



# GUIDE FOR PROMOTING SEXUAL AND REPRODUCTIVE HEALTH PRODUCTS AND SERVICES FOR MEN

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**Cover Photo:** The Uganda Health Marketing Group (UHMG), in partnership with the Strengthening TB and HIV/AIDS Response in eastern-central Uganda (STAR-EC), with funding from USAID, conduct a condom promotion for the Protector brand at a rural fisher community. © 2012 Kim Burns Case/JHUCCP, Courtesy of Photoshare.

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## ACRONYMS

<b>ACQUIRE</b>	Access, Quality and Use in Reproductive Health Project
<b>ART</b>	Antiretroviral Therapy
<b>ASSIST</b>	Applying Science to Strengthen and Improve Systems Project
<b>CBFP</b>	Community-based Family Planning Programs
<b>CBO</b>	Community-based Organizations
<b>CCP</b>	Johns Hopkins Center for Communication Programs
<b>CHTS</b>	Couples HIV Testing Services
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CQI</b>	Continuous Quality Improvement
<b>FP</b>	Family Planning
<b>FIFA</b>	Fédération Internationale de Football Association
<b>GVI</b>	Ghana Vasectomy Initiative
<b>HC3</b>	Health Communication Capacity Collaborative
<b>HCD</b>	Human-Centered Design
<b>HIV</b>	Human Immunodeficiency Virus
<b>HTC</b>	HIV Testing and Counseling
<b>HTS</b>	HIV Testing Services
<b>HPV</b>	Human Papillomavirus
<b>IEC</b>	Information Education Communication
<b>I-Kit</b>	Implementation Kit
<b>IPC</b>	Interpersonal Communication
<b>IPPF</b>	International Planned Parenthood Federation
<b>ITAP</b>	Innovations in Family Planning Services Technical Assistance Project
<b>IUD</b>	Intrauterine Device
<b>JHHESA</b>	Johns Hopkins Health and Education South Africa
<b>LMIC</b>	Low- and Middle-Income Countries
<b>LCI</b>	Learning Center Initiative
<b>MC</b>	Male Circumcision
<b>mCPR</b>	Modern Contraceptive Prevalence Rate
<b>mHealth</b>	Mobile Health
<b>MOH</b>	Ministry of Health
<b>MSI</b>	Marie Stopes International
<b>MSM</b>	Men Who Have Sex with Men
<b>NBA</b>	National Basketball Association
<b>NGO</b>	Non-Governmental Organization
<b>NSV</b>	No-Scalpel Vasectomy
<b>PBC</b>	Provider Behavior Change
<b>PEPFAR</b>	The President's Emergency Plan for AIDS Relief
<b>PLHIV</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>PRO-PATER</b>	Promocão de Paternidade Responsável
<b>PSI</b>	Population Services International
<b>RESPOND</b>	Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services Project
<b>RMNCH</b>	Reproductive, Maternal, Newborn and Child Health
<b>RMNCH+A</b>	Reproductive, Maternal, Newborn and Child Health + Adolescent Health
<b>SBC</b>	Social and Behavior Change
<b>SDG</b>	Sustainable Development Goal
<b>SEED</b>	Supply-Enabling Environment-Demand

<b>SIDHAS</b>	Strengthening Integrated Delivery of HIV/AIDS Services
<b>SMS</b>	Short Message Service
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually Transmitted Infection
<b>UHI</b>	Urban Health Initiative
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>URC</b>	University Research Co, LLC
<b>USAID</b>	United States Agency for International Development
<b>VMMC</b>	Voluntary Medical Male Circumcision
<b>WINGS</b>	Women's International Network for Guatemalan Solutions
<b>WHO</b>	World Health Organization

## EXECUTIVE SUMMARY

Achieving universal access to sexual and reproductive health (SRH) products and services is fundamental to empowering women and men with the tools to live healthy lives and fulfill their reproductive intentions. As a key component of Sustainable Development Goal (SDG) 3 – to ensure healthy lives and promote well-being for all at all ages – universal access to SRH products and services plays an important role in preventing unplanned pregnancies, reducing maternal and newborn mortality and controlling and ending the HIV epidemic.

Multiple global initiatives, including the SDGs and Family Planning 2020 (FP2020), focus on increasing access to and utilization of SRH products and services; however, they largely focus on women and youth, often forgetting men have their own SRH needs and are important end-users of these products and services too. As a result, men's use of SRH products and services in low- and middle-income countries (LMIC) often lags behind women's use.

The *Guide for Promoting Sexual and Reproductive Health Products and Services for Men* focuses on meaningfully engaging men and creating an enabling environment to increase men's use of SRH products and services. Drawing on lessons learned from the promotion of male condoms, vasectomy, voluntary medical male circumcision (VMMC), HIV testing services (HTS) and sexually transmitted infection (STI) testing and treatment, the guide provides guidance, resources and examples of approaches that have increased men's use of SRH products and services in a variety of settings.

In the guide, you will learn about programs that have successfully addressed harmful social and gender norms, which have traditionally excluded men from fully participating in their SRH care. You will also learn how programs have addressed beliefs and misinformation, and built social support for men's use of SRH products and services using a variety of social and behavior change (SBC) approaches.

The guide highlights key considerations for developing SBC strategies and activities for increasing men's SRH, including:

- Developing an SBC strategy;
- Developing a deeper understanding of audiences;
- Segmenting audiences for better messaging;
- Tailoring messages to the life stages of men;
- Engaging women as partners and mothers;
- Promoting couples communication;
- Using gender transformative programming;
- Utilizing peer educators and mentors;
- Engaging community and religious leaders;
- Using technology: mobile health (mHealth), hotlines and social media;
- Providing high-quality comprehensive counseling;
- Branding SRH products and services for men;
- Using client testimonials and engage male champions; and
- Considering the timings and design of communication campaigns.

By compiling lessons learned and key considerations for working with men, the *Guide for Promoting Sexual and Reproductive Health Products and Services for Men* is an essential resource for anyone working to achieve universal access to SRH products and services and improve health outcomes for men.

## ABOUT THE GUIDE

The *Guide for Promoting Sexual and Reproductive Health Products and Services for Men*, referred to hereafter as “the Guide,” provides guidance and recommendations for developing strategic communication interventions and activities to increase men’s demand for and utilization of sexual and reproductive health (SRH) products and services.

### WHAT IS THE PURPOSE OF THIS GUIDE?

The primary objective of the Guide is to support program managers and implementers in developing evidence-informed social and behavior change (SBC) interventions designed to increase men’s demand for and use of SRH products and services. The guidance and resources in this Guide will help program managers and implementers develop strong, tailored communication programs to better reach men with appropriate messaging and calls to action, while successfully raising knowledge about SRH products and services, dispelling misinformation and transforming harmful social and gender norms, ultimately leading to better health outcomes.

### WHO IS THIS GUIDE FOR?

Program managers and communication professionals can use this Guide to reach men in low- and middle-income countries (LMIC) with SRH information, messages, products and services. Staff from ministries of health (MOH), non-governmental organizations (NGOs) and community-based organizations (CBOs) will find relevant resources, guidance and examples to support their work to reach and engage men as users of SRH products and services.

While all levels of public health professionals can benefit from the Guide’s guidance, resources, tools and examples, the Guide assumes users have a basic knowledge of SBC key concepts; however, the Guide includes links to key resources for those who need more information on basic SBC concepts.

### WHAT DOES THE GUIDE INCLUDE?

The Guide highlights lessons learned, best practices and key insights from programmatic experience in the promotion of male condoms, vasectomy, voluntary medical male circumcision (VMMC), human immunodeficiency virus (HIV) testing and treatment and sexually transmitted infection (STI) testing and treatment services for men.

This Guide focuses on highlighting what is unique about reaching and engaging men to increase their utilization of SRH products and services and improve their health outcomes. The Guide does not include step-by-step guidance on how to develop an SBC communication strategy, as the process for developing an SBC strategy is the same as for other audiences or health areas. References and links to other resources for developing a strategy are included throughout the Guide and in the **Resources and Tools** section.

The Guide is organized into four sections:

**Section 1: Overview of SRH Products and Services for Men:** An examination of why the Guide focuses on engaging men as users of SRH products and services, and an overview of SRH products and services for men.

**Section 2: Influencing Behavior to Increase the Utilization of SRH Products and Services by Men:** An overview of the multiple levels that influence men’s use of SRH products and services, and the role SBC plays across the SRH continuum of care – getting men to products and services, improving the client experience during service delivery and product purchase and supporting behavioral maintenance after service delivery or product purchase.



**Section 3: Key Considerations for Increasing Utilization of SRH Products and Services by Men:** A summary of key considerations, lessons learned and emerging practices that should be considered when designing future SBC programs to increase men’s demand for and utilization of SRH products and services.

**Section 4: Resources and Tools:** Links to resources, additional guidance and useful tools to assist in the development of strategic SBC promoting SRH products and services for men.

## **HOW WAS THE GUIDE DEVELOPED?**

The Guide was developed by the Health Communication Capacity Collaborative (HC3) Project, led by the Johns Hopkins Center for Communication Programs (CCP), in partnership with Population Services International (PSI), one of the core partners on the HC3 Project. The Guide draws on proven practices from existing programs and research on promoting male condoms, vasectomy, VMMC, HIV testing services (HTS) and STI testing and treatment services to men in LMIC.

To inform the development of the Guide, HC3 reviewed literature reviews conducted by FHI360/Evidence and Population Council on lessons learned in creating demand for and increasing use of vasectomy and SRH services for men respectively, and conducted a rapid review of peer-reviewed and grey literature on the promotion of and demand generation for SRH products and services for men.

# SECTION 1: OVERVIEW OF SRH PRODUCTS AND SERVICES FOR MEN

Over the past three decades, SRH programs in LMICs have dramatically expanded access to and use of SRH products and services. These programs have traditionally focused on women of reproductive age, and often include male partners as influential decision makers; however, many programs have not focused directly on men as end-users themselves.

Globally, men's use of SRH products and services is significantly less than women's use. In 2013, the modern method contraceptive prevalence rate (mCPR) was 56 percent in LMICs, with male methods (such as male condoms and vasectomy) accounting for only 8 percent of the mCPR (6.3 percent and 1.9 percent, respectively). In the least developed countries, male methods account for only 3 percent (male condoms 2.7 percent and vasectomy 0.7 percent) of the mCPR of 30 percent.<sup>1</sup> In a study of 29 countries in Africa, the median national uptake of HTS was 28.8 percent for women and 17.2 percent for men.<sup>2</sup> Further, compared to women, men continue to access care at later stages of HIV infection. A global review based on 36 studies found that being a heterosexual male was a consistent risk factor for presenting with low CD4 counts, resulting in worse outcomes for men once enrolled in treatment. Additional evidence demonstrates that once men initiate antiretroviral therapy (ART), they often have lower retention and worse treatment adherence.<sup>3,4,5</sup>

Multiple barriers prevent a man's use of SRH products and services, including: a lack of awareness, knowledge or access to products or services; negative beliefs and misinformation; and social and gender norms (including norms around men's fertility and roles and responsibilities for reproduction and family planning). Gender norms, for example, are important determinants of decisions to undergo HTS and subsequent progression through the HIV care pathway.<sup>6</sup> Men often avoid health facilities due to the belief that going to them displays weakness, embarrasses them and compromises their leadership position – all potentially degrading internal perceptions of masculinity. Social norms regarding care-seeking and disclosure of HIV status present significant barriers to access and adherence for men.<sup>7</sup>

Strategic communication activities can address these issues by raising awareness of, increasing knowledge about and reducing normative barriers to men's utilization of SRH products and services.

The Guide focuses on men as a general population, providing guidance and relevant program examples that are generalizable and can be applied to diverse segments of men across different regions and countries. Where appropriate, links to resources for reaching specific populations have been included, such as resources for reaching youth.

## WHAT IS SEXUAL AND REPRODUCTIVE HEALTH?

According to the United Nations Population Fund (UNFPA), "good SRH is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so."<sup>8</sup> Good SRH depends on equal access to accurate SRH information and high-quality, affordable SRH products and services for men, women and other gendered groups (i.e., individuals who identify as transgender, intersex, third gender, etc.), as well as autonomy in sexual and reproductive decision-making.

## SRH PRODUCTS AND SERVICES FOR MEN

While most SRH products and services focus on women as the end-users, a growing number of SRH products and services are available to provide men with the ability to space or limit pregnancies, prevent and treat STIs, prevent and treat HIV and improve their SRH. This Guide focuses on five of these products and services: male condoms, vasectomy, VMMC, HTS and STI testing and treatment.

Some additional SRH products and services for men are not included in the Guide due to their limited availability in LMIC and/or limited research on their use in these settings. These include products and services for infertility, impotence, male reproductive system cancers and psychosocial sexual health. However, as mentioned above, the Guide is generalizable and may be applied to the development of strategic communication interventions and activities for these other products and services.

### Male Condoms

A male condom is a thin latex or polyurethane sheath that is placed over the entire shaft of the penis to prevent pregnancy and reduce the risk of transmitting and acquiring STIs, including HIV.

Male condoms, when used correctly and consistently, are effective at preventing pregnancy by preventing semen from entering a woman's vagina during sexual intercourse; thereby preventing sperm from fertilizing an egg. Similarly, male condoms prevent the transmission of STIs during oral, vaginal and anal sex by preventing the exchange of semen and vaginal fluids and reducing skin-to-skin contact with mucosal surfaces, all known pathways for the transmission of various STIs.

