reproduction (or refer)	Provide infertility services to diagnose and treat the underlying condition, consider referral to a sperm bank, or refer the male client to specialist care for a full infertility workup and treatment, where possible.	Men’s reproductive health curriculum: Management of men’s reproductive health problems. EngenderHealth, 2003. Available at: http://www.engenderhealth.org/files/pubs/gender/mrhc-3/participant/mrh_3p.pdf
g. Counsel client (and partner) on adoption (or refer)	Provide counselling, education and support on adoption or refer to an adoption agency or the relevant health/social services.	Preparing and supporting foster parents who adopt. Child Welfare Information Gateway, 2013. Available at: https://www.childwelfare.gov/pubPDFs/fospro.pdf Information for professionals. Infertility and Adoption Counseling Center, 2016. Available at: https://iaccenter.com/professionals/
9. Supporting prenatal and postnatal care, including safe motherhood		
a. Counsel client on preconception, support during prenatal and postnatal period and care-giving	Provide information on the role and responsibilities of parents, particularly the father, during prenatal health, childbirth, newborn care, child development, and child care. Provide information on the positive role men can play in supporting safe motherhood, including: • Reducing the delay in women getting treatment by learning to recognize complications of pregnancy and delivery and the ways to respond to them • Being supportive of her decision to seek medical attention, despite possible resistance from others including family members • Paying for her transport • Allocating family and community resources for transportation and delivery Counselling should ideally be linked to the provision of skills development for men as positive parents, such as through men’s involvement in fathers groups (see category 9b below).	Men’s reproductive health curriculum: Introduction to men’s reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf State of the World’s Fathers. MenCare, 2015. Available at: http://sowf.s3.amazonaws.com/wp-content/uploads/2015/06/08181421/State-of-the-Worlds-Fathers_23June2015.pdf Men Matter: Engaging men in MNCH outcomes. Burnet Institute et al, 2015. Available at: https://plan-international.org/publications/men-matter-engaging-men-better-mnch-outcomes

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Provide link to a support group for expectant and new fathers, classes on parenting, fatherhood skills	Provide support groups for expectant and new fathers. These groups should include a skills development component on parenting and communication skills, which contribute to stronger parent-child and father-mother relationships. See resources section for further information.	Men’s reproductive health curriculum: Introduction to men’s reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf Program P: A manual for engaging men in fatherhood, caregiving and maternal and child health. Promundo, CulturaSalud and REDMAS, 2013. Available at: http://men-care.org/resources/program-p/
10. Supporting safe abortion care		
a. Counsel clients who are partners in safe abortion care on the role they can play as a source of support	Acknowledge that men have a role to play in increasing their partner’s access to safe abortion services, thus contributing to a decline in maternal morbidity and mortality related to unsafe abortion.⁷⁷ Provide specific information and education for men on abortion and how to support interventions to increase access to safe abortion. It is of fundamental importance that any approach to working with male partners within the context of safe abortion services are underpinned by support for a women’s right to choose, including whether or not to involve her partner. Such male engagement should never produce unnecessary barriers to women accessing safe abortion services.	Safe abortion: Technical and policy guidance for health systems, 2nd edition. WHO, 2012. Available at: http://www.who.int/reproductivehealth/publications/unsafe-abortion/9789241548434/en/ IPPF policy 4.6 men and SRH (see Annex 6)
b. Support client to be a supportive partner and participate in pre- and post-abortion care counselling sessions (if the partner wants)	Enable and encourage men and adolescent boys to participate in pre- and post-abortion care counselling sessions, if a woman so desires. Some women want their partner, husband or other support person present for such counselling. And likewise, many male partners express the desire for more information about their partner’s condition during post-abortion care and about family planning. ⁷⁸	Postabortion Care Resource Guide. K4Health, 2014. Available at: http://www.postabortioncare.org

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
11. Sexual and gender-based violence (SGBV) support		
a. Screen for experience of SGBV, including intimate partner violence	The health service plays a crucial role in responding to sexual and gender-based violence, through breaking the silence around such violence and preventing violence from happening (through detection and referral services) and offering care.⁷⁹ Also, for many survivors of violence, visiting a health care facility may be one of the only opportunities (and potentially a lost opportunity) for detecting and stopping abuse, and providing them with the necessary medical and counselling services. Globally, women and girls have been found to report lifetime experiences of physical and sexual violence at between 10-70% (with most estimates falling between 30-60%).⁸⁰ Emerging data is also finding that adolescent boys and men, particularly in high-violence settings, may experience concerning levels of physical and sexual violence, including during childhood.⁸¹ Given that violence violates human rights and the evidence that adolescent boys who experience SGBV are more likely to go on to perpetrate violence in later life, it is important to intervene, where possible, to stop this cycle of violence.⁸² There is also stigma associated with men and adolescent boys acknowledging that they have been the victims of SGBV. This may already have been covered in 1f, above. If not, assess for history of incidences of violence and abuse, including sexual violence and domestic violence. This should include assessing both experience and perpetration of violence, as well as a history of exposure to childhood family violence (given links between childhood experience of violence and future perpetration in men).⁸³ Screening can either be done in response to situations where signs of abuse are present or routine screening for all clients of a particular service. Provide counselling and referrals, as is appropriate, for survivors and perpetrators of sexual abuse and domestic violence. Note that routine screening of men as survivors of SGBV may not necessarily be the most effective way of detecting this hidden population. Screening tools should be validated, precise and safe.	Improving the health sector response to gender-based violence: A resource manual for health care professionals in developing countries. IPPF Western Hemisphere Region, 2004. Available at: https://www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. WHO, 2013. Available at: http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf Working with Men and Boy Survivors of Sexual and Gender-based Violence in Forced Displacement. UNHCR, 2012. Available at: http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=5006aa262 A practical approach to gender-based violence: A programme guide for health care providers & managers. UNFPA, 2001. Available at: http://www.unfpa.org/resources/practical-approach-gender-based-violence

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Counsel and support clients affected by violence and refer for clinical, psychosocial and protection services	Provide counselling and support to those affected by sexual and gender-based violence. Beyond immediate medical attention, survivors of violence may need additional clinical tests, psychological support and other protection services. Refer the client to these medical, social and legal services for assistance.	As above
c. Refer clients who have a history of perpetrating violence against women to a relevant programme or support group	Provide support groups (or referrals) for men dealing with violence. These programmes have been shown, in some contexts, to be effective, though there are important pre-conditions, methodological considerations and areas for caution before initiating such work (or referring men to such support groups). ⁸⁴ See resources section for additional details.	Programs for men who have used violence against women: Recommendations for action and caution. MenEngage, 2013. Available at: http://menengage.org/wp-content/uploads/2014/04/Final-Programs-for-Men-who-use-IPV-Briefing-Paper-1.pdf

12. Information and counselling

a. Provide information and counsel client on sex, sexuality and sexual health, including pleasure (for man and partner)	Provide counselling and information to men and adolescent boys in the following areas: • Basic sexuality and fertility • Changes in sexual functioning during reproductive life span, including male and female puberty • Penis size • Masturbation • Male and female anatomy and physiology • Social and emotional development • Sexuality, sexual orientation, and gender identity • Pleasure (for men and adolescent boys, and women and girls) and libido • Accessing clinical care regularly for testing and screening and treatment • Sexual myths and cultural barriers	Men's reproductive health curriculum: Introduction to men's reproductive health services, revised edition. EngenderHealth, 2008. Available at: https://www.engenderhealth.org/files/pubs/gender/mrhc-1/mrh_participants_hndbk.pdf Brief sexuality-related communication: Recommendations for a public health approach. WHO, 2015. Available at: http://www.who.int/reproductivehealth/publications/sexual_health/sexuality-related-communication/en/ Engaging adolescent boys and men in gender transformation: The group education manual. The ACQUIRE Project/ EngenderHealth and Promundo, 2008. Available at: http://www.acquireproject.org/archive/files/7.0_engage_men_as_partners/7.2_resources/7.2.3_tools/Group_Education_Manual_final.pdf Dicktionary: What every guy needs to know about his knob. RFSU, 2008. Available at: http://www.rfsu.se/publications_rfsu.asp
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SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
b. Provide information and counsel client on self-confidence and self-esteem	Provide information and counsel men and adolescent boys on self-esteem, self-respect, positive masculinity and male role identity, personal potential, confidence in the future, and promoting a sense of control over one’s life and decisions.	As above
c. Provide information and counsel client on relationships and non-violent communication and negotiation	Provide information and counsel men and adolescent boys on effective communication and equitable sexual decision-making within relationships. Information should also be included on when sexual involvement is appropriate, forms of sexual expression, sexual coercion, abuse and violence, domestic violence, rape awareness, and the influence of alcohol and other drugs on sexual behaviour. This information should ideally be linked to a skills development component.	As above
d. Provide information on comprehensive sexuality education (CSE), values and gender equality, with specific focus on role of men to reach in- and out-of-school youth	Provide information to men and adolescent boys about the importance of gender equality and benefits for men and women as a result of more equitable relationships and communities. Positive values can include respect for others, positive manhood and responsible fatherhood. See resources section for further information.	It’s all one curriculum: Guidelines and activities for a unified approach to sexuality, gender, HIV, and human rights education. Population Council et al, 2009. Available at: http://www.popcouncil.org/research/its-all-one-curriculum-guidelines-and-activities-for-a-unified-approach-to- Deliver+Enable Toolkit: Scaling-up comprehensive sexuality education. IPPF, 2017. Available at: http://www.ippf.org/resource/deliverenable-toolkit-scaling-comprehensive-sexuality-education-cse International technical guidance on sexuality education: An evidence-informed approach, revised edition. UNESCO, 2017. (Forthcoming)
e. Provide information on genital/anal health and hygiene	Provide information to men and adolescent boys about: 1) Penile hygiene (circumcised and uncircumcised) 2) Anal hygiene 3) Normal male anatomy, function and SRH matters and to perform a self-exam to identify male genital structures (e.g. penis, testicles, epididymis, spermatic cord, vessels) and understand what is normal or not ⁸⁵ 4) Why important to maintain good hygiene in genital area to prevent fungal infections 5) General hygiene	Young men and HIV prevention: A toolkit for action. UNFPA and Promundo, 2007. Available at: http://menengage.org/resources/toolkit-action-young-men-hiv-prevention/ The male genital examination: A position paper of the Society for Adolescent Health and Medicine. Journal of Adolescent Health, 2012. Available at: https://www.ncbi.nlm.nih.gov/pubmed/22443851

SRH clinical service components for men and adolescent boys, per category	Key details and activities	Related guidelines and resources for further information
f. Counsel client and provide information on stigma reduction, particularly in the context of HIV	Provide details to men and adolescent boys on the different forms of stigma and how stigma affects people (consequences). Stigma can be due to many reasons such as sexual orientation, gender identity, ethnicity, HIV status, disability or many other reasons. Highlight that stigma can be both external (from others) and internal (self-stigma) and that stigma can lead to discrimination. Highlight that people who test for HIV and are found to be positive may face both external stigma (from family, friends, communities, employers, health providers and others) and internal stigma (self-stigma), both of which can prevent the person from seeking HIV treatment, care and support. Identify some of the root causes of stigma, particularly in the context of HIV. Explore steps that can be taken to address these causes, and thereby reduce stigma and discrimination.	Engaging men in HIV and AIDS at the service delivery level: A manual for service providers. The ACQUIRE Project/ EngenderHealth and Promundo, 2008. Available at: http://www.acquireproject.org/archive/html/7-engage-men/tools.html People living with HIV stigma index. UNAIDS, ICW, GNP+ and IPPF, 2008. Available at: http://www.stigmaindex.org/ Reduction of HIV-related stigma and discrimination. UNAIDS, 2014. Available at: http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf

5 Specific health and service delivery considerations



Section 5:

Specific health and service delivery considerations

Though the SRH needs of each man differs there are particular groups of men that have specific health needs and the service delivery mechanisms required to reach these groups have some subtle differences. In this service package, additional information is provided for adolescent boys, gay and bisexual men and other men who have sex with men, and transgender men and other gender-nonconforming individuals. This section looks at the specific service delivery and health considerations for each of the groups in turn. It builds on the SRH service package outlined in sections 3 and 4 above.

Specific considerations related to adolescence

Adolescence (ages 10-19) is a period of life with specific health and developmental needs and rights. Unique developmental processes take place during this period and adolescents have specific characteristics that need to be taken into consideration when it comes to health service provision and requirements.

When it comes to sexual and reproductive health, focusing on young men and adolescent boys is key for fostering healthy SRH attitudes and behaviours particularly as this is the time of life that many first become sexually active and health practices take shape and become cemented. However, during adolescence the components of physical and psychosocial development take place at different speeds and duration and the heterogeneity of adolescents needs to be taken into account, including the different developmental phases and abilities of younger and older adolescents and the differing needs of adolescent girls and boys.

Comprehensive sexuality education is key for adolescents to understand the physical and biological change taking place in their own bodies and to equip them with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their own as well as others' sexuality, in the context of their emotional and social development. The health sector can be an important source of correct information and offer opportunities for adolescents to discuss their concerns with trained service providers or peers, through health facilities or in other settings such as schools.

Adolescence is a time when boys and girls begin to form their opinions, ideas and beliefs – including around gender roles and sexuality. This is a critical time in which sexual feelings, identities and understandings of such issues are shaped, influenced and enjoyed. In early to mid-adolescence, the social and peer pressure to conform to normative attitudes and behaviours is at its peak. Attitudes and behaviours – both positive and harmful – formed in adolescence can carry over into adulthood. Therefore working with men and boys during adolescence and young fatherhood provides a critical opportunity to challenge dominant, inequitable and violent forms of masculinity.

The sexual and reproductive health needs of adolescent key populations such as men who have sex with men is also an important consideration, particularly as evidence shows that they start engaging in higher-risk behaviours at a young age.⁸⁶ Access for adolescents from key populations is even more difficult because of various factors such as age-related restrictions to HIV and SRH services and the limited availability of youth-friendly services. See specific considerations for gay and bisexual men and other men who have sex with men in the section below for further information.