Under typical use (i.e., using a condom during most, but not every, sex act), male condoms have a pregnancy failure rate of 18 percent. This means that 18 of every 100 men who use only male condoms during sexual intercourse will have a female partner who experiences an unplanned pregnancy in a year. **This percentage can be reduced to two percent, if male condoms are used correctly and consistently with every sex act.**<sup>9</sup>

Male condoms, when used correctly and consistently, are 90 to 95 percent effective at preventing HIV transmission between HIV discordant couples (couples in which one person is infected with HIV and the other is not). Under typical use, the effectiveness of male condoms at preventing HIV transmission is reduced to 79 percent.<sup>10</sup>

With regards to other STIs, male condoms are most effective at preventing STIs that are transmitted via semen and vaginal fluids, including gonorrhea, chlamydia and trichomoniasis. Male condoms are less effective at preventing STIs that are primarily transmitted through skin-to-skin contact, such as genital herpes, syphilis, chancroid and human papillomavirus (HPV).<sup>11</sup> This is due to the fact that male condoms do not prevent all skin-to-skin contact; however, male condoms are still highly recommended for STI prevention as they do reduce the risks of transmission and acquisition.

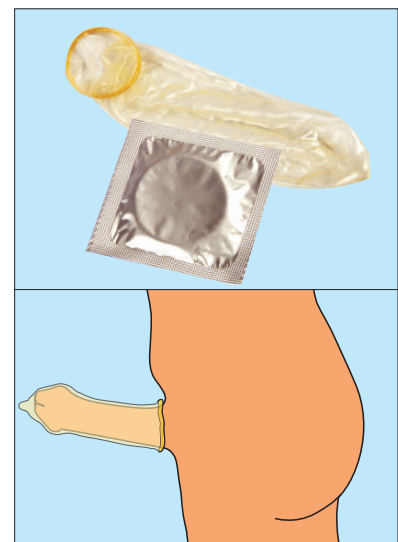


Image 1: Illustration of male condom

### Vasectomy

Vasectomy is a permanent, surgical form of male sterilization. During vasectomy, the vas deferens – the tubes that carry sperm from the testicles to the penis – are tied, severed or otherwise sealed to prevent sperm from mixing with seminal fluid. Instead, the sperm are absorbed by the body and are not released during ejaculation. As a result, the seminal fluid of a man who has undergone a vasectomy does not contain sperm and therefore is unable to fertilize an egg.

Vasectomy is one of the most effective modern methods of contraception, with a pregnancy failure rate of approximately 0.15 percent. This means that in the first year after vasectomy, less than one of every 100 men who have undergone vasectomy will have a female partner who experiences an

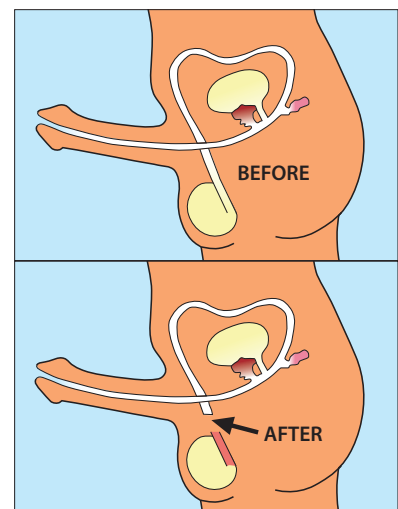


Image 2: Illustration of vasectomy

unplanned pregnancy.<sup>12</sup>

Vasectomy is safer and more cost effective than surgical female sterilization with tubal ligation because it is generally a much shorter procedure, does not normally require an incision and requires less recovery time than tubal ligation.<sup>13</sup>

While a highly effective form of contraception, vasectomy does not prevent STIs, including HIV.

### **Voluntary Medical Male Circumcision**

VMMC refers to the complete removal of the penile foreskin. It is the only permanent, surgical intervention used for HIV prevention and is highly effective at preventing new HIV infections in males. Three randomized controlled trials have shown VMMC reduces men's risk of HIV infection from vaginal intercourse by at least 60 percent.<sup>14,15,16</sup> VMMC has been proven to reduce HIV transmission to males exposed to the virus through vaginal intercourse with HIV-infected females. Although VMMC has not been proven to reduce HIV transmission from HIV-infected males to their female sexual partners, as more males get circumcised in the community, the likelihood of them being HIV infected is reduced, therefore reducing the HIV infection risk to women.

In addition to effectively reducing the risk of heterosexual transmission of HIV from females to males during vaginal intercourse, VMMC provides other health benefits to men and women, including reducing HPV, genital ulcer disease, bacterial vaginosis and trichomoniasis among female partners while also reducing the risk of penile cancer in men.<sup>17</sup>

In recognition of the potential of VMMC to reduce new HIV infections, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) promote VMMC for HIV prevention in countries with high HIV prevalence and low male circumcision coverage. Since 2007, the scale up of VMMC for HIV prevention has been prioritized in 14 countries in Southern and Eastern Africa, including Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe.<sup>18</sup>

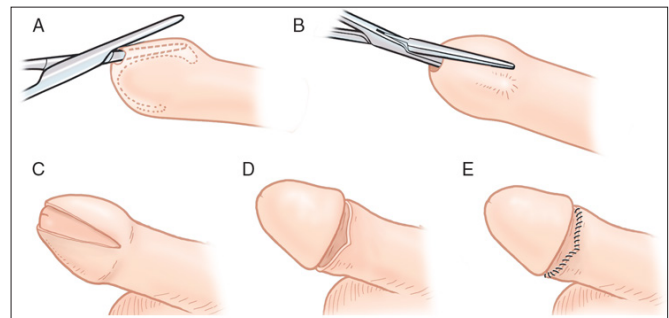


Image 3: Illustration of VMMC using Dorsal Split method

### **HIV Testing Services**

In 2015, men accounted for approximately 49 percent of all adults (age 15 and above) living with HIV worldwide. Of the estimated 1.9 million new HIV infections reported in 2015, 53 percent of the infections were among men.<sup>19</sup> HTS is an important component of the continuum of HIV prevention, care and treatment services. HTS is the entry point for individuals to know their HIV status while becoming educated about HIV and their own risk behaviors, and to be linked to care and treatment, if HIV positive.

HTS includes pre-test information, quality HIV testing (using either a rapid or laboratory test), post-test counseling and linkages to appropriate HIV



Image 4: Man receiving HTS during an outreach event

prevention, care and treatment services and other clinical and support services, as needed.

HTS should follow the WHO's five essential standards<sup>20</sup>:

1. **Consent:** Men receiving HTS must give informed consent to be tested and counseled. They should be informed of the process and of their right to decline testing.
2. **Confidentiality:** HTS is provided in a confidential manner, meaning that what the provider and a man discuss will not be shared with anyone else without the expressed consent of the man being tested. Although confidentiality should be respected, it should not reinforce secrecy, stigma or shame. Providers should discuss with whom a man may want to inform of his results (i.e., his wife, girlfriend, sexual partners, family members and friends), how they would like this to be done, etc.
3. **Counseling:** HTS must be accompanied by appropriate, high-quality pre-test and post-test counseling. Quality assurance mechanisms and supportive supervision and mentoring systems should be utilized to ensure high-quality counseling.
4. **Correct test results:** Providers should provide high-quality testing services, and quality assurance mechanisms should be in place to ensure the correct test results are given to men being tested.
5. **Care and treatment services:** HTS should provide linkages to prevention, care and treatment services. This includes the provision of effective referrals to follow-up services as indicated, including long-term prevention and ART support.

### **STI Testing and Treatment**

STIs include more than 30 bacterial, viral and parasitic infections that are predominantly transmitted from person-to-person during oral, vaginal or anal sex. Some STIs can also be spread via blood and from mother-to-child during pregnancy and childbirth.

Globally, more than one million men and women acquire a STI each day.<sup>21</sup> The eight most common STIs globally are chlamydia, gonorrhea, syphilis, trichomoniasis, hepatitis B, human papillomavirus, herpes simplex virus and HIV. Of these eight STIs, four are curable (chlamydia, gonorrhea, syphilis and trichomoniasis) and four are treatable, but no cure currently exists (herpes simplex virus, HIV, hepatitis B and HPV). Effective vaccines exist to prevent hepatitis B and some strains of HPV.<sup>22</sup>

STI testing and treatment services are an important health service for ensuring the SRH of men. Untreated STIs in men can lead to serious long-term health consequences, including infertility, increased risk of HIV acquisition, penile cancer, prostatitis, epididymitis and reactive arthritis.<sup>23</sup>

Since many STIs are asymptomatic in men, STI testing and treatment services for men also have important health implications for women. Routine untreated STIs in men place their female sexual partners at greater risk of acquiring a STI. In women, untreated STIs can lead to serious long-term health consequences, including infertility, increased risk of HIV acquisition, female reproductive system cancers (cervical, vagina and vulva), pelvic inflammatory disease, ectopic pregnancy and, if acquired during pregnancy, spontaneous abortion and infections in newborns.<sup>24</sup>



*Image 5: Man receives STI counseling*

### **What Is Unique about Reaching Men?**

While the process for developing SBC strategies and activities are the same for reaching men and women, there are unique characteristics that should be considered when reaching men:

- Men seldom use health care. Unlike women who have frequent interactions with health care providers for maternal and child health needs, men have very few touch points with health care providers.
- SRH has been traditionally seen as a women's sphere, with products, services and clinical settings designed with women in mind. There is a need to reframe SRH as being gender equitable, with both men and women feeling empowered to use these products and welcome at services.
- Since men typically spend a majority of their time outside of the home, either at work or in social settings, it is important to bring communications and SBC activities to men where they work and spend their free time.
- Due to the social and gender norms that create stigma around men's use of SRH products and services, technology (i.e., smartphones, social media, etc.) allows men to access information about SRH products and services in a confidential and private manner, in a place and time that is convenient for them.
- Many men enjoy sports. Sports can be used to both reach men in person (when they are participating in sporting events), as well as through mass media during sporting competitions (when men are watching or listening to sports on the television or radio).
- In order to normalize men's use of SRH products and services, SBC messages are best delivered using multiple channels, with repeated use of the same key messages. Messages should be focused not only on men, but also influencing audiences – such as wives and female sexual partners, family members and peers, and religious and community leaders – to create an enabling environment.

### ***What Motivates Men to Use SRH Products and Services?***

The programmatic examples included in this guide provide illustrative examples that highlight the key motivators for engaging men in the use of SRH products and services. In developing SBC strategies and activities, these motivators should be considered and leveraged, as applicable:

- Economic benefits of SRH products and services; men are better able to provide for themselves and their families
- Health benefits of SRH products and services; the use of SRH products and services provide protection against STIs, including HIV, avoid unintended pregnancies and space child births
- Benefits of men's use of SRH products and services on the health of women and children, including reduced maternal and newborn mortality
- Increased sexual satisfaction or pleasure as a result of using a SRH product or service
- Positive support from peers and/or partner (i.e., wife or female sexual partners)
- Positive social and gender norms around men's use of SRH products and services – social acceptability
- Providing SRH products and services in places and at times that are convenient for men to access
- Accurate and detailed information about what to expect during and after a SRH clinical service or product use, including openly and honestly addressing concerns associated with pain and abstinence periods following SRH services
- Addressing the perceptions of men's use of a SRH product or service on concepts of sexuality, masculinity and role in the family
- Reduced cost of accessing SRH products and services – not only monetary costs for service fees and transportation, but also opportunity costs for time away from work
- Age-appropriate counseling and messaging
- Providers and clinical staff trained to provide male-friendly health services

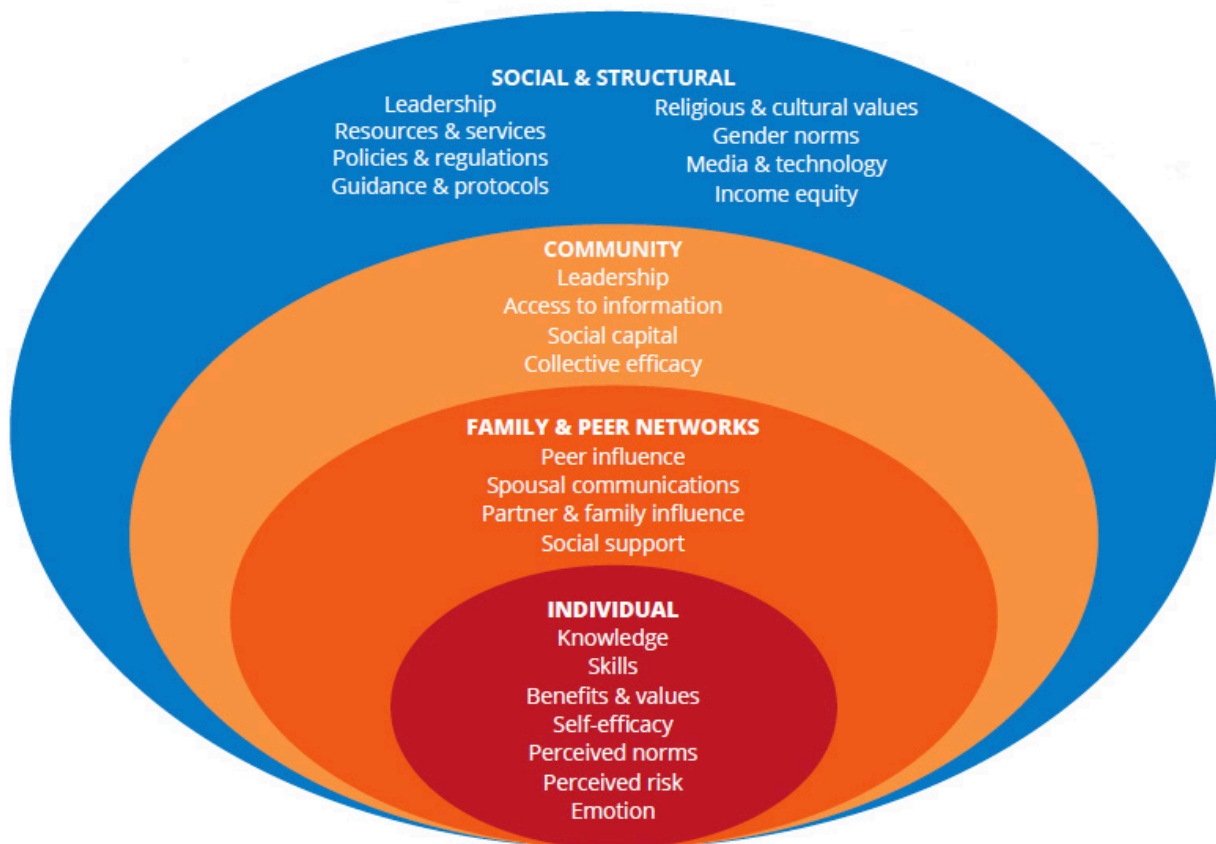
## SECTION 2: INFLUENCING BEHAVIOR TO INCREASE THE UTILIZATION OF SRH PRODUCTS AND SERVICES BY MEN

This section highlights various SBC approaches that have been used to increase men’s demand for and use of SRH products and services. By taking a holistic view of men – one which takes into account the external environment and actors that influence men’s decision-making – SBC strategies have been designed to address and decrease barriers, transform social and gender norms, and create an enabling environment that supports and promotes men’s SRH. Examples of interventions that have worked to promote and sustain men’s use of SRH products and services before, during or after service delivery or product purchase are highlighted.

### WHAT INFLUENCES BEHAVIOR?

A person’s behavior is influenced on many levels – it could be something an individual learns on his own, or learns from a family member or friend, or could be encouraged or limited by his access to health products or services, or the way his culture expects him to act given his gender and role in society. These levels of influence are displayed in the Socio-Ecological Model (see **Figure 1**).<sup>25,26</sup> This approach recognizes that behavior change can be achieved through activities that take place at four levels: the individual, family and peer networks, community, and structural and policy.

**Figure 1: Socio-Ecological Approach**



The Socio-Ecological Model is helpful when designing an SBC strategy for promoting SRH products and services for men. To most effectively change behaviors, communication efforts should address factors at each level, thereby creating an enabling environment in which men’s use of SRH products and services is promoted, reinforced and ultimately practiced.

At each socio-ecological level, there are factors affecting behavior in a positive way (i.e., facilitators) and factors affecting behavior in a negative way (i.e., barriers). **Table 1** lists examples of potential barriers and facilitators for men’s uptake of SRH products and services, and the intervention that addressed them.

**Table 1: Potential Barriers and Facilitators for SRH Products and Services at Different Levels of the SEM**

Level	Examples of Potential Barriers	Examples of Facilitators	Examples of Interventions
<b>Individual</b>	<ul style="list-style-type: none"> <li>• Lack of knowledge regarding vasectomy, VMMC, HTS or STIs</li> <li>• Fear of pain associated with vasectomy or VMMC</li> <li>• Beliefs and misinformation regarding vasectomy and VMMC (i.e., negative effects on sexual pleasure, sexual performance or ejaculation)</li> <li>• Lack of self-efficacy to use SRH products and services</li> </ul>	<ul style="list-style-type: none"> <li>• Family planning (FP) can enhance the lives of men and their ability to care for their families</li> <li>• Pain associated with vasectomy and VMMC can be managed with medication and care measures</li> <li>• Interpersonal communication (IPC) and comprehensive counseling can address beliefs and misinformation</li> </ul>	<ul style="list-style-type: none"> <li>• Employer-based Outreach Initiative, India (page 21)</li> <li>• STI Testing and Treatment Program, Nigeria (page 23)</li> <li>• Dancing Hearts campaign, Brazil (page 25)</li> <li>• Brothers for Life Short Message Service (SMS) Initiative, South Africa (page 26-27)</li> <li>• Strengthening Integrated Delivery of HIV/AIDS Services, Nigeria (page 36)</li> </ul>
<b>Family and Peer Networks</b>	<ul style="list-style-type: none"> <li>• Familial pressure to have a large family</li> <li>• Peer pressure to engage in risky sexual activities</li> <li>• Lack of peer support for vasectomy, VMMC, HTS or male condoms</li> <li>• Wife/girlfriend suspicious of vasectomy, fears man will cheat if pregnancy is no longer possible</li> <li>• Wife/girlfriend suspicious of VMMC, fear man is having sex with other women if he needs to protect himself from HIV</li> </ul>	<ul style="list-style-type: none"> <li>• Wives/girlfriends are supportive of men’s use of SRH products and services</li> <li>• Peer support for the use of SRH products and services by men</li> </ul>	<ul style="list-style-type: none"> <li>• Family Planning Results Initiative, Kenya (page 18)</li> <li>• Dancing Hearts campaign, Brazil (page 25)</li> </ul>
<b>Community</b>	<ul style="list-style-type: none"> <li>• Lack of community support for men playing a role in FP</li> <li>• FP seen as a woman’s responsibility</li> <li>• SRH seen as a “woman’s arena”</li> <li>• Masculinity linked to a man’s virility and the number of children he has and his ability to have more children</li> <li>• Religious and traditional leaders who oppose the use of modern FP methods</li> </ul>	<ul style="list-style-type: none"> <li>• Social norms that support men’s use of SRH products and services</li> <li>• Gender norms that support men’s use of SRH products and services</li> <li>• Religious and traditional leaders who champion men’s involvement in FP</li> </ul>	<ul style="list-style-type: none"> <li>• Family Planning Results Initiative, Kenya (page 18)</li> </ul>



<b>Structural and Policy</b>	<ul style="list-style-type: none"> <li>• Lack of trained providers at local health clinics to perform vasectomy, VMMC, HTS or STI testing and treatment</li> <li>• Stockouts of medical supplies or medicines</li> </ul>	<ul style="list-style-type: none"> <li>• Trained providers available at the local health clinics to perform SRH clinical services</li> <li>• Clinics located in places and open at times that are convenient for men</li> </ul>	<ul style="list-style-type: none"> <li>• Ghana Vasectomy Initiative, Ghana (see page 30)</li> <li>• Supportive Supervision (see page 34)</li> </ul>
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## SOCIAL AND GENDER NORMS

Social and gender norms play key roles in the demand for and use of SRH products and services by men across the four levels of the Socio-Ecological Model. When designing an SBC strategy, it is important to understand the social and gender norms that influence men and how they can create barriers or facilitators to behavior change. Norms that create barriers will need to be reduced or addressed in order to create an enabling environment and strengthen men’s self-efficacy to use SRH products and services. At the same time, norms that facilitate men’s health-seeking behaviors should be leveraged and supported.

### Social Norms

**Social norms** are unwritten rules that dictate what behaviors are acceptable within a society or individual group. The ways in which the majority of individual’s think and act often become the norms within that group and the expectation is that all members of that society will adhere to or adopt the same behaviors. Social norms not only specify which behaviors are acceptable, but also penalize behaviors that do not follow the norms. Those who do not conform to social norms often face disapproval or ridicule from peers and family or discrimination by community members and, in extreme cases, they can experience marginalization or exclusion from their peers and community. Fear of negative consequences for not conforming to social norms can be a strong motivating factor that prevents individuals from adopting new behaviors or challenging accepted norms within the group.

Promoting SRH products and services for men often requires addressing social norms that are either in direct or indirect opposition to these behaviors. In many societies around the world, the definition of masculinity and gender norms surrounding men’s fertility and their roles and responsibilities for reproduction and FP represent significant barriers to men’s utilization of SRH products and services. For example, in Tanzania, FP is seen as a woman’s responsibility. While men are key decision makers about the use of FP, they rarely use the FP methods, rather relying on their wives or female partners to select a particular method (once the decision to use FP has been made).<sup>27</sup> In other societies, the social construct of masculinity is tied to a man’s ability to reproduce. In these cultures, the promotion of vasectomy can be challenging, as permanently preventing a man’s ability to reproduce is in direct opposition to a defining characteristics of what it means to be a “man.” In Rwanda, for example, a common belief is that once a man undergoes a vasectomy, he will become a woman.<sup>28</sup>

When it comes to HIV-related services, gender and social norms can influence HTS uptake and adherence to ART. For example, South African men reported fear of becoming a burden and no longer being able to fulfill their role as a provider as reasons for not testing.<sup>29</sup> Prevalent gendered attitudes and norms can lead to delays in seeking ART and in loss to healthcare services. A study in Malawi found that widely held concepts of masculinity and femininity strongly inhibit willingness to seek care.<sup>30</sup> In Burkina Faso, gendered values attached to femininity motivate women to seek care, whereas gender norms inhibit men from seeking care early, which also places their partners at risk of HIV infection.<sup>31</sup> Community-level stigma can also inhibit adherence. In Zimbabwe, for example, many men struggle to adhere to ART because they avoid clinics identified as “AIDS clinics” by their community.<sup>32</sup> That said, social support can be equally supportive for adherence to ART and retention in care. Social support is critical in encouraging people living with HIV (PLHIV) to adhere to treatment and remain in care. Networks of family members, friends, CBOs and employers are important in supporting adherence and retention in care for both men and women.<sup>33,34,35,36,37,38</sup>

Addressing social norms that prevent the use of SRH products and services by men is challenging and requires communication programs to focus on each level of the Socio-Ecological Model, not only on the individual, but also on interpersonal relationships, as well as the community and society. Changing social norms is a slow process, requiring collective change in the way men’s involvement in SRH is viewed and defined. If most men do not use SRH products and services, this will continue to create social pressure not to use them. Conversely, if social norms support men’s use of SRH products and services, then these positive behaviors can increase.

**The HC3 Gender and SBC Communication I-Kit**

The HC3 [Gender and SBC Communication I-Kit](#) provides a step-by-step approach to integrating gender into an existing SBC strategy or marketing plan. This I-Kit is designed to help users understand gender concepts, theories and frameworks, assess the current level of gender integration in a project and use a series of tools to uncover new information that can be applied to an existing SBC strategy or marketing plan.

**Gender Norms**

Social norms surrounding gender dictate what it means to be a “man” or a “woman” in a society. These **gender norms** set forth the acceptable characteristics for how men and women look, act and behave within a society. Similarities and differences in gender norms will vary within and between societies.

Men and women who do not conform to the gender norms associated with their gender can be met with rejection, prejudice and stigma. For example, if a man takes on gender roles typically associated with women, he may not be seen as a “real man.”

Some common gender norms that can present barriers to promoting SRH products and services to men are illustrated in **Table 2**.

**Table 2: Examples of Common Gender Norms**

Male Gender Norms	Female Gender Norms
<ul style="list-style-type: none"> <li>• Avoid or rarely use medical care</li> <li>• Responsible for deciding if FP is used</li> <li>• Sexually assertive</li> <li>• Independent</li> <li>• Virility and masculinity tied to ability to reproduce</li> </ul>	<ul style="list-style-type: none"> <li>• Responsible for raising children</li> <li>• Responsible for the health of the family</li> <li>• Responsible for using FP</li> <li>• Sexually passive</li> <li>• Financial dependence on men</li> </ul>

From an early age, boys and girls internalize the gender norms they see in their families and communities and copy them. As they become men and women these gender norms can create inequalities in the roles they play regarding their health and the health of their families, including the utilization of SRH products and services. For example, if a society’s gender norm states that women are responsible for the health of the family, then women are often expected to take full responsibility for preventing unintended pregnancies by using FP. In such societies, promoting vasectomy will be more challenging as it is in direct opposition to the prevailing gender norm. Likewise, men may avoid seeking services so as not to be seen as weak, and therefore delay testing for HIV and STIs, and subsequently are linked to treatment later than women.

**Transforming Gender Norms**

To promote SRH products and services for men, it is necessary to address gender norms that prevent men from realizing their SRH goals. In designing an SBC strategy to promote SRH products and services for men, the **Gender Equality Continuum**<sup>39</sup> (see **Figure 2**) can be used as a planning framework for addressing gender norms and inequities, helping program managers determine how to design and plan interventions that move along the continuum toward transformative gender programming. The Gender Equality Continuum can also

be used as a diagnostic tool during and after implementation to determine where a program falls along the continuum.

The continuum shows a process of analysis that begins with determining whether interventions are gender-blind or gender-aware. **Gender-blind** programs ignore gender considerations, and are designed without any analysis of the gender norms or dynamics in a society. **Gender-aware** programs, on the other hand, examine and address the 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 women and men, and girls and boys.

The Gender Equality Continuum moves from gender-blind to gender-aware programs, towards the goal of creating gender equality and better health outcomes.