Service considerations

Service providers play a crucial role in creating services that young people trust and feel are “there” for them and their needs – these are commonly known as “youth-friendly services”. Young men report they want more information on SRH than they currently receive, and face challenges in accessing accepting and non-judgmental services.

Adolescent and youth-friendly services are those that are based on a comprehensive understanding of, and respect for, young people’s rights, and the realities of their diverse sexual and reproductive lives. To be considered adolescent friendly, health services should be:

- Accessible: Adolescents and youth *are able to* obtain the health services that are available.
- Acceptable: Adolescents and youth feel health services are suitable for them and *are willing to* obtain services that are available.
- Equitable: *All adolescents and youth*, not just selected groups, are able to obtain the health services. Serving a selected group could mean that some barriers including stigma, or services not being available in some areas, are preventing some young people from accessing the services. Some form of discrimination is present, which may be intentional or due to failure to address barriers to access.
- Appropriate: *The right, comprehensive health services* (i.e. all the services they need) are provided to them.
- Effective: The *services are provided in the right way*, and make a positive contribution to their health.⁸⁷

Furthermore, services should have these qualities:

- Non-judgmental attitudes of providers (the key issue)
- Comprehensive, holistic services with clear charter of service
- Discrete and confidential service provision
- Choice of service providers who are knowledgeable – i.e. both male and female clinical, counselling, educator and social work staff
- Participation and/or inclusion of community-led services, engagement of peer youth outreach workers and health system navigators
- Flexible opening hours
- Affordable
- Combined fixed-site and mobile outreach
- Ensuring voluntary and informed consent

As is highlighted above, an adolescent's use of a service depends not only on their ability to access the services, but on their perceived need and knowledge of available services. A necessary part of youth-friendly service provision, therefore, is awareness among the providers of the special difficulties that young people face in accessing sexual and reproductive health services. For example, inconvenient hours, legal and policy hurdles, concerns about confidentiality, fear of discrimination (in particular among sexually active girls), being treated with disrespect and high costs are among the factors that can inhibit young people's ability to access services.

Youth-friendly services should therefore be accessible to all adolescents and young people irrespective of their age, marital status, HIV status, sexual orientation, gender identity, occupation, social status, geographical location or ability to pay. Services must be confidential, non-judgmental, stigma-free and private.

Health considerations

Adolescent boys have specific sexual and reproductive health needs particularly as they become sexually active. Unprotected sex can lead to a variety of adverse outcomes, from sexually transmitted infections to unintended pregnancy.

The median age at first sexual intercourse among men aged 20-24 is during adolescence – i.e. between 15.8 and 19.9 years in every country that has reported on this demographic health survey (DHS) indicator.⁸⁸ In most participating countries, more boys than girls at these ages report that they have had sex (although it is important to note that this is not true in every country).⁸⁹ Therefore, many adolescent boys are having sex but they are not always getting the information and knowledge they need to ensure that they are having sex safely and with due regard for their sexual partners. Of the 80 countries whose school-based surveys ask about sexual intercourse, 74 also ask about sexual health-related behaviours. In most of these countries, half or more of sexually active 15-year-olds reported using condoms the last time that they had sex but again this varies by country.⁹⁰

Adolescents represent the only age group in which AIDS-related deaths rose between 2001 and 2014.⁹¹ This is particularly relevant in much of sub-Saharan Africa, where AIDS is the leading cause of death among adolescents and AIDS-related deaths among this population

have increased by 62 per cent since 2005.⁹² Young women in sub-Saharan Africa acquire HIV at significantly higher rates than young men; however young men are twice as likely to die of AIDS-related complications as their female adolescent counterparts.⁹³

SRH considerations include:

- Building knowledge and skills on SRH through providing comprehensive sexuality education and using peer education
- Providing SRH services to all adolescents and young people irrespective of their age, marital status, HIV status, sexual orientation, gender identity, occupation, social status, geographical location or ability to pay
- Confidential, non-judgemental, stigma-free SRH services
- Access to condoms and condom-compatible lubricant
- Challenging norms on gender, masculinity and sexuality

Box 9: Global Accelerated Action for the Health of Adolescents (AA-HA!)

Adolescence is a period of change, opportunity and great risk. To date, there has been a lack of knowledge about the health of adolescents. In the last few years, the importance of focusing specifically on adolescent health and development was made an integral part of the *Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)* launched in 2015 to support the Sustainable Development Goals.

In 2017, the *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation* was produced by WHO, UNFPA, UNESCO, UNAIDS, UN Women, UNICEF and the World Bank. This guidance gives practical and concrete examples through over 70 case studies from around the world. It provides a wealth of information to policymakers, practitioners, researchers, educators, donors and civil society organizations – including the most up-to-date data on the major disease and injury burdens that affect adolescents.

This guidance is a milestone for translating the *Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)* into action, and builds on ongoing efforts to ensure that adolescents can “Survive” and “Thrive” and are in a position to “Transform” the societies in which they live – the three overarching objectives of the Global Strategy.

Resources

Below are key documents that can be used to help guide development and delivery of SRH services for adolescent boys. All programmes need to be evidence-informed, human rights-based and tailored to deliver a comprehensive package of services in a holistic manner.

Provide: A self-assessment tool for youth friendly services. IPPF, 2014. Available at: <http://www.ippf.org/resource/Provide-Self-Assessment-Tool-Youth-Friendly-Services>

Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation. WHO, 2017. Available at: <http://apps.who.int/iris/bitstream/10665/255415/1/9789241512343-eng.pdf?ua=1>

Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services. WHO, 2012. Available at: http://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/

Adolescents: Health risks and solutions, fact sheet N°345. WHO, 2014. Available at: <http://www.who.int/mediacentre/factsheets/fs345/en/>

Health for the world's adolescents. WHO, 2014. Available at: <http://apps.who.int/adolescent/second-decade/>

Global standards for quality health-care services for adolescents: A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents. WHO, 2015. Available at: <http://apps.who.int/iris/handle/10665/183935>

Adolescent boys and young men: Engaging them as supporters of gender equality and health and understanding their vulnerabilities. UNFPA and Promundo, 2016. Available at: <http://promundoglobal.org/wp-content/uploads/2016/03/Adolescent-Boys-and-Young-Men-final-web.pdf>

HIV and young men who have sex with men: Technical brief. WHO et al, 2015. Available at: <http://www.who.int/hiv/pub/toolkits/hiv-young-msm/en/>

HIV and young transgender people: Technical brief. WHO et al, 2015. Available at: <http://www.who.int/hiv/pub/toolkits/hiv-young-transgender/en/>

HIV and young people who sell sex: Technical brief. WHO et al, 2015. Available at: <http://www.who.int/hiv/pub/toolkits/hiv-young-sexworkers/en/>

Specific considerations related to sexual orientation

Sexual orientation refers to each person's capacity for emotional, physical and sexual attraction to, and intimate and sexual relations with, individuals of the opposite sex (heterosexual), the same sex or gender (homosexual), or more than one sex or gender (bisexual). For the majority of males, they are attracted to the opposite sex or gender (females), and often identify with terms such as "heterosexual" or "straight". For other males, they are attracted to the same sex or gender (males), and may identify with terms such as "gay" or "bisexual" (if also attracted to females).

The term "men who have sex with men" refers to all men who engage in sexual and/or romantic relations with other men. The term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex. Some men who have sex with men also form relationships with, or are married to, women. Some men sell sex to other men, regardless of their sexual identity. Some men who have sex with men do not associate themselves with any particular identity or community.

Sexual orientation and homophobia have a significant impact on healthcare needs and these needs can differ depending on the stage of life of the person. For young people who think they might be gay, are gay, or who are perceived to be gay, it can be difficult to be in school and in their communities. There are very few mechanisms in place in schools or communities to support young people who experience homophobic bullying themselves or are targeted because they have gay family members or friends. Some people find themselves excluded from their families due to their sexual orientation. There are often community organizations to support people of diverse sexual identities, but finding out about these, and having the resources and freedom to access them, depends entirely on the individual situation, and can be particularly difficult for some people, which can lead to a sense of isolation and exclusion.

Service considerations

Service providers can play a crucial role in supporting and informing gay and bisexual men and other men who have sex with men. It is important to understand that not all men who have sex with men identify as gay or bisexual. Service providers should not assume that men in this situation are gay, but should instead discuss behaviour. This includes men who may be in relationships with women and seek health services with their opposite sex partner. Service providers should be sensitive to this when taking histories. Service providers should also consider the impact that any disclosure may have on partners and therefore take steps to be discreet. Men in this position may feel excluded from services targeted at gay and bisexual men.

Gay and bisexual men and other men who have sex with men often find it difficult to access the healthcare they need due to fear of discrimination. These men need to feel comfortable when accessing services and know that they can use health services without experiencing or fearing poor treatment. If they feel they've been treated with respect, they're more likely to feel confident talking about their health and more likely to continue using services. Service providers who understand the particular health needs of gay and bisexual men and other men who have sex with men are in turn able to provide a better, more tailored service to their clients.

Some men are reluctant to disclose their sexual orientation to service providers as they are anxious about potentially negative reactions or discrimination. It is important that clients can be open about their sexual orientation with service providers, and those who feel comfortable are much more likely to be honest about aspects of their lifestyle that may have an impact on their health. Rather than making assumptions about sexual orientation, service providers should ask open-ended questions. For example, rather than asking a client “Are you married?” or “Do you have a girlfriend?” consider asking “Do you have a partner?” or “Are you in a relationship?” Training can give service providers the confidence to take an open, non-judgmental sexual and social history, which is key to building trust among clients.

It is important for services to send a clear message that they have considered the needs of gay men and other men who have sex with men, and will deliver a service that is free from discrimination. Working with community organizations is a good way of learning what local people think about how health services are run, and are well placed to understand the needs of gay and bisexual men and other men who have sex with men in the area and to make suggestions about how to improve healthcare services.

Key considerations:

1. Create a welcoming environment.
2. Take an open, non-judgmental sexual and social history.
3. Avoid making assumptions and ask open-ended questions.
4. Be aware of the importance of confidentiality.
5. Refer to other sources of support within the community.

Health considerations

Gay and bisexual men and other men who have sex with men are at higher risk of sexually transmitted infections, including HIV. Some men may not feel secure about obtaining or using condoms and lubricant for sex because if they are seen purchasing or in possession of them it might be interpreted as a disclosure of gay identity. Young men also rarely have the benefit of sex education in school in which sexual behaviour between same sex partners is discussed. This can make it more challenging for young gay men to feel comfortable about negotiating safer sex.

Cancer can affect anyone, regardless of their sexual orientation; however, some men may be at higher risk from certain cancers because of sexual behaviour or other lifestyle choices (i.e. smoking, alcohol use). Gay men and other men who have sex with men are at higher risk of anal cancer due to sexual exposure to human papillomavirus (HPV), and a higher risk of viral hepatitis including hepatitis A, B and C, which affect the liver. Mental health issues, including depression and anxiety, are often more common among gay and bisexual men, and could be due to experiences of homophobia or social exclusion.

Some SRH considerations include:

- Appropriate STI screening in relation to sexual activities (i.e. anorectal, pharyngeal)
- Access to condoms and condom-compatible lubricant
- HPV vaccine for young men
- Cancer screening (i.e. anal, oropharyngeal)

Resources

Below are key documents that can be used to help guide development and delivery of SRH services for gay and bisexual men and other men who have sex with men, including men engaged in sex work. All programmes need to be evidence-informed, human rights-based and tailored to deliver a comprehensive package of services in a holistic manner.

Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: Recommendations for a public health approach. WHO, 2011. Available at: http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/

Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. WHO, 2016. Available at: <http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>

HIV and young men who have sex with men: Technical brief. WHO et al, 2015. Available at: <http://www.who.int/hiv/pub/toolkits/hiv-young-msm/en/>

Improving the Health Care of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Understanding and Eliminating Health Disparities. Fenway Health, 2012. Available at: <http://www.lgbthealtheducation.org/wp-content/uploads/Improving-the-Health-of-LGBT-People.pdf>

Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. UNFPA et al, 2015. Available at: <http://www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-men-who-have-sex-men>

Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. UNFPA et al, 2013. Available at: <http://www.unfpa.org/publications/implementing-comprehensive-hivsti-programmes-sex-workers-practical-approaches>

Specific considerations related to gender identity

Gender identity refers to an individual's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. For most people, their sense of gender identity is congruent with their biological sex. That is, a person who is born as a male (defined as their "biological sex") usually self-identifies as a boy/man (defined as their "gender"). However, for some people, their sense of gender identity may not match or be congruent with their biological sex or the gender assigned to them at birth, or their gender identity does not match the appearance and/or anatomy with which they were born.

"Transgender" or "trans" are people of any age whose gender identity and expression does not conform to norms and expectations traditionally associated with their sex assigned at birth. Other terms used include "gender-nonconforming" or "non-binary" people. A *transgender man* (or *trans man*) is an individual who is born as a female but whose gender identity is a man (or express their gender in a masculine and/or androgynous way), while a *transgender woman* (or *trans woman*) is an individual who is born as a male but whose gender identity is a woman (or express their gender in a feminine and/or androgynous way). Being transgender is not a sexual orientation and cannot be assumed – trans men can be attracted to women or men or both, and the same applies to trans women. Transgender people have a sexual orientation and have relationships accordingly.

Transgender people face many challenges such as suffering family rejection, police harassment, suffering violence (including sexual violence), engaging in sex work, and being highly vulnerable to HIV. Poor mental health can arise because of social stigma, prejudice and discrimination or the breakdown in relationships and the resulting social isolation, as well as the conflict between their birth sex and gender identity. It is important to recognize that transgender people often encounter challenges dealing with a health care system and society that often thinks in terms of two fixed gender identities, and are less likely to seek help due to negative past experiences. Transgender people living with HIV face a double stigma. As a consequence of these challenges, their health-seeking behaviour is poor and they often do not see health as a priority.

Service considerations

An understanding and supportive service is essential to the health and well-being of transgender people. A key factor in engagement is an open, non-judgemental approach. Clients' views, especially if there is ambiguity regarding their gender identity, need to be taken seriously. If a client is presenting as unhappy or confused about their gender, it is important that they are referred to a specialist counselling and gender services and/or local transgender organizations for support and information. It is not necessary for them to be completely sure that they are transgender for a referral to be sought.

Often there are practical concerns for staff such as how to identify and/or address a client who is transgender. Identifying a transgender client is easiest if intake forms have a place for transgender clients to safely and confidentially identify themselves, and the staff is trained to handle the information respectfully. This can include asking for preferred names and pronouns on the intake form, or to discreetly ask if unsure. Staff should ensure they address the client by the appropriate name in all communications. Clients should be recognized as the gender with which they identify and have the same rights as any other client. It is important to recognize that gender affirmation may or may not include hormonal or surgical intervention, and not all

transgender people want to undergo sex reassignment surgery or want to initiate hormone therapy. Clinic management need to ensure that all staff are provided with relevant training in order to deepen understanding of the needs of this population and how to be respectful and best provide care.

Key considerations:

1. Be understanding and non-judgmental. A negative reaction can do serious harm.
2. Ensure intake form asks for “gender” and “assigned-sex-at-birth”.
3. Get names and pronouns correct (ask discreetly if necessary).
4. Be aware of the importance of confidentiality.
5. Refer to appropriate, specialist gender services and/or other sources of support.

Health considerations

Not every service provider will be able to offer all elements of comprehensive transgender care; however, every service provider can become comfortable in working with transgender clients to meet their healthcare needs. It is important to be aware of trans issues and that clients may vary widely in terms of anatomy and hormonal status when they present, and these attributes may further change over time.

Examination should be broached sensitively as clients may be reluctant to discuss these parts of their body or they may use different terminology. While clients may be in a process of transition it is essential that screening is targeted to a client’s current anatomy. When consider sexual health screening, it is also important to remember that transgender people also have diverse sexual orientations (see “Special considerations for diversity in sexual orientation”).

If an individual desires to undergo gender affirming procedures, it is important to refer to appropriate services and be supportive in an effort to help an individual through the process. Clients may opt to self-medicate with hormones and/or anti-androgens so it is useful to ask them directly about this as it can adversely impact on their health and well-being. They may ask to be monitored for side effects including checking blood tests and this is something that should be negotiated between the provider and the client. It is important to note that not all transgender people want to undergo sex reassignment surgery and not all require or want to initiate hormone therapy.

If gender dysphoria persists during adolescence, then there is a likelihood that those adolescents will benefit from counselling and medical intervention in the form of puberty suppression. This could be regarded as buying time until they have the capacity to make their own decisions (which may be regulated by country-specific laws) on whether or not to start hormone therapy and/or whether or not to undergo sex reassignment surgery.

Specific considerations for transgender men

Transgender men, irrespective of the stage of their transition, may still need cervical and breast screening. Those who have undergone reconstructive chest surgery should be encouraged to continue to check for changes and lumps. Others who have not undergone surgery to reconstruct their breasts may use binding for gender affirmation. The use of breast binders may cause breathing, back and skin problems. Transgender men who have sex with men are often at higher risk for HIV and other STIs.

Some SRH considerations include:

- Appropriate STI screening to current anatomy and sexual activities
- Cancer screening (i.e. breast, cervical, anal, oropharyngeal) and offering pap smears, cervical, ovarian, uterine and breast cancer screenings
- Contraceptive services and gynaecologic care
- Information about options for gender affirming procedures, including masculinizing hormones
- If using hormones, access to appropriate monitoring (i.e. liver function testing)

Specific considerations for transgender women

Transgender women may require breast cancer screening if they are on lifelong oestrogen therapy. If they have undergone sex reassignment surgery it is worth noting that transwomen will still retain their prostate and will remain at risk of prostate cancer (although this is small). Post-surgical depression can manifest and further support may be required. Transgender women are often at higher risk for HIV and other STIs.

Some SRH considerations include:

- Appropriate STI screening to current anatomy and sexual activities
- Cancer screening (i.e. breast, prostate, anal, oropharyngeal)
- Information about options for gender-affirming procedures, including feminising hormones
- If using hormones, access to appropriate monitoring (i.e. liver function testing)

Resources

Below are key documents that can be used to help guide development and delivery of SRH services for transgender people, including transgender people who identify as men and other gender-nonconforming individuals. All programmes need to be evidence-informed, human rights-based and tailored to deliver a comprehensive package of services in a holistic manner.

Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7. World Professional Association for Transgender Health, 2012. Available at: http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926

IMAP statement: Hormone therapy for transgender people. IPPF, 2015. Available at: <http://www.ippf.org/resource/IMAP-Statement-hormone-therapy-transgender-people>

Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: Recommendations for a public health approach. WHO, 2011. Available at: http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/

Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. WHO, 2016. Available at: <http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>

HIV and young transgender people: Technical brief. WHO et al, 2015. Available at: <http://www.who.int/hiv/pub/toolkits/hiv-young-transgender/en/>

Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions. UNDP et al, 2016. Available at: <http://www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-transgender-people-practical-guidance>

Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. UNFPA et al, 2013. Available at: <http://www.unfpa.org/publications/implementing-comprehensive-hivsti-programmes-sex-workers-practical-approaches>



6 Operationalizing the service package

Section 6:

Operationalizing the service package

Organizations interested in operationalizing this service package will find it important to follow certain steps, each of which is explored in more detail below:

- Step 1.** Assess your current situation
- Step 2.** Build capacity and skills, organizational commitment, and partnerships
- Step 3.** Design the programme
- Step 4.** Implement, monitor and evaluate the Action Plan

Steps 1 through 3 are about developing an Operational Action Plan. Use the template provided in Annex 3, which supports organizations in moving through these steps.

Step 1: Assess the current situation

Self-assessment checklist for action

The self-assessment checklist (in Annex 4) will provide a useful tool and should be completed as a starting point.

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The first step is to have a detailed understanding of your current SRH service provision, and opportunities to scale-up a focus on men’s and adolescent boys’ SRH within your work. Elements for consideration are outlined below.

What are your current SRH services to men and adolescent boys, and levels of uptake?

The organization should address the following issues:

- Detail the current services and outreach to men and adolescent boys, and existing levels of service uptake among men and adolescent boys (of all ages) against each of those services. Include an analysis of whether couples, adolescents/young men, men who have sex with men and transgender men and other gender-nonconforming individuals are currently being served.
- Assess whether you currently engage men and adolescent boys as partners. This should include partner notification processes and whether male clients are encouraged to bring their partners to clinics or programme sites, regardless of their sexual orientation.
- Identify whether you have an existing advocacy agenda in relation to men and SRH, including whether this includes building the capacity of men and adolescent boys to advocate for, and support, key sexual and reproductive health and rights issues (SRHR).

What is your policy context in relation to men’s and adolescent boys’ SRH and organizational values?

The organization should explore the following issues:

- Identify internal champions/focal points/key staff on the issue of men and adolescent boys, and SRH within your organization.
- Detail whether or not there is a policy and/or operational context that supports a greater focus on men’s and adolescent boys’ SRH within your work. The policy context would include specific organizational commitments within mandates or a strategic plan. The operational context would include specific commitments within an operational plan or annual workplan.
- Review the principles that guide your work, and identify whether they are in line with the principles of this service package. Do your principles include, for example, acknowledging women’s and men’s, adolescent girls’ and boys’ vulnerabilities? Are you programming for the social construction of masculinities and supporting gender-transformative approaches to increase gender equality?
- Identify if there is a commitment to expanding this work in your organization, and advocate internally to do so.
- Review relevant national guidelines and protocols that relate to men and SRH. Assess whether you are currently in compliance with the commitments within these documents.

Box 10: Integrating policies to support male SRHR⁹⁴

Understand the policy context by asking questions about men’s and women’s SRH issues, conducting a needs assessment and gathering consensus on the analysis.

It is also crucial to **gain institutional support and commitment** in order to implement any actions to ensure men and adolescent boys’, women’s and girls’ sexual and reproductive health and rights.

Create a policy statement (including a statement of principles) It should address the health needs and rights of males and females within the local context, identify what has already been done/what needs to be done for improved health outcomes and to secure support for the new policy.

Review your existing policies by assessing their impact to ensure that they include a gender perspective and direct actions towards the desired results.

Involve stakeholders. Once key stakeholders and the ways they will be involved have been identified, they should be included at all stages of policy development, if possible.

Implementation, monitoring and evaluation of policies requires the collaboration of stakeholders and other institutional partners, as well as identifying training needs. The policies will need to be communicated to all parties involved, and a monitoring and evaluation strategy must be in place to measure the achieved results using performance indicators and reflect on the process used.

To implement rights-based policies, a needs assessment should be carried out to evaluate the issues the policy seeks to address (see box 9 and Annex 6). Government and institutions' educational and health policies should support responsible sexual behaviour and harm reduction by men and youth, and provide spaces where they can explore alternative social norms that do not encourage risky behaviour and help to decrease stigma and discrimination. These policies should also encourage men's and adolescent boys' active involvement in maintaining their and their partner's sexual and reproductive health and rights, for example, clinic or government-sponsored educational programmes that promote couples' counselling, HIV testing or family planning decisions.

One key way to do this is to implement "do no harm" approaches⁹⁵ to education for sexual and reproductive health and rights. Such approaches include a diverse and inclusive perspective on sexuality, as well as gender equality and reproductive health. Also, men in leadership positions in government, healthcare and traditional/religious institutions should publicly encourage men and adolescent boys to take action to protect their own and women's and girls' sexual and reproductive health and rights. Governments must also remove the barriers that prevent men and adolescent boys from doing this, such as clinics discouraging men from accompanying women during labour or not providing contraception to male youth.⁹⁶

What is your clinical set-up and geographical focus/location?

In order to explore at a later stage where and how you would like to reach men, it is important to have a good overall understanding of your current clinical set-up. Questions to explore include:

- Do you only run static clinics? If so, at what level (main clinic in cities, or smaller rural clinics?) Or do you also operate, or only operate, mobile and/or satellite clinics?
- Do you run static (fixed location) clinics that provide potential opportunities to expand services for men and adolescent boys? Are there other existing service entry points that could be extended to incorporate a new or greater focus on men and SRH?
- Do you have an existing effective referral mechanism?
- Decide where geographically your organization plans to work (or already works), if this is not clear. Make a map and draw the boundaries for this area. Highlight locations of existing services that you operate within the geographical area.

Identify your target group

Reflect on current SRH provision to men and adolescent boys, identified in the first part of this step (above). Target selection should be based on relevant goals, for example reducing the transmission of STIs including HIV. If you do not deliberately target any specific group of men and adolescent boys at present, you will need to consider how you wish to approach this. If you already target a specific group of men and adolescent boys, you should decide whether or not you wish to maintain this focus and/or build upon it.

Important questions to answer here will include:

- Do you intend to provide services to men in general?
- Do you wish to include a focus on young men and adolescents, or focus exclusively on younger men?
- Do you want to reach men having sex with men or other special populations of men?
- Can you also incorporate a stronger focus on couples within your work?

Understand your local context and needs⁹⁷

As noted in the building blocks, understanding your local context and men’s and adolescent boys’ SRH needs is imperative. This is best achieved through participatory research led by both male and female community members. This will help you to “know” your “target group” as identified above, understand how and where to best reach this group, and what services they need. To understand the context and needs, organizations should explore the following:

- What is, or what are estimations for, the current level of SRH service uptake among men and adolescent boys in your communities/target locations? Quantitative health utilization data can be gathered from specific clinics or district health officials. Interviews with service providers and with district health managers, as well as qualitative data gathered from individual men (users or non-users of services), will also be useful.
- What are barriers in the community to men accessing SRH services? How and where is best to reach men and adolescent boys? What components of this service package are most-suited to their needs within your context (given the need for services to vary by age and population, etc.)?
- Are men involved as SRH partners in your communities? For example, to what extent are men aware of gender inequality and displaying more gender equal attitudes and behaviour/ roles? This can be answered through surveys of community members, discussions with local groups/organizations working on gender issues, or participatory methods with groups of community members and stakeholders. It is important to include women and adolescent girls to provide guidance on their wants and needs, such as more supportive, respectful and equitable partners.
- To what extent are men active in the community in terms of promoting gender equality and/or promotion of sexual and reproductive health and rights? This can also be answered through surveys of community members, interviews with key stakeholders, or participatory methods with groups of community members and stakeholders. Include male and female interviewers and respondents and people of a variety of different ages.
- Use your findings to identify priority actions. Ideally, if you have the resources, include a focus on men as clients, partners and change agents, rather than only focusing on men as clients.
- Identify stakeholders, both individuals and organizations, with whom you currently work that would be supportive to this initiative.

Critically analyse the environment and skills within your chosen location and services



Facility walk-through questions

Use the helpful walk-through tool provided in Annex 5 for critically analysing the clinic space and services currently being provided.

Once you have identified your focus area and set-up, take some time to critically analyse the space and SRH services currently being provided. Important considerations in this regard are:

- Review the reception/waiting area, and service areas/examinations rooms to see whether or not they are welcoming to men and adolescent boys.
- Consider the signage within your organization or clinic to see whether it is welcoming to men. Sometimes simply having a sign that says “male-friendly services” can make a significant difference.
- Visualize how you would like your services to look. Consider the above issues, including the workflow within your setting. It may be beneficial to look at ways to adapt existing facilities, rather than creating new facilities, which can be time-consuming and costly. This is situation dependant, however. New types of services may be needed that require new facilities to meet newly identified needs (e.g. dental services as an entry point for SRH services).
- Assess the competencies and concerns of existing staff within the chosen service delivery points. Important questions to explore include:
 - Is there existing staff capacity? Are all staff (non-clinician and clinician) trained to work with men? Do they understand what SRH care for men is and how to communicate this effectively to the target population if asked?
 - Do all staff have the skills to ensure quality of care in their clinician-client interactions, including counselling approaches that are appropriate for men and adolescent boys in all their diversity?
 - Is there an understanding of the different approaches needed to reach men and adolescent boys?
 - Are there values that need to be clarified?
 - Are there specific needs of the clinic staff? Do they have the certification to see men and adolescent boys (e.g. training as family planning or women’s health providers) and to examine them?
 - What would additional training look like commensurate with the diversity of the clients?
 - Undertake a needs assessments among these staff to provide answers to these questions, and to guide training needs.
- Assess whether high-quality SRH care is being provided to men and adolescent boys.
- Review the impact of expanding the provision of men’s SRH services on the quality of care for women and adolescent girls to ensure it is not having any negative unintended consequences.