The process then considers whether gender-aware interventions are exploitative, accommodating or transformative:

**Gender Exploitative:** Program intentionally or unintentionally reinforces or takes advantage of gender inequalities and stereotypes. This approach is harmful and can undermine program objectives in the long run.

- **Example:** *In order to increase condom sales, a program could design a mass media campaign to capitalize on social and gender norms that focus on male virility and men's control in sexual relationships. Television and print advertisements depicting men having multiple female partners and women as sex objects, reinforces gender inequalities.*

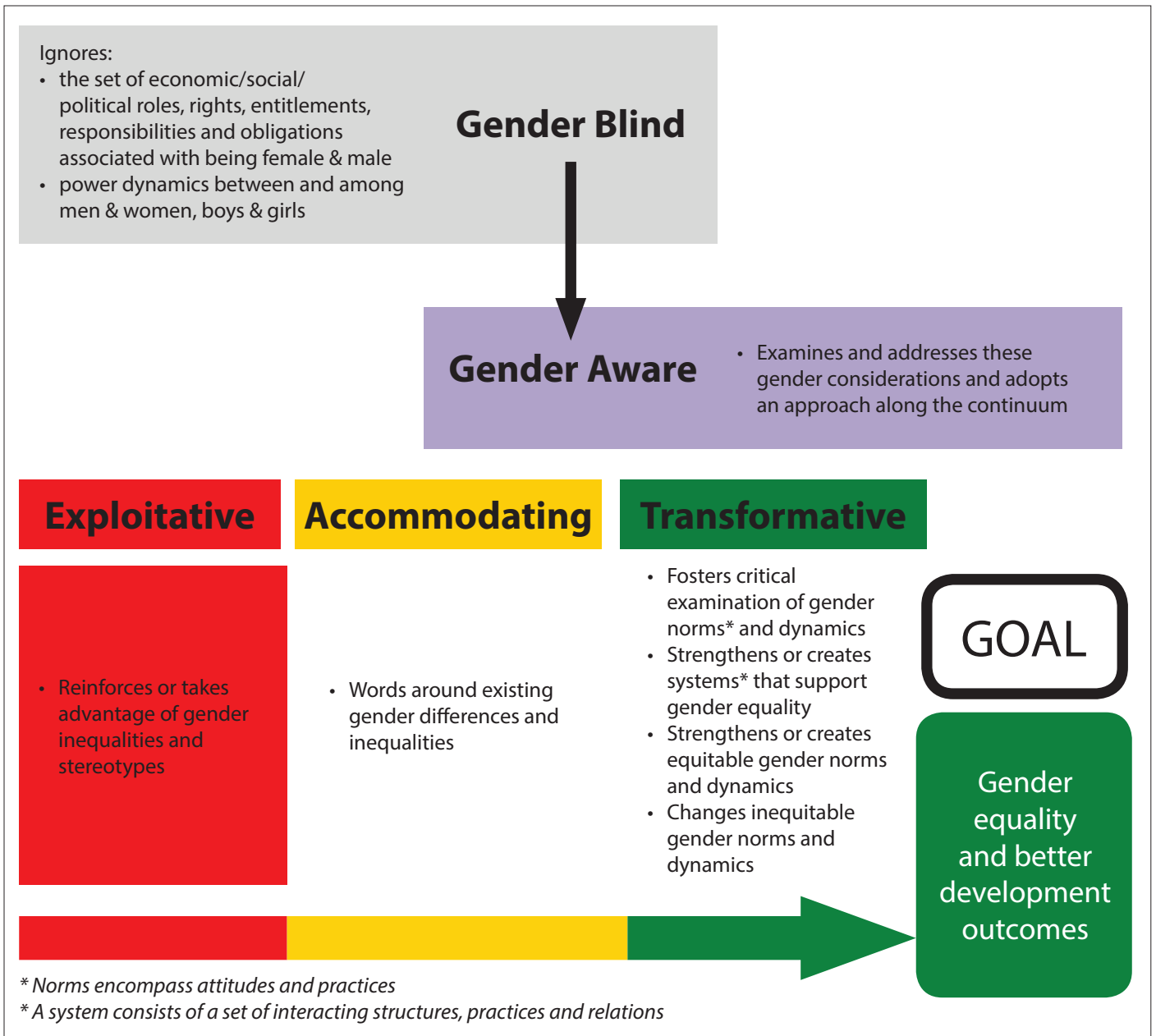
**Gender Neutral:** Program acknowledges – but works around – gender differences and inequalities. This approach does not attempt to reduce gender inequalities or address the gender norms contributing to differences or inequalities.

- **Example:** *To increase adolescent use of STI testing and treatment, after being unable to convince community and religious leaders to allow comprehensive sexual education for adolescent men and women in mixed-gender schools, a program could design a communication strategy using peer educators to conduct IPC sessions with small groups of adolescents. While the program reaches adolescents with information on STIs, it does not address the gender and social norms which prevent adolescents from discussing sexual health openly in mixed-sex settings.*

**Gender Transformative:** Program seeks to transform gender relations to promote equality. This approach seeks to transform gender relations by (1) fostering a critical examination of gender roles, norms and dynamics; (2) recognizing and strengthening positive norms that support equality and an enabling environment; and (3) transforming underlying social structures, policies and broadly-held social norms that perpetuate gender inequalities.

- **Example:** *In order to increase men's use of vasectomy, a program could design a communication strategy to engage men, women, community leaders, religious leaders and providers to examine the existing gender norms and beliefs around men's use of FP. The communication strategy challenges gender norms stating that FP is a woman's responsibility and reframe FP as a joint responsibility of men and women.*

**Figure 2: Gender Equality Continuum Tool**



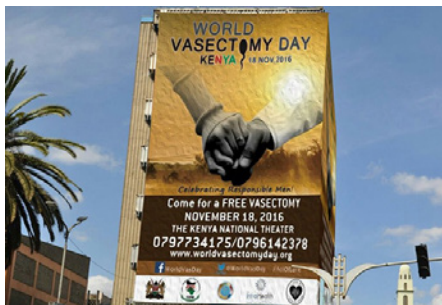
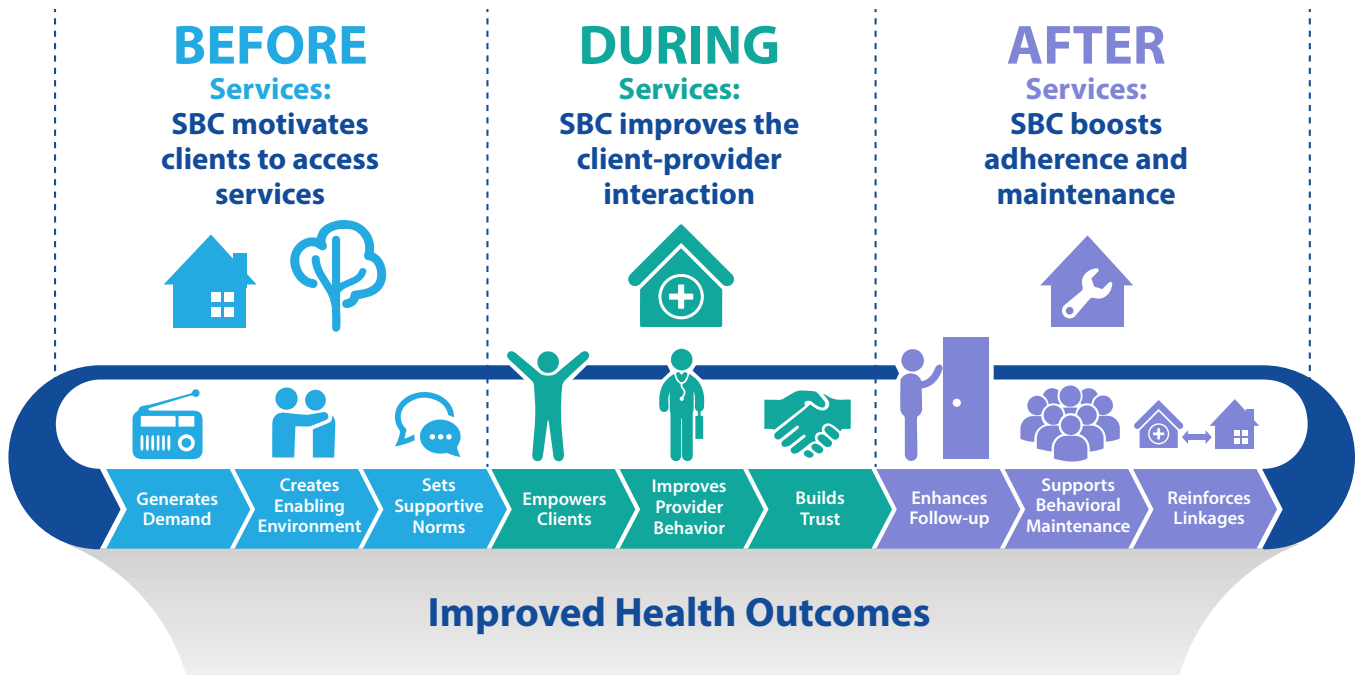
The Gender Equality Continuum emphasizes two key principles:

1. Programs promoting SRH products and services for men must never be gender exploitative. While some interventions may be or contain elements that are (intentionally or unintentionally) exploitative, the aim should always be to move them toward transformative approaches.
2. Programs should ultimately work toward transforming gender roles, norms and dynamics for positive and sustainable change. Gender transformative programs seek to transform gender roles and promote gender-equitable relationships between men and women. They do not seek to make men and women the same, but rather identify and change those gender characteristics that are harmful to men and women, to give them equal access to information, products and services.

## SBC ALONG THE SERVICE DELIVERY CONTINUUM

SBC can improve behavior and health outcomes for men across the SRH continuum of care, which this Guide defines as before, during and after SRH product or service use. SBC can be used to increase the demand for (before) and utilization of SRH products and services (during), and improve the long-term maintenance of behaviors (after). Refer to Figure 3 for further explanation of the communication activities at each phase of care.

Figure 3: Social and Behavior Change (SBC) along the Service Delivery Continuum



In the **before** stage, SBC can help get men to use SRH products and access SRH services by raising awareness and increasing knowledge, addressing social and cultural norms that act as barriers to use, dispelling common beliefs and misinformation and increasing self-efficacy and community support.

**During** product purchase and service delivery, SBC techniques can be used to enhance men's experience and ensure new behaviors are adopted by improving counseling and client support.

**After** service delivery and product purchase, SBC can support follow-up and behavioral maintenance by building and maintaining linkages between men and health care providers.

### *What Is Demand Generation?*

**Demand generation** increases awareness of and demand for health products or services among an intended audience through SBC approaches. Demand generation goes beyond simply providing information, by addressing normative barriers and enlisting key motivators to encourage audiences to seek and use health products and services. In the case of promoting SRH products and services for men, demand generation can occur in three ways by:

- **Encouraging new users** – motivating men to adopt new behaviors, products or services.
- **Increasing demand among existing users** – supporting current users to increase or sustain the practice of the promoted behavior and/or to increase or sustain the use of promoted products or services.
- **Switching users from competing behaviors** (e.g., convincing men to seek health care immediately, instead of not seeking care until their health situation has severely deteriorated or been compromised) **and products or services** (e.g., convincing men to use male condoms instead of withdrawal as a FP method).

When well designed and implemented, demand generation programs and activities can help men address their SRH needs by:

- Creating informed and voluntary demand for SRH products and services for men;
- Helping service providers and men interact with each other in an effective manner, such that the SRH needs of men are being met in a supportive environment;
- Shifting social norms that can influence individual and collective behavior related to men's product or service uptake; and
- Encouraging correct and appropriate use of products and services by men and service providers.

Demand generation efforts should be matched with efforts to improve logistics and the supply chain, expand service coverage, increase access to products and services and train and equip providers to meet the increased demand for SRH products and/or services. Without these simultaneous improvements, men may become discouraged and demand could then decrease. Programs should coordinate and collaborate with appropriate partners when forming demand generation communication strategies and programs.

### *Alignment Example: Vasectomies Increased When Supply, Demand and Enabling Environment Coordinated*

#### **Program Description:**

EngenderHealth developed the **Supply-Enabling Environment-Demand (SEED) Programming Model** (see **Figure 4**) to align and coordinate supply and demand with the enabling environment. EngenderHealth successfully applied this framework (see diagram) to the **Access, Quality and Use in Reproductive Health (ACQUIRE) Project**, a global initiative aimed at increasing the quality and use of SRH services, including vasectomy.