Reminder on quality of care

Quality SRH care should be safe, effective and reliable as well as acceptable/client-centred, timely, efficient and equitable. In addition, it should provide clients the right to information, access to services, choice, privacy and confidentiality, dignity and comfort, and continuity of services and opinion.

Examine your existing monitoring and evaluation system

Identify your existing processes for monitoring and evaluation (M&E), including to what extent they can be expanded to include a focus on men and adolescent boys in all their diversity, and SRH (where necessary). Are your current service statistics disaggregated by age and by sex?

Look at the cost implications and opportunities to raise any requested funds

It is important to be aware of the cost implications of expanding your work on men and adolescent boys, and SRH. An increase in costs can be covered through a variety of different means including user fees, funding reallocations and innovative financing mechanisms. If external funds are required, explore whether there are opportunities to expand your funding base to support this work. To support funding applications, it will be important to show the potential efficiency gains and long-term cost savings from positive health outcomes, such as saving on anti-retroviral therapy within a community, fewer unintended pregnancies and the increase in workforce productivity.

Step 2: Build capacity and skills, organizational commitment and partnerships

Once you have undertaken a detailed assessment, you are ready to move on to the next step. This is preparing your organization for a scale-up of work on men's and adolescent boys' SRH. The key activities within this second step are as follows:

Develop skills and competencies

As noted in the building blocks, it is critical that all health providers, staff and volunteers in your services are aware of men's and adolescent boys' sexual and reproductive health issues, have the skills and confidence to deal with these issues, and are committed to doing so. You now have the results from the needs assessment of your providers. Developing their skills and competencies is the next stage. This process should include measures to:

- Develop service provider capacity/understanding on common SRH issues and needs of different groups of men and adolescent boys (informed by the findings of your formative research).
- Develop skills and understanding around SRH care to young men and the importance of being a supportive partner and couple testing and counselling.
- Develop confidence among staff to provide SRH services to men and adolescent boys, and empower them to provide non-judgemental services. This will ensure that providers have a supportive attitude.
- Provide regular refresher courses to staff, supportive supervision and (where possible) incentives.
- Provide specific training and support for community/peer health workers, tailored to their specific role within your service provision.

As part of ensuring sustainability, these skills should be built across the whole organization as much as possible, rather than being the preserve of certain people who become male SRH “experts”.

Organizational commitment and mandate

A broad organization mandate for this work is essential, including at the management and policy levels. Steps to be followed include:

- Gain the commitment of senior management across the organization to scaling-up work on men’s and adolescent boys’ SRH. Sometimes branch or lower level staff may be committed, but their work is limited by the lack of support from higher levels. As such, securing senior level support, if possible, is very important.
- Adopt an organizational policy commitment to working on men’s SRH. The assessment in Step 1 will have identified whether or not such a policy commitment already exists within your organization. If it does, it may require updating. If not, you should seek to adopt such a commitment on a greater focus on men’s SRH as soon as possible. Steps to follow in developing such a policy include understanding your context, reviewing existing policies, working with stakeholders and ensuring implementation of the policy. The IPPF Men-streaming Toolkit (see resources section) provides a helpful step-by-step guide to this process.
- Consider adopting a charter on SRH services for men and adolescent boys as part of your service provision. This will be informed by the analysis of your clinical environment in Step 1 above.

Partnerships and referral pathways

Providing SRH services for men and adolescent boys should not be about one organization trying to operate in isolation, but should be seen as a collective endeavour in collaboration with other partner organizations and service providers. These partners can include those that provide other SRH services – and can therefore be used for referrals and to ease the burden on your work – and those that will support broader advocacy activities. A multi-sectoral approach is key to success. You will have already identified important organizational and individual stakeholders with whom you currently work as part of the assessment in Step 1. Considerations at this stage include:

- Identifying key stakeholders who are supportive and like-minded organizations with which you can partner. This includes:
 - Clinic committees and clients to oversee the operations of SRH service provision and ensure accountability.
 - Other organizations working on gender justice and SRH. Such groups can be identified through a MenEngage country network (see www.menengage.org). The MenEngage Alliance is a global alliance of dozens of country networks spread across many regions of the world, hundreds of non-governmental organizations, as well as UN partners, working to promote gender justice, human rights and social justice. If there is not such a network near you, consider establishing a local or national task team to look at different work being undertaken in your location on SRH for men and adolescent boys.

- Identify key allies in government, UN agencies, donors and other critical players on SRH within your location.
- Conduct a service mapping to find out which stakeholders are providing which SRH services for men. Where there are gaps, if you are unable to expand your own service provision to cover them, can you establish a strong referral mechanism with another organization to ensure continuity of care is continued for the client? These referral systems should include a mechanism for tracking uptake of referrals and addressing the situations that contribute to clients being lost to follow-up.

Step 3: Design the programme

By now, you have a clear understanding of your context and service provision. You have sufficient organizational commitment and the support of partners to begin developing a stronger focus on the SRH of men and adolescent boys within your work. Designing this programme should incorporate the following steps, among others.

Reminder	
SRH clinical services:	SRH non-clinical supportive programmes:
1. Assessment questions on male client history	1. Information, education and communication materials
2. Physical exam of male client	2. Skills building and group support
3. Contraception	3. Advocacy issues in which to engage men and adolescent boys
4. Sexually transmitted infections	
5. HIV and AIDS	
6. Disorders of male reproductive system including sexual dysfunctions	
7. Male cancers	
8. Fertility and infertility	
9. Supporting prenatal and postnatal care, including safe motherhood	
10. Supporting safe abortion care	
11. Sexual and gender-based violence support	
12. Information and counselling	

Involve the community, particularly men and adolescent boys, in the design and delivery of SRH services

Consider how your approach is seeking to empower the community. Are men and adolescent boys, in particular, involved in the design and delivery of these services? If not, create opportunities to receive the feedback of community members and groups before the roll-out of any new SRH services or approaches.

Identify the appropriate SRH clinical services for men and adolescent boys

With adolescent boys and men's full participation, identify which services you wish to provide or improve. Refer to Section 4 for the SRH service package (the listed services may be considered as a minimum starting point). Refer also to Section 5 for more information. Remember to consider the specific needs of young men and/or men who have sex with men, where appropriate. Try to include as broad a range as possible of services for men and adolescent boys, including both services for them as SRH clients and as SRH partners. Address both primary prevention and disease management.

Identify the accompanying supporting strategies on men's SRH

Refer to the non-clinical supporting strategies in Section 4, to broaden your clinical services, where possible, ensuring men and adolescent boys are fully involved throughout the process. Consideration should be made to provide the following:

- Specific information, education and communication (IEC) materials, posters and other information on SRH for men
- Skills building and group support for men
- Advocacy around male involvement in SRH as clients, partners and agents of change

What else is needed to provide extra services to men?

After identifying the clinical services and supporting strategies you wish to expand or introduce, it is necessary to identify the associated resources/facilities required. This includes consideration of:

- Infrastructure, if necessary
- Equipment needs
- Commodities/supplies for clients and providers
- Lab facility/services required (or referrals for)
- Human resources (see staffing considerations below)
- Job aids and clinical guidance on men's SRH for your service providers and staff
- Changes, if any, to monitoring and evaluation systems

Locate appropriate structures/approaches to provide quality SRH services to men

Based on your formative research and the analysis of your services and skills, you should identify how you will actually provide SRH services to men. This is the supply side of service provision. It will be informed by your earlier visualization of male services. Considerations include:

- Dedicated clinic days and times for men and adolescent boys within existing services
- Male-only clinics as separate entities
- Male clients being able to choose to be seen by male providers, if appropriate
- Using youth-targeted services and youth centres to reach more young men
- Couple/partner approach: reaching more men through family planning and prenatal care services
- Workplace interventions
- School-based interventions
- Outreach/mobile/satellite SRH clinics for men and adolescent boys, including as part of community-based events and peer education
- Workshops on SRH for men and adolescent boys (male only), or together with women and girls
- Exploring other ways that services for men and adolescent boys can be integrated with other SRH services

Services should seek to take a preventative and integrated approach (primary prevention), are decentralized and convenient for men and adolescent boys.

Ensure your services are confidential, private, and free of stigma and discrimination within the context of quality SRH care for everyone

After you have identified where you will provide these services to men, use your earlier analysis to address the following questions:

- Can the services be provided at specific times for men? Consider evenings and weekends for those not available during weekdays.
- Is the name and signage now more welcoming to men?
- Is the clinic environment now more welcoming to men?
- Is there specific information for men and adolescent boys in the consultation rooms?
- How will voluntary and informed consent, confidentiality and confidential care be ensured?
- Are services in line with the IPPF quality of care standards (where applicable) and/or the Institute of Medicine's six characteristics of quality of care? See box above on quality of care.

Ensure effective partnerships and links are in place

It is essential to provide coordinated and multidisciplinary SRH care for men and adolescent boys. Steps 1 and 2 will have identified your existing partnerships and organizations and providers you would like to engage as part of this project. At this point, you should outline the specific roles of each partner, including those to which you will refer and for what services. Approach these organizations to seek their buy-in and support. Develop a Memorandum of Understanding, where necessary, with these organisations.

Staffing considerations

As part of developing skills and competencies among existing staff and volunteers to work on men’s SRH, there are a number of staffing and clinical considerations as follows:

- If expanding the number of SRH services provided for men, ensure that all relevant staff are trained and required internal and external referral procedures are in place.
- Plan for the ongoing training needs for existing staff to keep updated on changes to medical practice and guidelines on men’s SRH-related services.
- Provide training on approaches to providing high-quality counselling and clinical interactions with men and adolescent boys.
- If needed, explore ways to increase the number of male healthcare staff, in particular male counsellors and service providers to provide SRH services to men and adolescent boys.
- Consider providing incentives for this work, where feasible and appropriate.
- Explore task-shifting and task-sharing between doctors and nurses or counsellors, so that more junior staff are able to deal with men’s SRH complications (such as point of care CD4 tests for HIV being done by nurses), and to improve all providers’ skills at communicating with clients and supporting their rights.
- Consider recruiting additional staff, including peers/community health workers or expanding the roles and responsibilities of existing cadres of staffing, where feasible.

Ensure your approach is gender-transformative: would it pass the gender-transformative test?

Applying the gender continuum	!
Annex 2 contains useful assistance for determining whether or not your current approach is gender-transformative, and steps to ensure you embed this approach within your work.	

Is your programme seeking to be gender-transformative at all levels (e.g. within both service provision and awareness-raising)? Do you intend to engage men not only in improving their SRH, but also in challenging current gender norms and inequalities? What will the effect be on existing services for women and girls? What does taking a gender-transformative approach look like within clinical practice and your organization? Discuss this with your colleagues, to guide how this translates for service providers and their counselling approach. Outline in your action plan key steps you will follow to ensure that your programmes and services are gender-transformative.

Demand generation and activities for raising awareness

Increasing your clinical services for men should be accompanied by steps to increase awareness among the population, particularly the male target group, of the availability of services designed for men and adolescent boys. You will also need to decide what you wish to promote. For example, is it the new/expanded services you want to advertise? Are you seeking to raise awareness on the importance of couple testing for HIV/STIs? It is important that these messages take a positive approach. Strategies that can be used to generate demand include using the following:

- Materials and information (IEC)
- Peer education (see IPPF Peer Education guidelines in resources)
- Campaigns targeting men
- Campaigns targeting women and current female clientele to market services to their male partners, and sons, brothers, etc.
- Community mobilisation and organization (including using a men-to-men approach)
- Social media and social marketing
- Public awareness campaigns using mass media, such as radio and television
- Internet and telephone hotlines
- Street theatre and stunts to attract attention
- Public meetings and workshops
- Engaging male leaders and role models/champions, such as teachers, religious leaders and public figures
- Generating demand through outreach and existing services, including youth activities and existing female clients
- Targeting specific spaces where men congregate
- Networking with other partner organizations, including NGOs

Cost, charging and funding considerations

When a new activity is identified, consider the cost. Services can be split into the following categories: no-cost; low cost; moderate to high cost; and high cost. This will assist with the prioritization of actions in light of your available budget.

During Step 1 you will have identified whether there are funds available to support this work, whether funds need to be allocated from elsewhere (if possible, but not from work for women and girls) or if fundraising should be undertaken to cover costs. If fundraising is required, this will be potentially more successful if you have completed the detailed assessment and action planning process, as you will have a clear idea of the activities for which you are seeking assistance and the related impact and benefits.

If you intend to charge for your services, consider the effect of such fees. As far as possible, seek to minimize (and even eliminate) fees, where appropriate.

Technical assistance needs (if they can be addressed)

Outline specific areas where additional support is needed. Other organizations may be able to provide you with technical assistance, e.g. Member Associations may look to IPPF Regional Offices. It is important that this support is targeted and clear, in order to be most effective. As far as possible, utilize existing skills and resources within your organization before seeking external technical support, as this builds internal ownership and strengthens sustainability. Also explore opportunities for South-to-South learning (between developing countries), as well as more traditional North-to-South learning (between developed and developing countries).