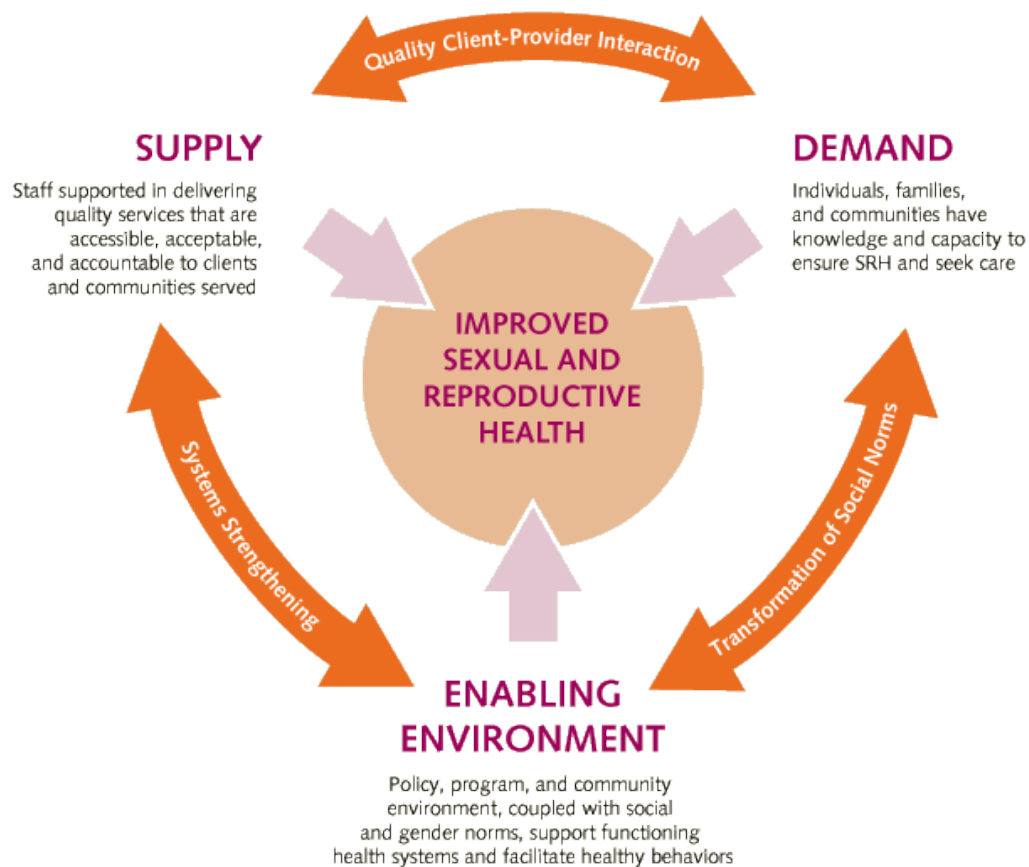
#### **Intervention:**

The ACQUIRE Project<sup>40</sup> implemented an intervention in Honduras from 2003 to 2007 to strengthen and coordinate the supply, demand and enabling environment for vasectomy services. This intervention was done in the following ways:

- **Supply:** Strengthened provider skills and service delivery through provider training, training of support staff on service provision for men, service quality improvement and the development and application of tools and standards

- **Demand:** Built demand for vasectomy services by conducting formative research to understand the views of key stakeholders and potential vasectomy clients; developed a communication strategy to provide information on how the method works, its benefits and its contraindications<sup>41</sup>; and implemented a multi-channel communication initiative to increase demand for vasectomy
- **Advocacy:** Developed and implemented an integrated public relations and advocacy strategy targeting both the medical community and the media to address beliefs and misinformation related to vasectomy

Figure 4: SEED Model



**Results:**

By strengthening the supply, demand and enabling environment for vasectomy in an integrated manner, the ACQUIRE project increased the availability and acceptability of vasectomy. The intervention resulted in an increase in the number of vasectomies conducted in public-sector clinics by 152 percent during the intervention period.

For more information on the SEED Programming model, [see The SEED Assessment Guide for Family Planning here.](#)

**Contact:**

For more information contact EngenderHealth at [www.engenderhealth.org](http://www.engenderhealth.org).



### **SBC Approaches for Demand Generation**

Five core SBC approaches are commonly used and have been shown to increase men's demand for and utilization of SRH products and services:

1. **Community mobilization**
2. **Community outreach**
3. **IPC**
4. **Mass media**
5. **mHealth**

Each approach is described below, including a definition, benefits and examples of how each approach has been used to generate demand. Several of the programmatic examples include multiple SBC approaches and communication channels.

#### **1. Community Mobilization**

Community mobilization is a capacity-building process through which individuals, groups or organizations design, conduct and evaluate activities on a participatory and sustained basis. Successful community mobilization works to solve problems at the community level by increasing the ability of communities to successfully identify and address their own health needs.

Engagement of community members in mobilization activities allows communities to identify their own SRH priorities, mobilize resources and develop and implement solutions for reaching their collective set of goals.

Community mobilization benefits demand generation for SRH products and services for men by:

- Developing an ongoing dialogue between community members regarding men's use of SRH products and services;
- Assisting in creating an environment in which men, couples and communities can address their own SRH needs;
- Promoting community members' participation in ways that recognize diversity and equity, including gender equity;
- Working in partnership with men and other community members in all phases of project design, implementation and evaluation to create locally appropriate responses to men's SRH needs;
- Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve men's SRH – even interventions that may not have been recommended by funders and other external actors; and
- Linking communities with external resources to aid them in their efforts to improve men's SRH.



## Community Mobilization Example: Increasing Men's Use of Family Planning

### Program Description:

The **Family Planning Results Initiative**, implemented by CARE Kenya from 2009 to 2012 in Western Kenya, used a community mobilization approach to increase the acceptability and demand for FP among men and women, while addressing gender roles and norms which prevent men's participation in FP.

### Intervention:

The program used a variety of techniques to reach and engage men and women, including:

- Facilitating ongoing discussions on social and gender norms in the community with community groups, men's and women's groups and village savings and loans groups;
- Conducting community drama performances on gender, sexuality and FP;
- Supporting religious leaders and prominent male leaders to deliver messages normalizing FP and legitimizing men's participation in FP; and
- Employing role model couples to share their personal experiences with FP.



Image 6: Actors perform in a community drama on FP and gender norms

**Figure 5** lists the activities that the Family Planning Results Initiative used to affect the intermediate outcomes and key determinants to increase FP use.

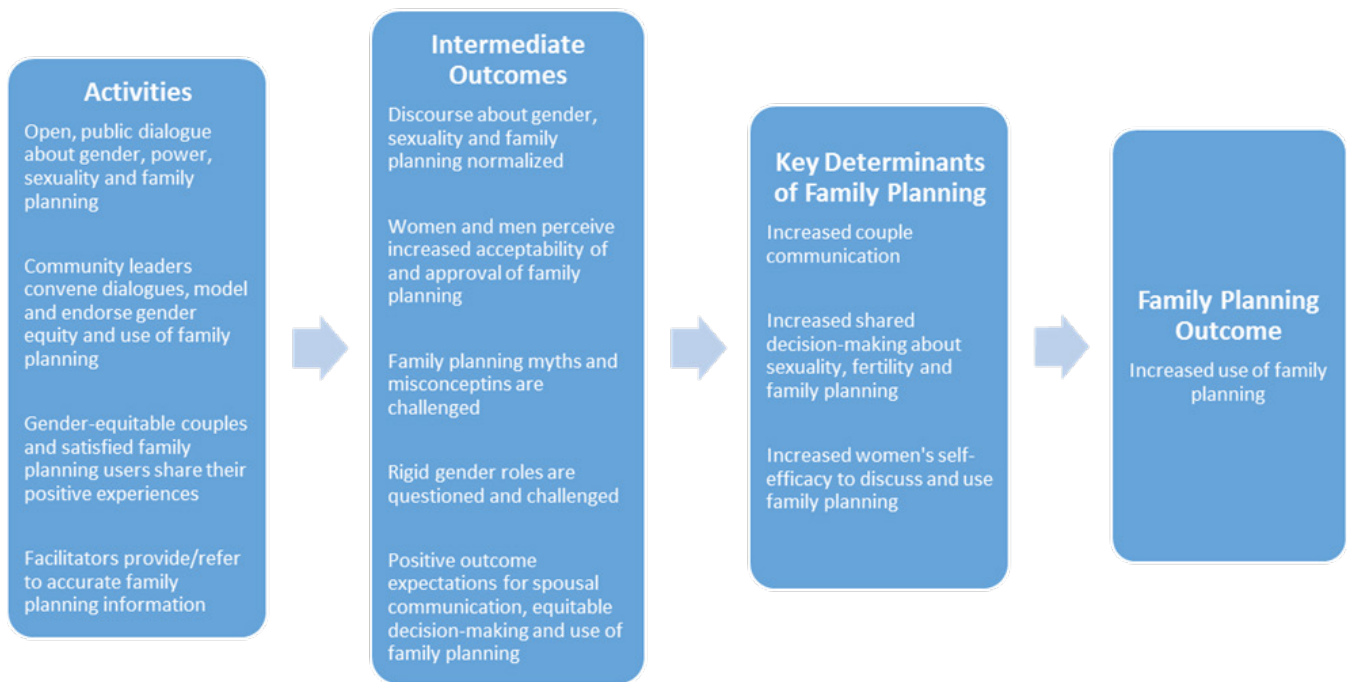
### Results:

The community mobilization activities contributed to successful outcomes. At the end of the initiative, men's use of a modern method of contraception – specifically male condoms or vasectomy – increased from 24.7 percent in 2009 to 51.1 percent in 2012. The majority of this increase in men's use of modern methods of contraception was driven by an increase in male condom use. The initiative also increased dialogue between men and women about FP, with an increase in both couple communication and women's equitable participation in household decision-making.<sup>42</sup>

### Contact:

For more information, contact CARE at [www.care.org](http://www.care.org).

**Figure 5: Activities implemented under the Family Planning Results Initiative in Kenya Resources**



**Resources**

For more information and guidance on community mobilization, see:

- [How to Mobilize Communities for Health and Social Change](#)

**2. Community Outreach**

Community outreach is a process through which information regarding SRH products and services for men is delivered to the intended audience(s) in places where they live, work or socialize. In some instances, community outreach is conducted in coordination with the provision of SRH products and services (e.g., mobile outreach clinics).

Community outreach to promote SRH products and services for men has been done in numerous settings, including outreach at churches, men and women's groups, markets, workplaces, schools, bars, village savings and loan groups and sports fields or clubs. Community outreach can take many forms, including group discussions, one-on-one sessions, home visits, community drama performances, health talks and community health fairs.



*Image 7: Nurse assesses health of male residents during mobile clinic in remote Muslim village in Chad*



By bringing the dissemination of information into the community and directly to the intended audiences, community outreach activities are able to:

- Eliminate the barriers of time and distance by making information (and sometimes services) available in places where men and secondary audiences (e.g., wives, female partners, parents and community leaders) typically spend their time;
- Educate and inform men about SRH products and services for men, thereby increasing their knowledge and/or skills;
- Educate and inform secondary audiences about SRH products and services for men, thereby increasing support for men using SRH products and services and creating an enabling environment for their use;
- Encourage community dialogue on SRH products and services for men, which can support the normalization of men's use of SRH products and services;
- Dispel beliefs and misinformation regarding SRH products and services;
- Challenge gender attitudes and norms that may inhibit the use of SRH products and services by men;
- Generate demand for SRH products and services for men; and
- Establish linkages between intended audience(s) and service provision or product purchase sites.

### **Community Outreach Example: Workplace Outreach Increases Couples Communication and Adoption of Family Planning**

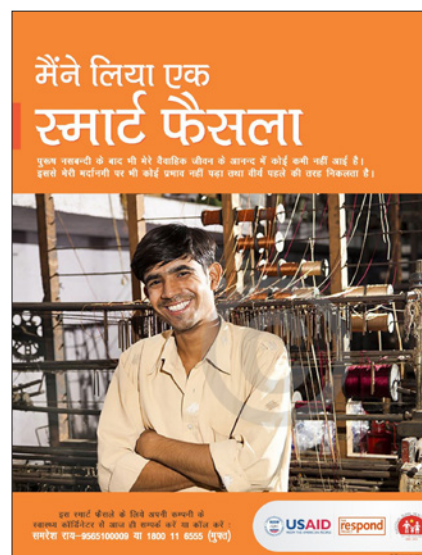
#### **Program Description:**

In India, the **Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) Project** implemented an employer-based intervention to increase workers' awareness of and utilization of FP, with a focus on increasing the use of long-acting and permanent methods of contraception.<sup>43</sup> The intervention, implemented by EngenderHealth and partners from 2011 to 2012, was staged in workplaces to increase men's involvement by reducing time spent away from work and eliminating distance barriers.

#### **Intervention:**

Ten companies participated in the intervention, where approximately 90 percent of the employees were men. The intervention included the following activities:

- Development and distribution of print materials, including posters and brochures, in the workplace
- Orientation of health coordinators from the companies on FP and IPC skills
- Implementation of FP health talks, which included an overview of FP methods and a focused discussion on long-acting and permanent methods
- Health desks staffed by RESPOND program officers or trained counselors, located in high-trafficked areas of the companies, who could answer questions and distribute FP materials
- Identification of private-sector referral sites that provide high-quality FP services
- Provision of referral to FP services through a hotline and program staff



*Image 8: Workplace FP campaign poster in India*



**Results:**

RESPOND reached 95 percent of the workforce in the participating companies with messages on FP. Exposure to the intervention resulted in an increase in couple communication regarding FP. The intervention also increased the likelihood that a married non-user would adopt a FP method or that a current FP user would switch from a short-term method to a long-acting or permanent method, including vasectomy, compared to individuals not exposed to the intervention. Among married non-users exposed to the intervention, 13 percent reported adopting a FP method, with 42 percent selecting male condoms compared to zero percent of married non-users who were not exposed to the intervention. Among current FP users, the percentages of adoption of new methods varied based on the original method used (see **Table 3**).