Step 4: Implement, monitor and evaluate the Action Plan

The first three steps have looked at how to develop an Operational Action Plan. Once this Action Plan has been developed, approved and financed, roles and responsibilities for implementation need to be assigned as well as key milestones and timescales. A key part of implementation is ongoing monitoring and evaluation, with a consistent focus on promoting gender-transformative practices and measuring the results. This should ideally be integrated within existing activities. This M&E should, at a minimum, include the following:

- Monitoring effectiveness of implementation of male services (feasibility and acceptability)
- Indicators to measure the success of activities intended to reduce gender inequalities in access to SRH, such as increased knowledge, attitude change and behaviour change, from the individual to the state level
- Recording and reporting new service statistics
- Undertaking regular male client satisfaction of care surveys
- Assessing provider knowledge, attitudes and perceptions in working with men and adolescent boys (in all their diversity) as well as provider satisfaction
- Encompassing both quality assurance and quality improvement approaches:⁹⁸
 - Quality assurance refers to the idea of some measurement of “compliance” within the processes of service provision. It involves setting standards, measuring performance against standards and addressing gaps in compliance.
 - Quality improvement reflects both an objective and a process with a focus on implementing changes in a system in order to achieve an improvement objective.

Some example indicators for programmes working with men and adolescent boys can be found in box 11.

Box 11: Sample indicators for programmes working with men and adolescent boys⁹⁹

- Men's knowledge about family planning; HIV and AIDS; sexually transmitted infections; reproductive rights; partners' attitudes about family planning
- Knowledge of and attitudes towards vasectomy by service providers and men and women; demand for vasectomies; level of technical skill to provide no-scalpel vasectomy
- Knowledge, attitudes and practices among young men about rights; violence; gender roles; RH behaviours; age at first sexual experience or marriage; good parenting
- Provider awareness of signs of violence; referral systems; community attitudes; police attitudes and behaviours
- Decline in restrictions on services and information; access of adolescents to services
- Age and sex mix of clients; client satisfaction with services
- Policymakers' knowledge of and attitude towards human rights approach; assessment of whether State-level RH rights enforcement mechanisms are in place and whether revised service delivery protocols include human rights language; existence of clients' bills of rights
- Funds allocated for RH programmes
- Number of information, education and communication (IEC) activities and materials developed, pretested, and disseminated; men's knowledge and attitudes about their sexual behaviour related to women's RH; increase in condom use; increase in demand for STI counselling services
- Number of visits by young men to SRH services tailored to them
- Percentage of pregnant women receiving prenatal services whose male partner was tested for HIV

These indicators are examples and do not cover the full range of indicators that would be required.

Sources: Population Reference Bureau. (2002). A Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming. Washington, DC: PRB; Bloom SS, Negroustoeva S. Compendium of Gender Equality and HIV Indicators. MEASURE Evaluation. November 2013.



7

Country case studies on men and SRH

Section 7:

Country case studies on men and SRH

Case Study 1, Togo: What? A contraceptive method for men!



Koffi Sêvi* is a 52-year-old man from Togo. He became a strong advocate for vasectomy after having himself learned about this method of contraception from ATBEF (Association Togolaise pour le Bien-Etre Familial) – an IPPF Member Association.

“ While listening to an ATBEF radio programme on NANA FM I heard about a method that enables men to take responsibility for family planning instead of women. Of course everyone

knows about male condoms, but a contraceptive method for men was new to me.

I’ve been married to Akoua for 17 years, nature has given us nine children, who we love, but for a carpenter and housewife, raising and caring for nine children is not easy.

We considered family planning after our fifth child, but unfortunately my wife had an adverse reaction to the modern contraceptive methods we tried and I didn’t realize there was a contraceptive method that I could use! I still remember the time when she tried using an implant – every day she suffered from dizziness and headaches. So we stopped and as a result ended up six years later with four more children.

After hearing the radio programme, my wife and I decided to go to the ATBEF clinic for more information on vasectomy. At the first consultation, the provider assured me that my manhood would still be intact after the surgery, but my wife and I still had questions and doubts. You know the importance of sex in marriage. What if I cannot get my manhood back after the surgery? However, a week later, the second consultation with the provider eased my fears. Two weeks later, it was done.

Vasectomy is not as complicated as you might imagine. It lasted 30 minutes in total and I was able to go home straight after the procedure. What I had heard on radio was right: from the follow-up consultation to the spermogram, everything was straightforward.

At last my wife and I are free! Free to express our sexuality and love without fear of an unwanted pregnancy. Free to educate our children without refusing one to another. Moreover, I think it is my duty to help ATBEF disseminate useful information to men.

My wife and I have become now become vasectomy champions and it is with pleasure that I participate in awareness campaigns and programmes on the topic.”

*Names changed to protect confidentiality

Case study 2, Botswana: I want to be part of a family



After growing up with an absent father, Olepolotse Othuseng, who has a two-month-old baby, wants to be the change he had hoped for as a boy growing up.

“We are learning to be better men and to be better parents,” said Olepolotse Othuseng, a young man who grew up without a father present. After completing a UNFPA-supported sensitizing men and boys on gender equality, he doesn’t want to repeat the mistakes of the past but wants to be

a present and supportive father for his own baby. This change in attitude is due to the MenCare programme, which is helping to change minds about the value of women and what it means to be a man.

Run by Men and Boys for Gender Equality (MBGE), and supported by UNFPA Botswana, the MenCare programme targets men and boys with the aim of helping to reduce gender inequalities and gender-based violence, prevent HIV, and promote the health and well-being of women, men and children. The eight-week programme, which is targeted at expectant men and fathers, is delivered using the ‘3Ps’ of fatherhood – Presence, Partner support and Positive discipline.

After participating in MenCare, Olepolotse sees the value of spending time with his partner and his two-month old baby. He knows now that real change must start at home: “If a boy sees his father treating his sisters and mother with respect, he will pick up on it; if he sees his father beating his mother up, there’s a much higher chance that he too will be abusive.”

The fatherhood training programme facilitates lessons with fathers and encourages participant-led community campaigns that spread positive messages around men’s caregiving and share fathers’ stories of change. Upon completing the programme, the participants graduate in a ceremony and pledge to be loving fathers and caring partners.

Another result of this programme has been an increase in the uptake of health services at the local health centre. According to Lesego Mpudi, a registered nurse at the health post, use of health services by men has improved significantly, especially male circumcision services and HIV testing.

Case Study 3, Bangladesh: The kids can wait

Bangladeshi housemaid Rebeya* was just 14 when she married rickshaw puller Rafiquil*. Rafiquil knew that his income was not sufficient to raise a family, but his relatives were putting pressure on him and his wife to have a baby. Rebeya was also worried because she had heard about the consequences of having a baby too young.

A few months into their marriage Rebeya and her husband went to an information session at the Family Development Centre (FDC), run by the Family Planning Association of Bangladesh (FPAB). After the consultation they both agreed to wait until she was 18 to have their first child. But their decision was met with a negative reaction from his family, which only changed when Rafiquil explained the health risks of having a baby so young.

Four years later Rafiquil and Rebeya discussed it again and decided to have a child. When she became pregnant her husband took care of her. He took her to the FDC where she received antenatal services, medicine and advice, and made sure she had regular check-ups. When Rebeya went into labour her husband did not want to risk home delivery because he was worried about her giving birth with untrained birth attendants, so they went to hospital.

After the birth of his daughter, Rafiquil said: "If I had not attended the session at the FDC I would not have known about family planning, the right time to have a child or the consequences for girls of having a baby too young."

He thanked FPAB and its staff for providing them with the right information and services. Now they are happy with their child.

Case Study 4, Pakistan: Suffering in silence

This is the story of 16-year-old Amir* from the Faisalabad district of Pakistan and his interaction with Rahnuma-FPAP (the Family Planning Association of Pakistan) – an IPPF Member Association.

“Two years ago I developed a pain in my genitals but was too embarrassed and ashamed to discuss it with anyone. I hoped that it would go away if I ignored it, so I did and carried on with my normal routine but each day the pain got worse.

One day I noticed that my penis was swollen and there was blood in my urine. The pain was so intense that I had to crawl on the floor. I remained locked inside the toilet until the pain had subsided to a bearable level and then I put on a brave face before going outside again. I had to put on a brave face because I was convinced that if I shared this problem with my older brother he would make fun of me rather than help me.

In my desperation one day I picked up the courage to visit a local hakeem – a Muslim physician – but I lost my nerve and didn’t tell him about the problem. By this stage, my penis had swollen further and now also had boils on it. The pain was excruciating but I had no clue what to do and where to go for help so I kept quiet and suffered in silence.

Eventually I remembered a brochure I had been given about Rahnuma-FPAP’s youth resource centre. I had carelessly stuffed it in into my bookshelf. Fortunately I found the brochure and that day, instead of going to school, I went to the centre, but had no idea what to expect. When I got there the trained peer educators assured me that my appointment would be confidential and encouraged me to share my problem for the first time.

This I did and a peer educator accompanied me to the male doctor at the Rahnuma-FPAP clinic nearby and I was diagnosed with a sexually transmitted infection (STI). The doctor did not press me for details about how I had got the STI, but explained the importance of completing the treatment.

Today, I am a healthy 18-year-old. I still regularly visit the youth resource centre and receive information on safe sex and other useful information about sexual and reproductive health and rights.”



8

Resources on SRH for men and adolescent boys

Section 8:

Resources on SRH for men and adolescent boys

This section contains links to key websites with further information and resources on the SRH of men and adolescent boys. This is not an exhaustive list but should be used as a guide only. Please note that the resources are listed in alphabetical order, not in order of importance.

Clearinghouse on Male Circumcision for HIV Prevention: www.malecircumcision.org

EngenderHealth: www.engenderhealth.org/pubs/gender

Family Planning: A Global Handbook for Providers: www.fphandbook.org

Global Action for Men's Health: www.gamh.org/

Global Network of People Living with HIV: www.gnpplus.net

Guttmacher Institute: www.guttmacher.org/search/site/men

Health Provider Toolkit for Adolescents and Young Adult (AYA) Males: www.ayamalehealth.org

International Planned Parenthood Federation (IPPF): www.ippf.org/search?s=men

IPPF South Asia Region: www.ippfsar.org/search?s=men

Interagency Gender Working Group: www.igwg.org/priorityareas/male.aspx

Interagency Working Group on SRH and HIV Linkages: <http://srhhivlinkages.org/key-technical-topics/#male-engagement-male-circumcision>

Joint United Nations Programme on HIV/AIDS (UNAIDS): www.unaids.org/en/site-search?keywords=men

Male Sexual Health – Australia: www.sexualhealthaustralia.com.au/page/male_sexual_health1.html

Male Training Center: www.maletrainingcenter.org

MenCare Campaign: www.men-care.org

MenEngage Alliance: www.menengage.org

Men, Masculinities and Gender Politics Database: www.xyonline.net

Men's Health Forum – United Kingdom: www.menshealthforum.org.uk

Promundo: <http://promundoglobal.org>

Sonke Gender Justice: www.genderjustice.org.za

SRHR and HIV Linkages Toolkit: <http://toolkit.srhivlinkages.org/#6/4>

State of the World's Fathers: <http://sowf.men-care.org>

United Nations Population Fund (UNFPA): www.unfpa.org/search/site/men

UN Women: www.unwomen.org/en/news/in-focus/engaging-men

World Health Organization (WHO): www.who.int



Annexes

Annexes

Annex 1: Guiding principles

The overarching principles guiding this SRH service package are as follows:

- **Rights-based and client-centred:** We work on the foundation of human rights, which includes sexual and reproductive rights, and with a client-centred approach. We also aim to change from a biomedical focus towards a broader health care model that incorporates human and sexual rights and gender equity, and respects culture, values of choice, dignity, diversity and equality.
- **Evidence informed:** We seek to be informed by, and build upon, research, policy and good practice approaches to work on men and SRH.
- **Respecting sexual diversity:** We recognize and celebrate the diversity of sexualities, including heterosexual and lesbian, gay, bisexual, transgender and intersex people.
- **Non-discrimination and stigma-free:** We actively advocate against, question and seek to overcome, sexism, social exclusion, homophobia, racism or any form of discriminatory behaviour against anyone, or on any other basis. We also promote the provision of stigma-free SRH services, and thus reduce barriers to access.
- **Broad conception of gender and masculinities:** In their daily lives, women and men together, and with members of the same sex, experience and shape gender roles and relations. We therefore believe in a broad conception of gender and gender equality, with men and women working together. And just as gender is relational, we believe in a broad understanding of men and masculinities.
- **Transformative and positive approaches:** We support action to transform non-equitable and violent versions of manhood and redress power inequalities related to gender, including challenging men's violence against women. This approach should incorporate both the individual, as well as the broader social and structural contexts that shape gender inequalities. We also seek to involve men from a positive perspective, understanding that they can play a positive role in their partner's and their own sexual and reproductive health.
- **Women's rights and autonomy:** We uphold women's right to choose as to whether to include their partners in SRH counselling, service delivery and treatment. We believe in ensuring that positive changes that can result from involving men are extended to women, including that funding of efforts to involve men do not detract from ongoing and planned work with women.
- **Acknowledging the vulnerabilities of men:** We believe that the specific needs and experiences of men and adolescent boys have often not been well-understood nor taken into account in the development of public policy or professional practice. We believe that some men and adolescent boys are made vulnerable by non-equitable and violent versions of manhood.

- **Integrated, decentralized and cost-effective:** We seek to find ways to integrate new services into existing services wherever possible and practical. And we believe in the rational, safe and acceptable de-medicalization of SRH services through task sharing and/or shifting where applicable.
- **Collaboration and community participation:** We seek to involve the community – men and women, adolescent boys and girls – to lead and shape the response to SRH needs, taking into account gender considerations. We also pursue the continuum of care by strengthening partnership with and referral to higher level clinical, psychosocial and protection services of like-minded governmental and non-governmental agencies that do not contradict the above principles and objectives.