**Table 3: Percentage of current FP users exposed to intervention who switched methods**

Previous Method Used	Male Condoms	Oral Pills	Injectables	IUD	Female Sterilization	Vasectomy	Unknown
Male Condoms (n = 58)	0%	20.7%	8.6%	25.9%	25.9%	19%	0%
Oral Pills (n = 63)	17.5%	0%	4.8%	22.2%	41.3%	14.3%	0%
Injectables (n = 9)	0%	0%	0%	33.3%	44.4%	11.1%	11.1%

Key lessons learned from the intervention included:

- Full management support and buy-in from the employer is important to the success of an employer-based approach;
- Larger companies may have better structures in place to support health initiatives and allow employees to attend health talks during working hours; and
- Employees should be encouraged to discuss the information provided during health talks with their spouses, including inviting spouses to attend health talks and sharing printed materials with them.

For more information on the RESPOND Project’s employer-based approach and findings from India, [read the program report here](#).

**Contact:**

For more information, contact the RESPOND Project at [www.respond-project.org](http://www.respond-project.org) or EngenderHealth at [www.engenderhealth.org](http://www.engenderhealth.org).

**Resources**

For more information and guidance on developing community outreach activities, see:

- [Community-Based Family Planning Toolkit](#)

### 3. Interpersonal Communication

IPC is any face-to-face interaction with the intended audience, often with the objective of changing their behavior or increasing knowledge. IPC is typically one-on-one communication, but can also be done with a small group. Good IPC is a two-way dialogue where participants speak and are listened to without interruption, ask questions, express opinions and exchange information. Examples of IPC include peer-to-peer communication, community health worker-client communication, health provider-patient communication or pharmacist-client communication.

IPC is especially effective at:

- Engaging men and secondary audiences in personalized discussions about the benefits of SRH products and services and how the utilization of these products and services can help men and their families fulfill their SRH needs;
- Addressing barriers to behavior adoption that are inherently personal and require tailored messages or information, such as fear of pain or effect on sexual performance following VMMC or vasectomy;
- Reaching populations that are not exposed to other media;
- Moving men from interest in a SRH product or service to use;
- Reaching specific, highly-stigmatized populations (i.e., men who have sex with men [MSM]); and
- Conducting demonstrations, including skill building, such as improving negotiation skills through role plays and practice on how to discuss FP with a spouse or female partner, or putting on a male condom.

IPC plays a role in enhancing a man's self-efficacy to seek and utilize SRH products and services by addressing his specific barriers and providing him with tailored information and solutions to overcome these barriers.



*Image 9: A man receives male condoms from an IPC agent during an outreach event*



## **IPC Example: Peer Educators Increase Condom Use and STI Treatment-Seeking Behavior among Youth in Nigeria**

### **Program Description:**

The **STI Testing and Treatment Program** used peer educators to promote STI prevention, testing and treatment among sexually experienced youth, ages 14 to 18, enrolled in secondary schools in Benin City, Nigeria.<sup>44</sup> The Women's Health and Action Research Centre implemented the program between 1997 and 1998.

### **Intervention:**

The program established school-based reproductive health clubs where adolescents could discuss SRH matters. The clubs distributed information education communication (IEC) materials and sponsored debates, dramas, essay contests, symposia and films related to STI prevention, testing and treatment. Each club also hosted an STI Health Awareness Campaign, during which time health care professionals provided students with information on STI prevention, testing and treatment.

Select members of the reproductive health clubs were chosen by their peers to be trained as peer educators. Those peer educators received training on STI prevention and treatment, symptom recognition, the benefits of early treatment, the need for professional treatment, locations for professional treatment, the importance of partner notification and the need to abstain from sex during STI treatment. Peer educators provided counseling to other students, either one-on-one or in groups during breaks and after school, distributed educational materials on STIs and referred youth with STI symptoms to trained health care providers.

To complement efforts at increasing STI prevention and demand for STI testing and treatment among youth, the program also trained health care providers and pharmacists on STI diagnosis and treatment based on the WHO syndrome management system, which emphasizes condom use and partner notification.

### **Results:**

Compared to students enrolled in schools where the intervention was not implemented, the intervention resulted in increases. Condom use among males exposed to the intervention increased significantly from 31 to 41 percent. At the same time, the proportion of youth who went to private physicians for treatment for STI symptoms increased from 18 percent to 41 percent.

In the long-term, the intervention resulted in a statistically significant reduction in STI symptoms among students in the intervention schools. The odds of experiencing STI symptoms was 42 percent less for males exposed to the intervention and 30 percent less for females exposed to the intervention.

### **Contact:**

For more information, contact the Women's Health and Action Research Centre at [www.wharc-online.org](http://www.wharc-online.org).

## **Resources**

For more information and guidance on IPC, see:

- [How to Plan an Interpersonal Communication Intervention](#)



#### 4. Mass Media

Mass media is an SBC approach that has the ability to reach a large number of men and other primary and secondary audiences with the same messages over a short amount of time in a large geographic area. The most common formats of mass media are radio, television, newspapers and magazines. Mass media allows communication programs to raise awareness about and increase knowledge of SRH products and services for men. Mass media can also be used to model desired behaviors and depict positive deviations from social norms which prevent men from using SRH products and services. In addition to providing information on SRH products and services for men, mass media can also be used to stimulate community dialogue and couple communication, as well as normalize men's use of SRH products and services.

Mass media can build demand for SRH products and services for men by:

- Expanding the geographic reach of communication messages and information to a large population of men and secondary audiences (i.e., individuals that interact with men have the ability to influence them, such as wives and female partners, parents, peers and community leaders);
- Normalizing men's use of SRH products and services through modeling positive behaviors, thereby contributing to transforming social norms;
- Stimulating community and couples dialogue on SRH products and services for men;
- Engaging men and secondary audiences in dialogue through interactive media (i.e., radio call-in shows, television talk shows, etc.) and linkages to mHealth platforms (i.e. hotlines, Facebook pages, etc.);
- Allowing for repeated exposure to and reinforcement of the same health messages or information;
- Reaching rural and other hard to reach male populations with health messages and information; and
- Increasing awareness and knowledge of SRH products and service for men, including where to access and/or purchase them.

### *Mass Media Example: Mass Media Increased the Number of Vasectomies in Brazil*

**Program Description:**

Promocão de Paternidade Responsável (PRO-PATER) and CCP implemented an innovative mass media campaign to increase knowledge, awareness and utilization of vasectomy in three Brazilian cities – São Paulo, Fortaleza and Salvador – from 1989 to 1990.<sup>45</sup>

**Intervention:**

“Vasectomy is an act of love,” was the main theme for the campaign. A playful and creative 30-second television spot was developed featuring two animated hearts – one male, one female – to depict the purpose of vasectomy, its safety and illustrate that it does not interfere with sexual pleasure.



*Image 10: Still of a vasectomy TV spot from Pro-Pater*

In the television spot, the two animated hearts entered the scene to wedding music. Through animation and the sound of excitement and kissing, the hearts united twice and produce baby hearts. On the third attempt at uniting, the female heart scolded the male heart and pushed him away. A vasectomy was depicted with two lines and a voiceover stating “Vasectomy, the male operation, is a quick and painless way to avoid unwanted pregnancy.” As the spot closed, the two hearts reunited again to the sound of excitement and kissing.

At the end of the television spot, viewers were provided with the name of a local clinic and its phone number to contact for more information. The campaign theme was also shared in radio spots, pamphlets, billboards and magazine advertisements, and the image of the two hearts appeared in print media.

**Results:**

During the 15-month campaign period, it is estimated that four million people were reached through the combined activities and press coverage generated by the campaign.

The campaign is associated with a significant increase in the number of men seeking and utilizing vasectomy services in the three campaign cities. Clinical data showed that the monthly average of vasectomies performed increased by 82 percent in Sao Paulo, 108 percent in Fortaleza and 59 percent in Salvador during implementation.

Natural variations in demand were seen throughout campaign implementation; however, demand increased whenever television spots aired. This increase in demand highlights the importance of mass media in driving men to vasectomy services.

To learn more about this project in Brazil, [read the program report here](#).

**Contact:**

For more information, contact CCP at [www.ccp.jhu.edu](http://www.ccp.jhu.edu).



## Resources

For more information and guidance on mass media, see:

- [How to Develop SBCC Creative Materials](#)
- [Tips for Creating Print, Video and Radio Materials](#)
- [How to Design and Produce Radio Serial Drama for Social Development: A Program Manager's Guide](#)

## 5. mHealth

Mobile phones have dramatically changed the way men can and do access health information and resources by making information available anytime and anywhere, in the palm of their hand. Mobile health, or mHealth, is the use of mobile phones, smart phones and other wireless technology to share information about health and health products and services. mHealth can include: SMS/text messaging, websites, blogs, social networking sites, hotlines, online games, eLearning and phone applications (or apps).

mHealth can be used to increase demand for SRH products and service for men by:

- Modeling healthy behaviors and supportive norms, such as couples communication and gender-equitable decision-making;
- Improving access to health information, by providing information when and where men and secondary audiences want to access it;
- Linking men to SRH products and services by making service delivery sites and product outlet locations easier to find;
- Increasing communication between men and health providers, community health workers and peer educators; and
- Allowing health providers, community health workers and peer educators to send messages on SRH products and services for men to potential clients or patients.



*Image 11: Men using mobile phones to access health information*

### **mHealth Example: SMS Provides VMMC Information for Men in South Africa**

#### **Program Description:**

In South Africa, the **Brothers for Life** initiative integrated mobile phone messaging into its social mobilization campaign in an effort to scale up demand for and utilization of VMMC services. Implemented by Johns Hopkins Health and Education South Africa (JHHSEA), the SMS messages complemented IPC, mass and social media, and grassroots advocacy.



Image 12: Poster for the VMMC SMS campaign

#### **Intervention:**

Between 2010 and 2015, the campaign used mobile phones to link men to a VMMC service location, as well as provide post-operative messages and support.

Mobile phones were selected for use in the campaign due to widespread mobile phone access in South Africa within the target population. SMS provided men who elected to receive information on their phones to receive location-specific, personalized information in a confidential and private manner.

#### **Results:**

During the first year of implementation, the SMS service received over 50,000 requests for information on VMMC service locations. The SMS service allowed men to immediately take action (e.g., locate a VMMC clinic or schedule an appointment) when seeing or hearing a campaign message, thus creating an effective link between demand generation and service delivery.

#### **Contact:**

For more information, contact Brothers for Life at [www.brothersforlife.org](http://www.brothersforlife.org).

### **Resources**

For more information and guidance on mHealth, see:

- [The mHealth Planning Guide: Key Considerations for Integrating Mobile Technology into Health Programs](#)

Once a man is motivated to seek SRH products and services, it is essential to ensure he has a positive experience. A positive experience can increase the likelihood a man will continue using the product or service in the future, as well as refer other men to use the product or service. A negative experience can have damaging effects on demand generation efforts and uptake, since men who have negative experiences are likely to share these experiences with their family and friends.

SBC plays a role in ensuring a positive client experience. Men who receive high-quality, balanced counseling and respectful care are more likely to have a positive perception of the SRH product or service they receive and increased satisfaction with their decision to use it.

SBC can enhance the service delivery experience in three key ways:

1. **Provider Behavior Change**
2. **Client Counseling**
3. **Supportive Supervision of Providers**

### 1. Provider Behavior Change

Health providers are influenced by the social and cultural norms of the communities in which they live and work. These norms – along with their personal experiences, education, religious beliefs, etc. – influence their beliefs, values and, ultimately, their behavior. At times, the attitudes, beliefs and values of a provider can be at odds with providing certain SRH products or services to men.

Provider behavior change (PBC) is a strategic process used to identify individual provider's needs, motivations and barriers to adopting desired behaviors and tailoring communication-based solutions to address these needs and overcome identified barriers. PBC approaches work with providers to influence their knowledge, attitudes, beliefs, values or self-efficacy that may prevent their ability to provide a specific product or service.

For example, if a provider believes women are solely responsible for FP, she is not likely to counsel a couple or a male client on vasectomy as a form of FP due to her own beliefs and biases. In this scenario, a provider behavior support agent, would work with the provider to educate her on the benefits of vasectomy and help her to understand the shared responsibility men and women have in FP.

PBC activities can take many forms, including one-on-one or group sessions between provider(s) and supervisors, provider behavior support agents



### ***The HC3 Provider Behavior Change I-Kit***

The HC3 PBC I-Kit enables users to understand the barriers healthcare providers face, determine which barriers can be addressed by SBC and develop an intervention to improve provider performance. The PBC I-Kit includes information for working with community health workers or facility-based providers to improve their performance and counseling skills. The PBC I-Kit includes an assessment tool for identifying, understanding and prioritizing provider-related barriers to quality service provision; an intervention design tool for step-by-step guidance on designing an SBC intervention to address the identified barriers; and a collection of resources that showcase effective PBC interventions.

[See the PBC I-Kit here.](#)



with pharmacists and providers, pre-service training and in-service training of providers. Changing provider behavior often requires multiple interactions to help identify providers' barriers or needs, and then address the identified barriers or needs. PBC often uses a variety of methods, including discussions, trainings, role plays, mentoring and job aids.

While PBC cannot address all of the needs and barriers providers face, it can play a role in addressing many barriers linked to provider motivation and performance. Specifically, PBC can:

- Encourage providers to challenge negative attitudes and beliefs they may hold towards SRH products and services for men that prevent their adherence to key service delivery policies and guidelines (i.e., vasectomy for men under 30, HTS for adolescent males);
- Offer real solutions to address individual provider needs and barriers to behavior change;
- Identify what motivates provider performance (i.e., reputation in the community, recognition by peers, private sector profits or a sense of purpose and desire to do good);
- Improve providers technical knowledge on SRH products and services for men, protocols and men's health;
- Facilitate social and normative changes that impact how providers work and the kinds of attitudes and values they possess;
- Motivate providers to better adhere to national service delivery policies and guidelines; and
- Engage with providers to improve provider-client interactions and counseling.