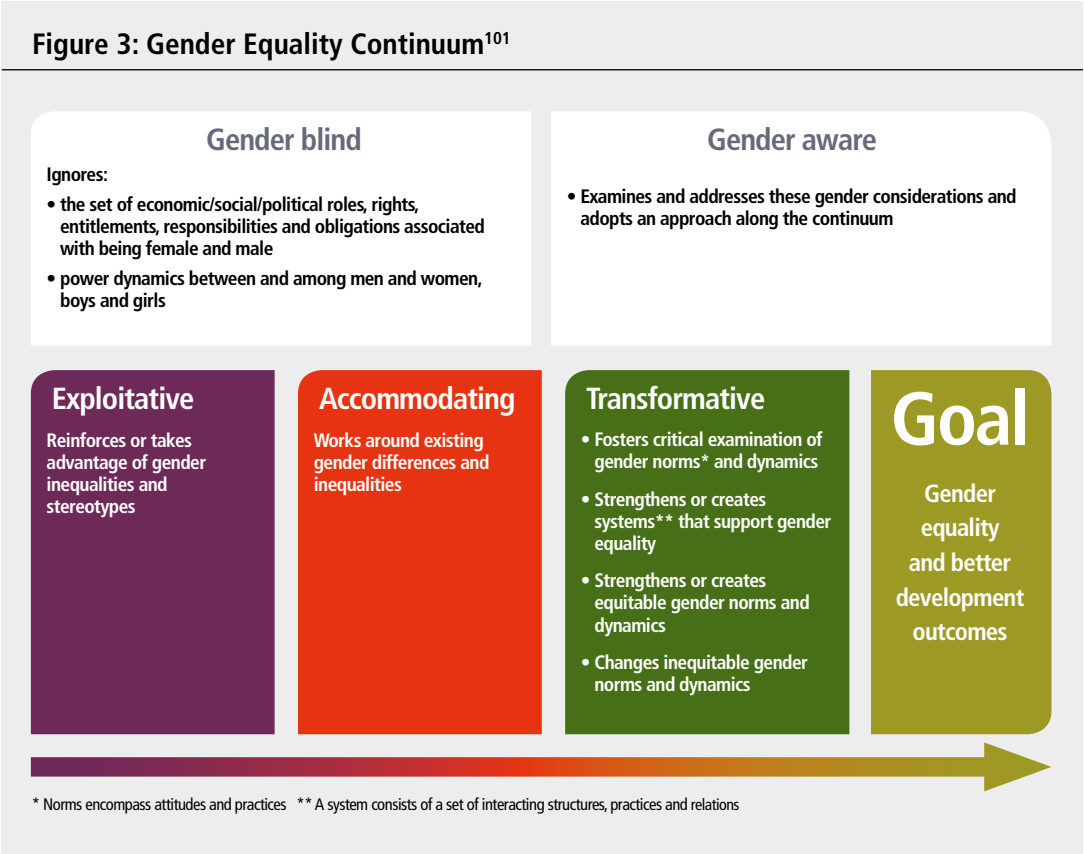
These principles build upon and reinforce those that guide the delivery of the IPPF Integrated Package of Essential Services (IPES), and are also informed by the MenEngage global principles.¹⁰⁰

Annex 2: Applying the gender continuum

Adapted from the Interagency Gender Working Group (IGWG) Gender Integration Continuum.

The continuum provides two categories: “gender blind” and “gender aware”. An important prerequisite for all gender-integrated interventions is to be gender aware.

The Gender Equality Continuum Tool takes users from gender blind to gender aware programmes, towards the goal of equality and better development outcomes (see figure 3). Awareness of the gender context is often a result of a gender analysis carried out prior to the development of a programme or policy. “Gender aware” contexts allow programme staff to consciously address gender constraints and opportunities, and plan their gender objectives.



“**Gender blind**” programmes are designed without prior analysis of the culturally-defined set of economic, social and political roles, responsibilities, rights, entitlements, obligations and power relations associated with being female and male and the dynamics between and among men and women and adolescent boys and girls.

In contrast, “**gender aware**” programmes deliberately examine and address the anticipated gender-related outcomes during both design and implementation.

Exploitative gender programmes/policies are those that intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of project outcomes, or whose approach exacerbates inequalities. This approach is harmful and can undermine the objectives of the programme in the long run.

Accommodating gender programmes/policies acknowledge but work around gender differences and inequalities to achieve project objectives. Although this approach may result in short term benefits and realisation of outcomes, it does not attempt to reduce gender inequality or address the gender systems that contribute to the differences and inequalities.

Transformative gender programming includes programmes and policies that seek to transform gender relations to promote equality while achieving programme 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.

Most importantly, planners and managers of programmes and policies should follow two gender integration principles:

1. First, **under no circumstances should programmes/policies adopt an exploitative approach** since one of the fundamental principles of development is to “do no harm”.
2. Second, **the overall objective of gender integration is to move towards gender-transformative programmes/policies**, thus gradually challenging existing gender inequities and promoting positive changes in gender roles, norms and power dynamics.

UNFPA and EngenderHealth have developed an online interactive resource guide for programmes and projects involving men in gender-transformative SRH and family planning. It is organized along six steps to aid in understanding what gender equality within SRH and family planning should look like and how to implement gender-transformative SRH and family planning services so that health care providers and their clients are both striving for equitable access to healthcare. These steps are:

1. Understanding gender and gender programming
2. Building support for change
3. Assessing the needs
4. Creating objectives and designing the programme
5. Building staff and organizational capacity
6. Monitoring and evaluating the project

Annex 3: Operational action plan template

Name/s: _____

Organization: _____

Date: _____

Topic area	What will you do short term (ST, next 12 months) and long term (LT)?	By when? Target date	Who? Person responsible	Signs of success/ Means of verification
Building capacity and skills, organizational commitment and partnerships				
Developing skills and competencies	ST:			
	LT:			
Organizational commitment and mandate	ST:			
	LT:			
Partnerships and referral pathways	ST:			
	LT:			

Topic area	What will you do short term (ST, next 12 months) and long term (LT)?	By when? Target date	Who? Person responsible	Signs of success/ Means of verification
Design the programme				
Identifying the appropriate SRH clinical services for men and adolescent boys	ST:			
	LT:			
Identifying the accompanying supporting strategies on men’s SRH	ST:			
	LT:			
What else is needed to provide extra services to men?	ST:			
	LT:			
Identifying appropriate structures/ approaches to provide SRH services to men	ST:			
	LT:			
Ensure your services are male friendly and confidential, within the context of quality SRH care for everyone	ST:			
	LT:			

Topic area	What will you do short term (ST, next 12 months) and long term (LT)?	By when? Target date	Who? Person responsible	Signs of success/ Means of verification
Ensuring effective partnerships and links are in place	ST:			
	LT:			
Involving the community, particularly men and adolescent boys, in the design and delivery of service	ST:			
	LT:			
Ensuring your approach is gender transformative	ST:			
	LT:			
Staffing considerations	ST:			
	LT:			
Demand generation and raising awareness activities	ST:			
	LT:			

Topic area	What will you do short term (ST, next 12 months) and long term (LT)?	By when? Target date	Who? Person responsible	Signs of success/ Means of verification
Cost, charging and funding considerations	ST:			
	LT:			
Technical assistance needs (if they can be addressed)	ST:			
	LT:			
Other	ST:			
	LT:			
Monitoring and evaluation: key outcomes				

Annex 4: Self-assessment checklist for action

The checklist presents 15 key steps towards addressing men’s sexual and reproductive health (SRH) within your organization. It has been developed to support the “Assessing your current situation” step within Section 6. An initial set of questions are provided, upon which organizations can build. As noted at the beginning of this document, this can be used as a tool by organizations that are either “getting started” in this area or by those that wish to assess their progress in terms of strengthening work on men’s SRH.

	Topic area	Issues to consider/ notes	Yes	No	In progress/ Ongoing	Not applicable
Institutional commitment						
1	Does your organization have an internal policy or operational commitments on men and SRH?					
2	Is there an internal commitment to expanding this work in your organization? In other words: • Does your organization advocate internally for a strong gender justice approach that includes working with men and adolescent boys to support women’s empowerment and also seeking to meet the SRH needs of all clients? • Does your organization have focal points/ champions/key staff that provide strategic guidance and support on meeting the SRH needs of men and adolescent boys in all their diversity?					
3	Is the work of your organization in line with the principles in this service package, including a commitment to understanding men’s and adolescent boys’ vulnerabilities and the social construction of masculinities?					

	Topic area	Issues to consider/ notes	Yes	No	In progress/ Ongoing	Not applicable
	Institutional capacity					
4	Do you have a clear understanding of the capacity and skills of service providers, including their ability to provide supportive, confidential and non-stigmatizing SRH services to men and adolescent boys (regardless of sexual orientation, socio-economic status and ethnicity), and any areas for training and development?					
5	Does your organization allocate adequate funding to pursue work on men and adolescent boys, and SRH, or do you have specific fundraising plans in place?					
6	Does your organization have systems and tools to implement, monitor and evaluate your work on men and adolescent boys, and SRH, as part of your broader work on gender?					
	Service provision					
7	Does your organization currently provide specific SRH clinical services for men and adolescent boys in the following areas: 1) Assessment questions on client history 2) Physical exam 3) Contraception 4) Sexually transmitted infections 5) HIV and AIDS 6) Disorders of male reproductive system including sexual dysfunctions 7) Male cancers 9) Fertility and infertility 9) Supporting safe abortion care 10) Supporting prenatal and postnatal care 11) Sexual and gender-based violence support 12) Information and counselling	Detail whether levels of uptake are sufficient within each area				
8	For the above services you do not provide, do you have an existing effective referral mechanism?					
9	Are your current clinical environment and SRH services male friendly? For example, are health and support services provided at hours and locations that are convenient for men and adolescent boys?	See Operationalizing Section 6 and Annex 5				

	Topic area	Issues to consider/ notes	Yes	No	In progress/ Ongoing	Not applicable
10	Are there existing service entry points that can be extended to incorporate a new or greater focus on men and adolescent boys, and SRH?					
11	Have you taken steps to ensure that increasing men’s adolescent boys’ SRH doesn’t impact on quality of care for women and girls?					
Community needs						
12	Do you have a clear understanding of your local context, your male target group and their SRH needs?	See building blocks, See Operationalizing Section 6				
13	Are there opportunities to reach couples and young men as part of your existing work? This should include partner notification, and male clients being encouraged to bring their partners to clinics or programme sites, regardless of their sexual orientation.					
External environment						
14	Does your organization have an advocacy agenda around men and SRH, including developing the capacity of men and adolescent boys to advocate for, and support, key sexual and reproductive health and rights issues?					
15	Does your organization have partnerships with other organizations and networks that can support its work on men and SRH, or able to initiate collaboration with others in this area?					

Annex 5: Facility walk-through questions

Adapted from Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers The ACQUIRE Project/EngenderHealth and Promundo 2008.

As you walk through the facility, imagine that you are a man coming to the facility for services or information for the first time. Keeping the man's perspective in mind, assess how the facility would appear on the basis of the following criteria.

Facility approachability

1. Does the name of the facility seem welcoming to men?
2. As you approach the facility, is it obvious that it is a suitable place for men to seek health services?
3. As you approach the facility, is it obvious that it is a suitable place for men to come with their partner for services?
4. Does the gatekeeper or guard know about all services that are available for men?

Services provided

5. Is there a sign or poster indicating that services are provided for men?
6. Is there a sign or poster indicating that men can come with their partner for services? Does that include prenatal care and PMTCT services?
7. Does the sign or poster indicate the types of services offered for men?
8. Are brochures or handouts with information about services for men readily available?
9. Are brochures or handouts on how men can be involved as partners in SRH readily available?
10. Does the receptionist know about all services available for men or that men can come with their partner for services?

Reception/waiting area

11. Is it a comfortable environment for men (as opposed to catering more to women or children)?
12. Are magazines, newspapers or other items that appeal to men readily available?
13. Are brochures, pamphlets, posters or other client-education materials that focus on issues on men's sexual and reproductive health readily available?
14. Is the area clean, neat and efficient-looking?
15. Do you see any other male clients in the area?
16. Do you see any male staff members?
17. Is a men's bathroom/toilet available?
18. Is it clear where you would go if you were coming for services or coming with your wife or partner for services?
19. Does the staff appear to be polite and respectful towards men?
20. If you came in only to get some condoms and did not want an examination, is it clear where you would get them?
21. Is illustrated literature or a diagram of how to use a condom readily available?

Service areas and examination rooms

22. Is it a comfortable environment for men (as opposed to catering more to women or children)?
23. Are brochures, pamphlets, posters or other client-education materials that focus on how men can be involved in SRH and HIV prevention readily available?
24. Do you think you could speak confidentially with a service provider or counsellor here, without being seen or overheard?

Annex 6: Related IPPF and UNFPA policies

Annex 6.1 Men and sexual and reproductive health (IPPF Policy 4.6)

Men and sexual and reproductive health

Introduction

1. IPPF is committed to working with men and boys as clients, partners and agents of change in our efforts to meet the goals and objectives of the Federation's Strategic Framework. This applies to males of all sexual orientations, including those who have sex with other men (homosexual, bisexual and transgender) and regardless of HIV status.
2. This policy reflects the importance the Federation attaches to addressing male sexual and reproductive health and rights, and the need to work with men and boys, together with women and girls, as equal partners in the provision of comprehensive sexual and reproductive health services. This is critical to meeting today's global public health challenges, and is in line with the ICPD Programme of Action, the global development goals and a wide body of international research.
3. This policy builds upon existing programmes and initiatives within IPPF, and provides guidance to volunteers and staff on where these may need to be developed or expanded. It outlines a number of steps to be undertaken by Member Associations and the IPPF Secretariat in order to implement services in line with this commitment. All policies and programmes within the Federation should be planned taking account of this policy, and implemented and evaluated accordingly.

Men's role in promoting gender equity in health

4. IPPF believes that in order to address underlying power and gender imbalances, and their effects on health, it is essential to work with men in promoting gender equity. Strategies and programmes seeking to challenge the practices and structures creating gender inequalities should, therefore, explicitly engage men and highlight their positive and influential role. Such engagement should, at all times, enhance rather than diminish women's autonomy. IPPF undertakes, where possible, to:
 - i. Promote gender equity as an issue of concern for men as well as women, and highlight the benefits of a more equal society for everyone.
 - ii. Work with positive male role models and undertake campaigns and educational programmes to empower men and boys to fully understand and promote gender equity and support the sexual and reproductive health and rights of others, in particular women and young people.
 - iii. Work with both sexes to challenge often 'negative' gender norms/stereotypes, tackle homophobia, and promote more equitable ways of living and loving.
 - iv. Work with women and girls to support the development of more equitable attitudes and behaviours amongst men and boys.