### ***PBC Example: PBC Improves the Quality of Vasectomy Counseling and Services***

#### ***Program Description:***

The **Ghana Vasectomy Initiative (GVI)** was implemented by EngenderHealth to improve client-provider communication by increasing knowledge and acceptance of no-scalpel vasectomy (NSV). GVI activities were conducted between 2003 and 2004 and included: training providers on NSV; training all facility staff (doctors, nurses, community health workers, health educators, receptionists, guards and janitors) on the provision of client-centered, male-friendly health services; and conducting health promotion activities.<sup>46</sup>

#### ***Intervention:***

The four-day training with facility staff included sessions on: NSV, counseling and referrals skills; client satisfaction and informed choice; fostering and maintaining high-quality care; and increasing engagement of all staff in responding to men's reproductive needs.

#### ***Results:***

As a result of the initiative, facility staff reported being more receptive to offering men SRH services, had fewer misconceptions regarding vasectomy, expressed greater comfort in talking to men about FP and expressed a more positive attitude towards providing SRH services to men. Mystery clients who visited the clinics after the intervention reported receiving accurate information regarding vasectomy and quality counseling compared to a baseline visit.

For more information on how GVI used PBC to improve the client experience, read the research report [here](#).

#### ***Contact:***

For more information, contact EngenderHealth at [www.engenderhealth.org](http://www.engenderhealth.org).



## Resources

For more information and guidance on PBC, see:

- [Provider Behavior Change Toolkit](#)
- [Strategies for Changing the Behavior of Private Providers](#)

## 2. Client Counseling

Client counseling is communication between a client or couple and a health provider or pharmacist. In some settings, client counseling may be task shifted to other health workers (e.g., community health worker) or client counselors, in order to improve service efficiency in clinics and pharmacies with high volume.

Effective communication between health providers or pharmacist and clients during service delivery or the purchase of health products is an important element for improving client satisfaction, compliance and health outcomes. Men who understand how their chosen SRH product or service works, its benefits and side effects and available alternative options may experience greater satisfaction with the care they receive. Satisfied clients are more likely to comply with follow-up instructions and continue use of the product or service in the future.

High-quality client counseling is essential for ensuring clients make informed, voluntary decisions about their health. During client counseling, providers are able to tailor their messages and information to address the specific needs and barriers of each individual client. Providers are able to present the product and service options most applicable to their client's SRH needs and life stage.

### **Couples Counseling**

Couples counseling is the provision of counseling to couples in order to facilitate open communication and joint-decision-making regarding SRH products and services. Couples counseling should be structured to promote gender equity and be centered on the belief that decisions related to SRH are a shared responsibility between married or cohabitating couples.

Couples counseling can be incorporated into programs at any stage along the SRH continuum of care – before, during or after service delivery or product purchase.

Couples counseling has been used in vasectomy, VMMC and HTS programs in LMICs.

Characteristics of high-quality client counseling:

- Counseling should be a two-way dialogue between the health providers and client, one in which both are active participants asking and answering questions.
- Questions are answered honestly and fully, by both the health providers and client.
- Benefits and side effects of the chosen SRH product or service are explained accurately to the client.
- Available alternative options are presented to the client in order for him to make an informed, voluntary decision.
- Adequate time is set aside before and after the provision of a SRH product or service to ask and answer additional questions.

## Resources

For more information and guidance on counseling on SRH products and services, see:

- [General Counseling – Men's Reproductive Health Curriculum: Counseling and Communicating with Men](#)
- [Counseling on Vasectomy – No-Scalpel Vasectomy Curriculum: A Training Course for Vasectomy Providers and Assistants](#)
- [Family Planning Handbook: Vasectomy](#)
- [Counseling on VMMC – The President's Emergency Plan for AIDS Relief \(PEPFAR\) Best Practices for Voluntary Medical Male Circumcision Site Operation](#)

- [VMMC Counseling Training Packet](#)
- [Voluntary Medical Male Circumcision In-Service Communication: Best Practice Guide](#)

### 3. Supportive Supervision of Providers

Supportive supervision is a feedback approach that provides mentorship, joint problem-solving and communication between supervisors and providers or pharmacists. Supportive supervision is a continuous quality improvement process, which can be used to strengthen and expand SBC provision in service delivery and product purchase settings.



*Image 13: Vasectomies being performed during World Vasectomy Day 2015 in Bali, Indonesia*

Ongoing supervision and technical support for health workers can improve the counseling skills and technical knowledge of providers. Supportive supervision can also address any new barriers or needs that may arise to impact a provider's ability to successfully provide SRH products and services to men. Through routine visits, support supervisors and providers are able to jointly identify issues or areas for improvement and develop a plan for addressing the identified barriers.

Supportive supervision may include the following:

- Trainings, new job aids or tools to support better counseling
- Coaching and routine support to address identified barriers to performing a specific SRH service for men or providing a specific SRH product to men
- Technical support through hotlines, mHealth or distance learning

### **Characteristics of Positive Clinical Experience and Setting**

The clinical setting in which men receive SRH services can have an impact on men's perception of the quality of the SRH service they receive. In designing SRH clinical services, it is important to ensure high-quality, confidential SRH services are provided in a comfortable environment, in a location and at a time that is convenient for men.

Characteristics of a positive clinical experience and setting include:

- Men receive counseling and service delivery in a clinical setting separate from women and children, including a separate waiting area, counseling room and clinical/operating space;
- Client flow for services, especially VMMC and vasectomy, are unidirectional – such that men move from the waiting area, to counseling, to the procedure, to recovery and to post-operative counseling without overlapping;
- Recovery space should accommodate more men than the clinical/operating space where the procedures are performed, as the recovery time is often longer than the operating time and inadequate recovery space can create bottlenecks;
- Providers dedicate adequate time for pre- and post- procedural counseling;
- Services are available to men in places and at times that are convenient for them, including evening and weekend clinics and mobile service delivery to minimize time away from work; and
- Providers and staff at clinics that provide SRH services to adolescent men (e.g., VMMC, HTS and STI testing and treatment) receive training on providing youth-friendly services.

### **Resources**

For more information on enhancing the clinical experience, see:

- [PEPFAR's Best Practices for VMMC](#)
- [HIV Testing and Counseling for Youth](#)



- Mentoring by high-performing peers or managers on technical procedures or counseling

In addition to routine supportive supervision, some programs also conduct annual or bi-annual program audits to look at the programmatic and clinical skills of their client counselors, providers and pharmacists to identify larger systemic areas for improvement and refresher trainings.

### ***Supportive Supervision Example: Supportive Supervision Visits to Improve VMMC Demand Generation and Client Counseling***

#### ***Program Description:***

With the expansion of VMMC programs, the importance of addressing quality issues across the continuum of services has gained greater attention. **Continuous quality improvement** or CQI provides a strong engine for improving the quality of VMMC services. CQI is the combined and ongoing efforts of stakeholders in the health system to make changes that lead to better patient outcomes and better system performance.

Since 2012, the United States Agency for International Development (USAID) **Applying Science to Strengthen and Improve Systems (ASSIST) Project**, led by University Research Co., LLC (URC), has worked to improve the quality and outcomes of health care and other services by enabling host country providers and managers to apply the science of improvement. ASSIST has worked in Uganda, South Africa, Tanzania, Malawi, Namibia, Lesotho, Swaziland and Mozambique to provide technical support for CQI of VMMC services.

#### ***Intervention:***

Supportive supervision (also known as coaching) for quality improvement involves a range of activities to help CQI teams understand and apply quality improvement methodology, and is done by a quality improvement expert with specialized skills. Supportive supervision facilitates the acquisition of skills, equipping facilities, teams or individuals with knowledge to evaluate the performance of their processes and systems and to design and implement interventions to improve and sustain health service quality and patient safety. On-site supportive supervision to CQI teams and facilities is critical for teams working to improve their own care processes.

The ASSIST team has developed a guide to supportive supervision and coaching for CQI, available at the ASSIST website (<https://www.usaidassist.org/VMMC-CQI-Resources>) along with a range of other tools for improving quality of VMMC services.

#### ***Results:***

Supportive supervision, in the context of a CQI approach to VMMC services and outcomes, has shown strong results. ASSIST sites in Uganda have dramatically increased the proportion of HIV-positives identified in VMMC who are linked to care and treatment as well as mitigation of tetanus risk through integrating tetanus toxoid immunization in VMMC services. In South Africa, sites receiving supportive supervision have applied CQI to improve coordination with local health authorities, data quality, client follow-up and the management of adverse events. And CQI-supported sites in Malawi have made steady gains in increasing 48-hour review.

#### ***Contact:***

For more information, contact URC at <http://www.urb-chs.com/>.



## Resources

For more information and guidance on supportive supervision, see:

- [Supportive Supervision Guidance](#)
- [Comprehensive Supportive Supervision Overview and Lessons Learned](#)
- [VMMC CQI Resources](#)
- [A Guide to Improving the Quality of Safe Male Circumcision](#)
- [Sample IPC Supportive Supervision Form and IPC Supervision Intended Audience Questionnaire for VMMC](#)



After a product or service has been provided, SBC can continue providing support for the newly adopted behavior(s) or promote additional behavior change to complement the SRH product or service a man has received. For example, if a man has undergone VMMC, he needs to return for follow-up visits, abstain from sex for six weeks following the procedure and, after the abstinence period, continue to use condoms, as VMMC provides partial (not total) protection from acquiring HIV. Similarly, if a man tests positive for HIV, he needs to be linked to and initiate HIV treatment, adhere to ART and use condoms to prevent transmitting HIV to sexual partners. It is important that these new behaviors – attending follow-up visits, abstaining from sex during the healing period, using condoms correctly and consistently and adhering to ART – are promoted and supported.

Behavioral maintenance is an important component of the comprehensive continuum of care for SRH products and services for men, either in the short-term immediately after service provision (e.g., VMMC and vasectomy) or long-term (e.g., ART, condom use or in changing gender norms around men's roles and responsibilities for FP).

Two key SBC approaches that have been used to support behavioral maintenance or complementary behavior change in men are:

1. **Support groups**
2. **mHealth and digital reminders of information services**

### 1. Support Groups

Support groups are ongoing meetings that allow people to connect with one another, mutually support each other, discuss issues and identify solutions. Support groups are often established to provide men with support after a significant life event (e.g., birth of a child or death of a spouse), after a diagnosis of illness (e.g., HIV, cancer or diabetes) or to reinforce and maintain new behaviors (e.g., recovery from alcohol or drug addiction).

Support groups benefit men in several ways:

- Allow men with similar health conditions to connect and share their experiences with each other
- Provide support for medication and treatment adherence
- Improve retention in care and treatment programs
- Encourage disclosure of health status to wives, sexual partners, family and friends
- Reduce stigma and discrimination associated with a health condition
- Enhance men's coping skills and psychosocial functioning



*Image 14: Men engage in a discussion in Democratic Republic of Congo*

With regards to SRH products and services for men, support groups have been successfully used to increase adherence to ART following a positive HIV test.<sup>47,48</sup>



### **Support Group Example: Increasing HIV Treatment Adherence Through the Use of Support Groups**

#### **Program Description:**

The **Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS)** project, implemented by FHI360 from 2011 to 2016, aimed to enhance accessibility, quality, integration and government ownership of comprehensive HIV and AIDS services in 15 states in Nigeria. The comprehensive package of HIV/AIDS services supported by the SIDHAS project include HIV testing and counseling (HTC), prevention of mother-to-child transmission of HIV (PMTCT), ART and care and support of PLHIV.

#### **Intervention:**

To strengthen retention in care and treatment programs and increase ART adherence, PLHIV support groups were established at sites supported by the program. PLHIV support groups met at least once a month and conducted activities and discussions related to positive prevention, stigma reduction and ART adherence, as well as participated in group psychosocial therapy.

Health providers at each site counseled pre-ART and ART initiating clients on the benefits of PLHIV support groups during counseling sessions, and encouraged newly diagnosed HIV clients to become members in the support groups to benefit from continuous adherence support and positive prevention and care services.

#### **Results:**

PLHIV who participated in the PLHIV support group activities reported a small but significant increase in ART adherence. Adherence to ART amongst PLHIV who participated in the support group activities was reported at 95 percent while adherence among PLHIV who never participated in the support group activities was reported at 92 percent. Both men and women enrolled in the support group reported an increase in adherence, when compared to PLHIV who did not participate in a support group. These findings are in line with other studies that have found that social support from peers, family members or health workers increased ART adherence.

#### **Contact:**

For more information, contact FHI360 at [www.fhi360.org](http://www.fhi360.org).