Reaching boys and young men

5. IPPF is committed to reaching boys and young men, together with girls and young womenⁱ, through comprehensive sexual and reproductive health information and services, to address the specific vulnerabilities and sexual and reproductive health needs of this group. The Federation also recognizes the importance of early intervention to foster healthy sexual health attitudes and behaviours among boys and young men. The Federation undertakes, where possible, to:
 - i. Address the specific needs of boys and young men within existing sexual and reproductive health programmes, clinics and youth friendly services.
 - ii. Provide appropriate information, counselling and outreach that empower boys and young men to feel respected and confident in accessing support and using condoms.
 - iii. Work with young men and boys through comprehensive sexuality education and peer education programmes to increase their life skills and understanding of personal health, equitable relationships and the negative impact of traditional gender stereotypes.

Men as partners in preventing HIV and other sexually transmitted infections

6. IPPF believes that the programmes and services of Member Associations should recognize the critical role that men and boys play as partners in addressing the HIV epidemic and preventing other Sexually Transmitted Infections (STIs), and seek to facilitate their involvement. IPPF undertakes, where possible, to:
 - i. Increase male access to, and utilization of, voluntary counselling and testing (VCT) services, and to increase their uptake of necessary treatment, care and support.
 - ii. Advocate for the involvement of positive male role models (particularly those living with HIV) to encourage other men and boys to use condoms and be tested for HIV and STIs.
 - iii. Address the sexual and reproductive health and positive preventionⁱⁱ needs of men living with HIV, their partners and family members, including providing support for men in serodiscordant relationships.
 - iv. Support the involvement of male partners in the prevention of mother-to-child transmission (PMTCT).
 - v. Involve men in strategies to reduce HIV and STI related stigma and discrimination.

Men as partners in the provision of safe abortion services

7. IPPF acknowledges that men and boys have a role to play in increasing their partners' access to safe abortion services, thus contributing to a decline in maternal morbidity and mortality related to unsafe abortion. This approach to working with men and boys should, at all times, be underpinned by support for a woman's right to choose. The Federation undertakes, where possible, to:
 - i. Provide specific information and education for men on abortion and how to support interventions to increase access to safe abortion services.

i Adolescent boys, young men, girls and young women refer to those between the ages 10-24.

ii Positive prevention is defined as prevention for, and with, people living with HIV.

- ii. Work with men and boys to advocate for changes in legislation, to address stigma and discrimination, and to remove obstacles to accessing safe abortion services.
- iii. Enable and encourage men and boys to participate in pre- and post-abortion counselling sessions, if a woman so desires.

Men as partners in improving access to services

8. IPPF recognizes the importance of working with men to reduce barriers and increase access to sexual and reproductive health information, sexuality education and high quality family planning services. This includes sensitizing men to their responsibilities in promoting women and adolescents' sexual and reproductive health, well-being and rights. IPPF undertakes, where possible, to:
 - i. Strengthen information and education which promote male responsibility and the sexual and reproductive health needs and rights of women, men and adolescents.
 - ii. Work with men to encourage them to assume full responsibility for their sexual behaviour and to protect the health, well-being and rights of their partner and family.
 - iii. Promote joint decision-making and shared responsibility by men and women, particularly in relation to use of contraception and other safer sex techniques, within a gender equity framework.

Men as fathers

9. IPPF promotes the important role that men play as fathers. The Federation supports the development and promotion of gender equitable fatherhood, and recognizes the important role of fathers in safe motherhood and antenatal care, as well as in the promotion of women and adolescents' physical and psychological well-being. The Federation undertakes, where possible, to:
 - i. Provide specific support, education and information to fathers, and promote the role of responsible fathering in improving family health and reducing fatality risks pre- and post-childbirth.
 - ii. Embrace fatherhood in its diversity of forms, recognizing that working with men as parents provides an important opportunity to also address other sexual and reproductive health needs and issues.
 - iii. Provide support and counselling services to facilitate the greater sharing of family responsibilities and the concerns for pregnancy support.

Men as partners in eliminating gender-based violence

10. The Federation is committed to involving men in the reduction of gender-based violence. The Federation believes that policies, programmes, services and campaigns should explicitly highlight the role of men as part of the solution to addressing and preventing this violence. Such an approach should remain accountable to women, and promote their empowerment. IPPF undertakes, where possible, to:
 - i. Highlight that violence against women also negatively impacts upon men and boys and their families, and that an end to such violence will bring benefits to everyone's health and well-being.
 - ii. Support men's anti-violence activism that demonstrates clear alignment with principles of gender equity.

- iii. Promote violence prevention strategies that address the root causes and impacts of violence, including violence and abuse against men and boys, particularly in high-risk settings.

Men's sexual and reproductive health needs and rights

11. The Federation is committed to ensuring that programmes and services also identify and address the sexual and reproductive health needs and rights of men and boys. IPPF believes that this is necessary both to improve the health of men and boys themselves, and as an important way of encouraging men to enhance the sexual and reproductive health of others, in particular women and young people. The Federation undertakes, where possible, to:
 - i. Create or expand programmes and services to specifically address men and boys' sexual health and reproductive needs and concerns.
 - ii. Review existing sexual and reproductive health policies, programmes and interventions to ensure that they actively promote the greater engagement of men and boys and facilitate their access to services.
 - iii. Promote the use of male role models to encourage other men to take greater care of their sexual and reproductive health.
 - iv. Enhance understanding among men of the sexual and reproductive health rights and needs of their partners, lovers and children.

Policy implementation

In line with this policy, the IPPF Secretariat and Member Associations are urged to raise awareness among volunteers and staff to develop their own appropriate strategies. More specifically:

12. Member Associations should endeavour to:
 - i. Integrate, based on the appropriate areas of this policy, a focus on working with men and boys, and addressing their sexual and reproductive health needs, within existing policies and programmes.
 - ii. Provide training and support to build the capacity, skills and attitudes of staff, service providers and peer educators to work with men and boys, particularly the most vulnerable.
 - iii. Create and maintain strategic partnerships with other organizations working with men and boys, including linkages to enable appropriate referrals.
 - iv. Work with parliamentarians and other decision makers on this issue.
 - v. Use language that will not exclude men and boys from our work.
 - vi. Review and/or plan, implement and evaluate programmes and activities in line with this policy.
13. The Central Office and Regional Offices will seek to:
 - i. Support development of these programmes and services and, where possible, provide Member Associations with technical support. The IPPF Central and Regional Offices will also endeavour to raise funds for the implementation, and scaling-up, of this work.
 - ii. Ensure that relevant IPPF standards and guidelines (clinical and non-clinical) reflect the above policy.

- iii. Develop strategies, where possible, to integrate a stronger focus on men and boys within the Federation's core business, including a monitoring and evaluation and gender analysis framework for this aspect of the strategic framework.
- iv. Establish and/or develop existing links with organizations working on this issue.

As adopted by IPPF Governing Council, May 2008

Annex 6.2 Gender equality (IPPF Policy 1.3)

Gender equality

Introduction

The Federation is committed to a human rights framework that prohibits any discrimination, exclusion or restriction on the basis of sex, age, gender, gender identity, sexual orientation, marital status, physical and mental disability or health status.ⁱⁱⁱ Gender equality is a human right. It is especially important for a rights-based, gender-transformative organization like IPPF to ensure that the needs, rights and experiences of individuals involved in the Federation (whether as staff, volunteers or clients) are reflected in policies and processes, and that they are supported to play an equal role in the Federation.

Mandate

This policy provides a set of guiding principles that reflect the Federation's commitment to advancing gender equality and the actions necessary to realize the goal. Gender inequality has been globally recognized as a root cause and consequence of poverty and exclusion. Gender equality mandates have emanated from core international human rights instruments in which IPPF's Declaration of Sexual Rights is grounded.^{iv}

IPPF believes gender equality to be inclusive of sexual orientation and gender identity. Throughout the policy, with exceptions where genders are significantly affected by particular issues, the term 'individuals' is used inclusively to cover women, men, intersex and transgender individuals of all ages regardless of their gender identities. This policy focuses on promoting gender equality, which is broader than equality between women and men and sets out specific and targeted actions required to ensure that all individuals, who identify as women, men, lesbian, gay, bisexual, transgender or intersex, have access to equality of outcome in the workplace and in programmes. The policy engages with the impact of social roles and norms, constructs of masculinity and femininity, and discrimination based on gender, sex, sexual orientation and gender identity.^v Definitions of key terms are provided in Appendix 1.

As the role of this policy is to achieve gender equality for all, it focuses on those social norms that impact on an individual's ability to participate equally and freely in society, to achieve their full potential. Gender norms and patriarchal structures are pervasive and affect women disproportionately. Women and girls have lower status, fewer opportunities and less access to power than men and boys. Therefore progress towards gender equality requires transformative complementary actions to promote women's rights and empowerment, including addressing gender gaps, unequal policies and discrimination that have historically disadvantaged women and girls and affected their full participation in development. Gender norms also reinforce constructs of masculinity and femininity that have a disproportionate impact on individuals whose sexual orientation and gender identity do not conform to these rigid constructs.

iii IPPF Sexual Rights Declaration, 2008, Principle 3, 'Non-discrimination underlies all human rights protection and promotion'.

iv These instruments include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the Cairo Programme of Action (1994), the Beijing Platform for Action (1995). The Millennium Development Goals (MDGs) (2000) identified gender equality and women's empowerment as a goal and as a basis for achieving all the other goals.

v United Nations Resolution on Sexual Orientation and Gender Identity, Human Rights Council adopted resolution 17/19 (A/HRC/RES/17/19), July, 2011 'Expressing grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity'.

Guiding principles

1. This policy reflects the Federation's commitment to human rights and to women's and girls' empowerment. IPPF believes that the equitable participation of women and girls from all socio-economic groups in all aspects of the Federation's work will empower them in their diverse identities and enable them to acquire the relevant skills and confidence to promote their sexual and reproductive health and rights. This policy also reflects the importance that the Federation places on actively supporting women and girls (staff, volunteers and beneficiaries) to become leaders and to participate on an equal basis with men in every area of the Federation's work.
2. Gender should be mainstreamed in all policies, programmes and structures of the Federation.^{vi} Women and men have different needs and experiences, as well as different sexual health risks. Gender disparities often serve as additional social, economic and bureaucratic barriers to how individuals promote and protect their sexual and reproductive health and rights. Individual employees also have different needs and experiences related to gender and experience gender-based discrimination in a variety of forms. Policies, programmes and services must seek to be transformative in addressing these gender specific differences and the underlying structural inequalities that sustain them. Enabling environments must be created for everyone to be able to influence and benefit from policies, programmes and services.
3. Gender equality should be applied to all issues in the Federation, whether with regard to representation on a board or committee, or with regard to the social division of labour. In an area such as sexual and reproductive health, in which women bear the largest share of the costs, dangers and burdens (physical, mental, social and economic), it is equitable and fair that women should have at least an equal share in all institutional decision-making processes.
4. Gender equality is achieved when all individuals, regardless of their gender identity are equal in every aspect of their lives. It does not imply that they are all the same, but that they have equal value, and that they should be treated in a way that ensures equal outcomes, not just equal opportunities. Where individuals have unequal status and unequal access to knowledge or resources in a community, special measures and affirmative action are needed to address these gender inequalities.
5. This policy reflects the importance that IPPF attaches to workplace safety and its integral link to physical and mental well-being. IPPF has a duty of care to ensure that individuals are free from all forms of sexual and gender-based harassment and violence in the workplace and when travelling away from their workplace.
6. IPPF believes that promoting gender equality requires working with all gender identities. IPPF recognizes and promotes the crucial role of men and boys as partners in ensuring women's and girls' sexual and reproductive health and to addressing underlying power and gender inequalities, including in the service delivery and employment contexts.

vi Supporting policies that complement and enhance implementation of the current policy, include the IPPF policy on Women and Family Planning (4.5); Men and Sexual and Reproductive Health (4.6); Monitoring and Evaluation (4.10); Protecting Children and Young people (4.17); Reproductive Health (4.15). A policy on Sexual orientation and Gender Identity should be developed to highlight specific issues and how they can be implemented.

7. IPPF recognizes diversity and is committed to working with all people to realize a world where they can enjoy their sexuality without fear, stigma or discrimination. This applies to gender identity and sexual orientation, both within the Federation and in the Federation's external facing roles.

Implementation

8. The IPPF Secretariat should use all available mechanisms in the Federation to periodically and consistently monitor implementation of the Gender Equality Policy and report to the appropriate governing body. The implementation of this policy should be adequately resourced and supported by senior management.

Programme delivery

9. To put this policy into action, the IPPF Secretariat and Member Associations should undertake actions that transform relationships of power. These transformative actions could include, promoting programmes that empower individuals (especially those individuals who are marginalized on the basis of their sex, gender, sexual orientation and gender identity) and making efforts to advance their sexual and reproductive health and rights.
10. Gender analysis (based on age and sex disaggregated data) should be undertaken, throughout the programme cycle and by:
 - a. making every effort to implement programmes that lead to empowerment, including into leadership positions, in particular for those who are poor and marginalized;
 - b. ensuring availability of services that actively address unique gender needs across the lifecycle;
 - c. engaging all, including men and boys, in sexual and reproductive health efforts and as allies in reducing gender inequality;
 - d. preventing, mitigating and responding to sexual and gender-based violence including intimate partner violence and sexual violence in humanitarian emergencies, and promoting sexual and reproductive health and rights;
 - e. tackling social norms that hinder meaningful participation on an equal basis, including but not exclusively: son preference; early and forced marriage; intimate partner and domestic violence; and, female genital mutilation (FGM);
 - f. creating and/or strengthening gender equality concerns and perspectives with partners; strengthening IPPF's identity as a gender expert; linking with those who work to promote women's rights and sexual rights and engaging LGBTI and men's organizations for gender equality, including in service delivery, programming and advocacy;
 - g. undertaking analysis of gender disaggregated roles and work patterns taking women's work load and care work into consideration;
 - h. responding to the needs of most at risk groups, specifically: those with disabilities; sex workers; intersex and transgender individuals; those who use drugs; those in institutions; and, those trafficked for sex;
 - i. abolishing internal policies relating to spousal/ partner consent for access to services (e.g. for an abortion, using family planning and/or emergency obstetric care);

- j. building staff capacity on gender perspectives and the effect of gender inequality on individual's access to services and human rights, including perspectives on sexual orientation and gender identity;
- k. making deliberate and focused efforts to promote meaningful participation in the programme cycle, including for adolescent girls.

Governance

12. To operationalize this policy, the IPPF Secretariat and Member Associations should practice affirmative action in order to alter the balance in the numbers of men and women at all levels of decision-making in volunteer bodies of the Federation, in favour of gender parity, taking into consideration women and individuals who are marginalized on the basis of sexual orientation and gender identity, including on:
 - a. Member Association governing bodies;
 - b. Regional Councils and Regional Executive Committees;
 - c. IPPF Governing Council;
 - d. IPPF Membership Committee;
 - e. IPPF Audit Committee.
6. Operationalizing affirmative action would include:
 - a. making additional efforts to recruit and promote women candidates when posts come up for election;
 - b. giving preference to eligible women where there is a choice of candidates;
 - c. sending more than one representative to a regional or international body (where MAs are permitted to do so) to ensure equal representation.

Recruitment and promotion

4. To operationalize this policy, the IPPF Secretariat and MAs should integrate affirmative action in employment policy (while respecting national legislation) to ensure gender parity, particularly in decision making positions, at all levels. Operationalizing affirmative action in employment would include:
 - a. active recruitment to high-level decision-making and high-salaried posts, as well as other posts with the objective of achieving at least 50 per cent representation by women in all posts at all levels;
 - b. recruitment and promotion of young women;
 - c. recruitment and promotion of staff from diverse backgrounds, regardless of sexual orientation and gender identity;
 - d. ensuring all recruitment panels have gender expertise.

Mainstreaming in the workplace

5. To ensure gender equality in the workplace (in the Secretariat and MAs) and the effective implementation of this policy, related policies will need to be audited to ensure compliance (while respecting national legislation). This should include, inter alia:
 - a. ensuring equitable representation and participation in senior management and relevant decision making committees;

- b. ensuring equal opportunities for personal development, in training, working conditions and promotion benefits, and reviewing up-take in these opportunities by gender;
- c. providing an enabling work environment so as to ensure the meaningful participation and a work/life balance for working parents – this includes, but is not limited to: providing flexible working hours; developing home-working policies; and, providing child care centres or child care subsidies.
- d. ensuring equal pay and reward structures for all employees. This requires every part of the Federation to conduct equal pay reviews to identify any imbalances and implement strategies to address them;
- e. providing maternity and paternity leave (for both adoptive and biological parenthood) and extending it to all staff regardless of gender, sexual orientation, gender identity or marital/relationship status;
- f. reviewing and taking steps to address gender imbalance where it exists within the Federation structure with the aim of attaining at least 50 per cent representation by women;
- g. identifying trained staff to act as dedicated gender focal point(s) with consistent and structured support from senior management;
- h. identifying a senior manager (in every Member Association and every office of the Secretariat) to act as a gender champion;
- i. undertaking refresher training for all staff, to enhance understanding and ensuring that gender perspectives are integral to new staff induction processes;
- j. ensuring that staff's access to and use of information technology is gender equitable;
- k. developing Federation wide standards on confidentiality that specifically refer to the situations of gender identity and sexual orientation.

Work place safety

12. Providing a safe and secure environment, for all staff (in the Secretariat and MAs) to be free from sexual harassment and physical, sexual and psychological violence, including homophobia. This will require:
 - a. Developing and implementing policies on sexual and gender-based violence, including violence against women that specifically consider the needs of the staff members experiencing harassment and violence (whether inside or outside the workplace). This should include: taking time off work for medical, psychosocial support, and social benefits appointments; confidentiality; and security while at work.
 - b. Extending work-related considerations as the situation requires, including secure transport facilities for staff who work late hours and ensuring security measures along with minimum basic facilities for individuals travelling in the field and individuals at personal risk on the basis of their gender, sexual orientation or gender identity;
3. Gender should be mainstreamed into all IPPF programmes, budgets, strategic plans and policies and should be systematically monitored and evaluated at all levels of the Federation on a continuous basis.

Gender audit

4. Recognizing existing gaps and challenges in pursuit of IPPF's commitment to achieve gender equality in all aspects of the Federation's work, responsibility for implementation and oversight of this policy will include the following:
 - a. the implementation and reporting of progress will be the responsibility of staff (in Secretariat Offices and MAs);
 - b. the monitoring and oversight of implementation and progress and accountability for lack of progress is the responsibility of the respective governance structures (at Secretariat and MA levels);
 - c. gender audits should be conducted at all levels to establish baseline information and set targets that should be achieved in a defined period of time. The gender audit should assess: programme delivery; governance; recruitment; mainstreaming in the work place; sex disaggregated numbers of volunteers and employees; positions disaggregated by sex and salary; leave practices; work place safety practices, etc. Progress reports should be compared to baseline and shared within the relevant part of the organization and support learning across the Federation;
 - d. monitoring the gender balance across the Federation every three years to determine the Federation-wide gender representation at every level of the Federation, including Member Association Boards; Regional Councils, and Regional Executive Committees; IPPF Governing Council; IPPF Membership Committee; IPPF Audit Committee; Regional Offices, Central Office, and Member Associations.

Appendix 1: Glossary of terms

Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/ time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context.^{vii}

Gender audit refers to assessments of organizational performance on the promotion of gender equality, in order to instigate gender-related analysis and activity in organizations and programmes; monitor implementation of gender equality policy commitments; translating them into action and impact; documenting and disseminating good practice.^{viii}

Gender-based violence (GBV) is violence and discrimination that is directed at a person on the basis of sex, gender, gender identity or sexual orientation. Sexual and gender-based violence (SGBV) underlies the inequitable power relationships between women and men and affects women disproportionately but also affects men and boys to some extent. GBV is often used interchangeably with violence against women (VAW).^{ix} SGBV includes violence

vii United Nations Entity for Gender Equality and the Empowerment of Women, <http://www.un.org/womenwatch/osagi/conceptsanddefinitions.htm>

viii The Gender Manual: A Practical Guide, 2008, <https://www.k4health.org/toolkits/igwg-gender/gender-manual-practical-guide>

ix UN Declaration on the Elimination of Violence against Women (1993) uses GBV to definition violence against women in part, as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Article 1).'

and discrimination experienced by individuals on the basis of sexual orientation and gender identity.^x GBV is both a violation of human rights and a key barrier to sexual and reproductive health services

Gender equality means equality of opportunity for women, men, intersex and transgender people to realize their full rights and potential. It signifies an aspiration to transform structural inequalities, behaviour patterns and social norms, leading to social change and sustainable development. Gender equality requires specific strategies aimed at eliminating gender inequities.

Gender equity means justice and fairness. It is the process and gender equality is the result of that process. Gender equity recognizes that women, men, intersex and transgender individuals have different needs and historical and social disadvantages that hinder them from otherwise operating on a level playing field. Equity leads to equality.

Gender identity refers to an individual's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means, and other expressions of gender, including dress, speech, and mannerisms.^{xi} The gender identity of intersex and transgender individuals does not always match the sex assigned to them at birth. Transgender individuals generally choose to dress and present themselves as the gender with which they identify, rather than their birth-assigned sex. They may or may not choose to alter their body physically through hormones or surgery. Intersex and transgender people should be treated as the gender with which they identify, and referred to by their chosen name and pronoun.

Gender mainstreaming is the process of incorporating a gender perspective into policies, strategies, programmes, project activities, and administrative functions, as well as into the institutional culture of an organization.^{xii}

Gender-transformative policies and programmes aim to change gender norms and promote relationships that are fair and just. Gender-transformative programming aims to build equitable social norms and structures; advance individual gender-equitable behaviour; transform gender roles; create more gender equitable relationships; advocate for policy and legislative change to support equitable social systems.^{xiii}

Intersex refers to people whose biological makeup (genetic, hormonal and physical features) are neither exclusively male nor exclusively female, but are typically both at once or not clearly defined as either. These features can manifest themselves in secondary sexual characteristics such as muscle mass, hair distribution, breasts and stature; primary sexual characteristics such as reproductive organs and genitalia; and/or in chromosomal structures and hormones.^{xiv}

x UN Resolution on Human Rights, Sexual Orientation and Gender Identity, which brought a focus on human rights violations based on SOGI, particularly violence and discrimination.

xi UNAIDS, Terminology Guidelines, October 2012

xii Interagency Gender Working Group (IGWG), <https://www.k4health.org/toolkits/igwg-gender>

xiii IPPF, 'The Truth about Men and Boys: Gender Transformative Policies and Programmes', June 2009

xiv IPPF, http://ec.europa.eu/justice/discrimination/files/trans_and_intersex_people_web3_en.pdf

Transgender is an umbrella term referring to individuals whose gender identity and expression does not conform to norms and expectations traditionally associated with their sex assigned at birth. Transgender individuals may self-identify as transgender, female, male, transwoman or transman, transsexual, hijra, kathoey, waria or one of many other transgender identities, and may express their genders in a variety of masculine, feminine and/or androgynous ways.^{xv}

Sex refers to the biological and physiological characteristics that define men and women. Sex differences are concerned with males' and females' physiology. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females.^{xvi}

Sexual orientation refers to each person's capacity for emotional, physical and sexual attraction to, and intimate and sexual relations with, individuals of a different sex (heterosexual) or the same sex (homosexual) or more than one sex (bisexual).

Sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. A wider range of sexually violent acts can take place in different circumstances and settings.^{xvii}

As adopted by IPPF Central Council, November 1995

Last amended by IPPF Governing Council, May 2014

xv IPPF, http://srhhivlinkages.org/wp-content/uploads/2013/04/web_whatworks_india_en.pdf

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Annex 6.3 Strategy on adolescents and youth (UNFPA 2013)

UNFPA's commitment and contribution

In order to contribute to high quality outcomes for young people, UNFPA upholds the principles of accountability to key stakeholders especially young people, delivery through partnerships, respect for diversity with a focus on the most disadvantaged, and tailoring actions to national and local contexts.

With offices in 140 countries, specialized expertise in demography and in sexual and reproductive health and rights and partnering with others in the UN system, UNFPA's contribution to the advancement of adolescents and youth has five strategic prongs:

Enable evidence-based advocacy for comprehensive policy and programme development, investment and implementation

- UNFPA compiles and analyses (and assists countries to generate and analyse) population and development data. These data are then deployed by countries, UNFPA, and our partners, to support and advocate for effective policies, programmes and investments across a range of sectors and at national, regional and global levels. The data and analysis enable partners and governments to also focus on the inter-relationships among various interventions for adolescents and youth and to encourage and support cross-sectoral collaboration to achieve common goals.

Promote comprehensive sexuality education

- Adolescents and youth have a right to the education and skills building as they experience physical and emotional maturation; begin relationships; and face decisions about sexual activity, substance use, diet and exercise: decisions that will affect their life-long physical and mental health and well-being.
- While sexuality education exists in most countries, it tends to be limited and rarely meets the standard described in international agreements and the relevant UNESCO guidelines. Curricula urgently need to be initiated or modified to include all the necessary topics, and to support skills building for sustainable relationships, communities and societies. Sustainability in this context relies on gender equality, mutual consent, non-violence and respect for human rights. Training of teachers and other providers must be enhanced so that they are: comfortable with the topics involved; supportive, rather than judgmental, of young as well as older adolescents; able to provide accurate and full information; and equipped to refer young people to appropriate health services.
- In collaboration with UNESCO, among other partners, UNFPA assists countries with: curriculum development for comprehensive sexuality education; provider training; monitoring and evaluation; and scaling-up of effective programmes.

Build capacity for sexual and reproductive health service delivery (including HIV prevention, treatment and care)

- UNFPA assists policy makers, service administrators and providers to improve their outreach to young people, and to strengthen their services so that young people will be comfortable using them.
- UNFPA provides tailored technical inputs, and supports relevant training of personnel, across all levels of the health system so that these systems better serve the young. With our partners, we work to leverage funds and priorities – at both national and global levels – for improvements in health systems, service delivery and expansion. These activities that UNFPA supports vary within and across countries, but all share the goals of improved quality and integration in all sexual and reproductive health services, including HIV prevention, treatment and care.

Take bold initiatives to reach marginalized and disadvantaged adolescents and youth, especially girls

- Millions of adolescent girls and young women live in deep poverty. With perhaps only one or no parent; married to a much older or abusive man; labouring in unsafe occupations such as domestic service or commercially sexually exploited (adolescent and youth under 18 years of age), engaged in sex work (those 18-24 years of age); as migrants or affected by conflict or disaster – young women and girls are commonly at the highest risk of poor sexual and reproductive health, violence and exploitation. For effective HIV prevention amongst young people, focus and priority should be placed on “young populations at higher risk of exposure”: defined as those already engaging in high risk behaviours (injecting drug users, young women and men involved in sex work and young men who have sex with men). Focusing on delivery to and support for these – the most marginalized, the poorest and the most vulnerable – is not only the right thing to do, it is the smart thing to do.

Promote youth leadership and participation

- A great deal is said in many quarters about the importance of youth participation and voice. In reality however, youth, especially girls and young women, rarely have opportunities to train and act as leaders or as advocates in places where the decisions that will affect their lives and their human rights are made.
- UNFPA actively consults with and engages young people in its own work and advocates for this in the work of others. Just as importantly, UNFPA also provides financial and technical support to adolescents and youth who are in the process of building networks and organizations, and are undertaking advocacy on behalf of adolescents and youth. UNFPA targets and prioritizes gender-equal inclusion of youth from diverse backgrounds, particularly the disadvantaged and marginalized.



Abbreviations and endnotes

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CSE	Comprehensive sexuality education
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MA	Member Association (of IPPF)
MSM	Men who have sex with men
NGO	Non-governmental organization
NSV	No-scalpel vasectomy
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund

Endnotes

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