### **Resources**

For more information and guidance on support groups, see:

- [Guidelines for Establishing and Operating Successful Support Groups for People Living with HIV](#)

## 2. mHealth and Digital Reminders of Information Services

Mobile phones and other handheld devices (e.g., tablet, iPad, etc.) can be used to provide digital reminders and information to men who have received an SRH service. SMS messages or phone calls are often used to remind men of follow-up appointments, provide information on appropriate wound care and offer support and encouragement.

mHealth and digital reminders allow providers to reach men in a convenient and discrete way with important health and support information after an SRH services.

mHealth and digital reminders can be used in the following ways:

- Follow-up appointment reminders for VMMC, vasectomy or HIV/STI test results
- Provide instructions to men on wound care and pain management following vasectomy or VMMC
- Provide encouragement and support to men during the healing period following vasectomy or VMMC
- Provide encouragement related to ART adherence

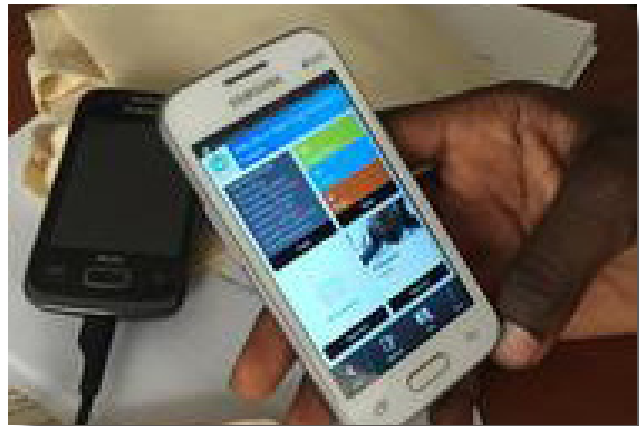


Image 15: Mobile phone used for digital reminders



## ***mHealth Example: SMS Messages Increase Attendance at VMMC Post-Operative Follow-up Appointment***

### ***Program Description:***

After receiving VMMC services, a high proportion of men fail to return for their seven-day post-operative follow-up appointment. In Nyanza Province, Kenya, a randomized control study was implemented between 2010 and 2011 to assess the effect of providing daily SMS messages for the seven days following VMMC on men's attendance at the seven-day post-operative appointment.<sup>49</sup>

### ***Intervention:***

Half of the men in the trial received daily SMS messages with instruction on wound care and pain management, and reminders to return for their seven-day post-operative appointment (see schedule of messages in Table 4 below). The other half of the men did not receive daily SMS reminders.

**Table 4: Daily SMS Reminders Received by Men Enrolled in Program**

<b>Post-op Day</b>	<b>Message (English)</b>
1	If u r not the intended recipient of the Male Circumcision (MC) message, please text STOP to 0722819835 and you will not receive future messages. Thank you. This is your MC provider. It is normal to feel a bit of pain and swelling, but if there is severe swelling, bleeding or pain please come back to the clinic.
2	This is your MC provider. Remember do not allow water to soak the dressing before removal on the 3rd day.
3	Remove the dressing today. Make sure you review the post-op instructions and use the blade provided. Throw away the blade after use.
4	This is your MC provider. Always keep the genital area dry n clean to avoid infection. Do not apply any ointment or creams that are not prescribed by the clinic.
5	This is your MC provider. If you feel heavy pain, swelling, bleeding, or any sign of infection please consult the clinic.
6	This is your MC provider. Don't forget to come back to the clinic for your day 7 follow-up visit. You will be checked to be certain the healing is going well.
7	This is your MC provider. See you at the clinic today for your follow-up visit.

### ***Results:***

The study found a modest statistically significant increase in the percentage of men who returned for the seven-day post-operative appointment amongst those who received the SMS messages (65.4 percent) versus those who did not (59.7 percent). The men who did not return for the seven-day post-operative visit had higher transportation costs or had lower educational levels. Thus, SMS messages can be one approach used to increase attendance at post-operative appointments, but other barriers may also need to be addressed to achieve higher results.<sup>50</sup>

### ***Contact:***

For more information, contact the corresponding author, R. Scott McClelland, at [mccllell@u.washington.edu](mailto:mccllell@u.washington.edu).

## SECTION 3: KEY CONSIDERATIONS FOR INCREASING MEN'S UTILIZATION OF SRH PRODUCTS AND SERVICES

Over the past two decades, much has been learned from efforts to increase demand for and use of SRH products and services for men in LMIC. This section provides a summary of key considerations when designing SBC programs to increase demand for and utilization of SRH products and services for men, including the need to:

1. **Develop an SBC strategy**
2. **Reach the right audiences**
  - » Develop a deeper understanding of audiences
  - » Segment audiences for better messaging
  - » Tailor messages to the life stages of men
  - » Engage women as partners and mothers
  - » Promote couples communication
3. **Use gender transformative programming**
4. **Select effective communication channels**
  - » Utilize peer educators and mentors
  - » Engage community and religious leaders
  - » Use technology: mHealth, hotlines and social media
  - » Provide high-quality comprehensive counseling
5. **Explore unique opportunities**
  - » Brand SRH products and services for men
  - » Use client testimonials and engage male champions
  - » Consider the timings and design of communication campaigns

### DEVELOP AN SBC STRATEGY

Successful SBC programs are developed using a systematic process and behavioral theory to design and implement communication activities that encourage sustainable social and behavior change. A communication strategy guides the entire program or intervention, setting the tone and direction, so that all communication activities, messages and materials work together to achieve the desired change in men's utilization of SRH products and services. Strategic activities and materials are more likely to promote change.

Regardless of the health topic or audience being reached, most SBC strategies are developed using the seven following steps:

- **Step 1:** Analyze the Situation
- **Step 2:** Select the Audience and Segment
- **Step 3:** Develop Communication Objectives
- **Step 4:** Determine the Strategic Approach
- **Step 5:** Positioning and Strategic Outline
- **Step 6:** Create an Implementation Plan
- **Step 7:** Develop a Monitoring and Evaluation Plan

The [Designing a Social and Behavior Change Communication Strategy Implementation Kit](#) (I-Kit) provides comprehensive guidance on how to develop a communication strategy for SBC. The Guide provides step-

by-step guidance and tools to assist program manager, communication specialists and relevant stakeholders prepare and plan for effective SBC initiatives through a comprehensive approach.

**Resources**

For more information and guidance on developing an SBC strategy, see:

- [Designing a Social and Behavior Change Communication Strategy I-Kit](#)

**REACH THE RIGHT AUDIENCES**

While many audiences influence men’s use of SRH products and services, to be as effective as possible an SBC strategy needs to focus on changing the behaviors of the groups of people whose behavior must change in order for men to use SRH products and services. The exact number of intended audiences will depend on the local context and project resources (i.e., budget, staff, length of implementation, etc.).

**Primary and Secondary Audiences**

Intended audiences are divided into two types, primary and secondary. Table 5 below provides illustrative examples of these audiences.

**Table 5: Illustrative Examples of Primary and Secondary Audiences**

Primary Audiences	Secondary Audiences
<p><i>Primary audiences</i> are the people whose behavior you want to change. These may be the people who are directly affected and will practice the desired behavior, or they may be the people who can make decisions on behalf of those who would benefit from the SRH product or service, such as parents of young men (for VMMC).</p>	<p><i>Secondary audiences</i> are people that interact with and influence the primary audience, either directly or indirectly.</p>
<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Adolescent boys</li> <li>• Men aged 15 to 49</li> <li>• Health providers</li> <li>• Pharmacists</li> <li>• Community health workers</li> <li>• Parents or caregivers of adolescent males (males under 18 years of age)</li> </ul>	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• Female partners (wives, girlfriends, etc.)</li> <li>• Peers</li> <li>• Co-workers and employers</li> <li>• Health providers</li> <li>• Pharmacists</li> <li>• Community health workers</li> <li>• Community leaders</li> <li>• Traditional leaders</li> <li>• Religious leaders</li> <li>• Media and journalists</li> </ul>

The primary and secondary audiences for SRH products and services for men may differ throughout the three stages of the SRH continuum of care. For example, when seeking to increase use of male condoms for FP, the primary audiences in the *before* stage may be men of reproductive age, with female partners, peers, community leaders and religious leaders as secondary audiences. *During* service delivery or product purchase, health providers may be the primary audience for behavior change, with the objective of motivating them to provide men with high-quality counseling on their FP options. In the *after* stage, men and their peers may comprise the primary and secondary audiences respectively, with the objective of helping men maintain consistent use of condoms and encourage social support.

**Develop a Deeper Understanding of Audiences**

In order to effectively motivate primary and secondary audiences to increase men’s utilization of SRH products and services, it is important to understand the audiences as much as possible. Research methods can be applied to allow programs to gain deeper, richer insights into what motivates some men to use SRH services and what prevents others, including:

- **Journey Mapping** is a method of storytelling which helps program staff learn about an intended audiences’ experience with an SRH product or service. In a journey mapping exercise, men or other primary or secondary audiences, are asked to describe their “journey” towards (or away from) the SRH product or service being promoted. The exercise focuses on understanding men’s (or the secondary audiences’) user experience and where their goals and objectives are not being met. Journey mapping can provide insights into social and gender norms, relationship dynamics and structural barriers that may hinder men’s use of an SRH product or service and the need to be addressed through SBC.
- **Behavioral Economics** is a method of analysis in which program staff apply psychological insights to the intended audiences’ behavior to explain economic decision-making. Behavioral economics has been used to understand how men and secondary audiences make decisions, and what motives and incentives influence men to use or not use an SRH product or service.

### **Segment Audiences for Better Messaging**

Segmenting the primary and secondary audiences into smaller, more-distinct groups that share similar interests, attitudes and needs relative to the male SRH product or service being promoted leads to more successful targeting of messages and channels. If the group shares common attributes, the members are more likely to respond similarly to a given communication strategy.

Segmenting allows for targeted use of limited resources to reach those audiences that will most affect increased demand and utilization. It ensures the activities developed and implemented are the most effective and appropriate for specific audiences and are focused on customized messages and materials designed to motivate action.

Traditionally, men and other primary and secondary audiences have been segmented using **demographics** (i.e., grouping based on characteristics such as age, sex, marital status, education level, socio-economic status, residence (urban/rural) and employment). However, this form of segmentation assumes all men who share these characteristics face similar barriers, motivators and triggers (i.e., cues that prompt a person) to take action, which may or may not be the case.

It is becoming more and more common for programs to segment audiences using **psychographic** characteristics, such as men’s knowledge, attitudes, beliefs, values, motivations, needs and hopes. Psychographic segmentation provides richer insights into what people believe and value, which can help determine the approach and messaging to reach that audience.

**Table 6** provides a list of common demographic and psychographic characteristics.

<b>Demographic Characteristics</b>	<b>Psychographic Characteristics</b>
<ul style="list-style-type: none"> <li>• Sex</li> <li>• Age</li> <li>• Education</li> <li>• Occupation</li> <li>• Marital status</li> <li>• Ethnicity</li> <li>• Religion</li> <li>• Socioeconomic status</li> <li>• Geographic location</li> <li>• Parity</li> </ul>	<ul style="list-style-type: none"> <li>• Attitudes</li> <li>• Knowledge</li> <li>• Beliefs</li> <li>• Values</li> <li>• Hopes</li> <li>• Aspirations</li> <li>• Preferences</li> <li>• Interests</li> <li>• Personality</li> <li>• Perceived social and gender norms</li> </ul>

## **Psychographic Segmentation Example: Psychographic Segmentation Creates More Effective VMMC Messages**

### **Program Description:**

VMMC is a priority intervention for HIV prevention in Zimbabwe. Despite concentrated demand generation efforts, the uptake of VMMC was not sufficient to reach the national policy's goal of 80 percent of 13-to-29-year-old Zimbabwean males (about 1.3 million young men) using VMMC services by 2015.

In order to increase VMMC in Zimbabwe, PSI Zimbabwe used psychographic segmentation to redesign its VMMC program to adequately motivate the desired primary audience to seek and use VMMC services.

### **Intervention:**

In 2015, IPSOS Healthcare, Final Mile and Upstream conducted extensive qualitative data collection using focus groups, in-depth interviews, journey mapping and ethnolabs. Multiple stakeholders were involved in the research, including circumcised and uncircumcised adolescent males and men, wives and female partners, male peers, providers, VMMC program leaders and community and religious leaders.

The three firms focused their research to:

- Understand the decision-making process for men intending to undergo VMMC (including the impact of secondary audiences);
- Identify physical and emotional motivators for and barriers to VMMC uptake and the impact of the social environment;
- Identify existing awareness, knowledge, perceptions and information or awareness gaps related to VMMC;
- Identify and map key stakeholders' information gaps; and
- Design a tailored communication and service approach for men seeking VMMC services.

### **Results:**

The research identified five key factors that influence men's action to undergo VMMC:

- Motivation/need for VMMC
- Rejection due to cognitive dissonance
- Perceived lack of ability
- Acceptance of social support
- Personal fears

PSI Zimbabwe used a hybrid psychographic-behavioral segmentation approach to profile men according to their perceptions about and orientation to VMMC. Men aged 15 to 29 were segmented into six audience groups (see **Figure 6**).



*Image 16: Man fills in a journey mapping workbook*



*Image 17: Female partners engage in an ethnolab game*



Based on this segmentation, PSI Zimbabwe developed audience profiles and a tailored approach to reach each of the segments. PSI Zimbabwe used techniques adapted from **human-centered design** (HCD) to develop strategies and messages, which provided richer insights into what motivates men to undergo VMMC and prototyped messages and tools with the intended audiences (see messages and channels in chart).

PSI Zimbabwe staff adapted a segmenting tool to quickly segment clients into one of the archetypes. This tool has a series of questions set up like a decision tree. The questions are based on psychographics rather than typical demographics. Once the questions are answered the color-coded guide helps mobilizers categorize each potential client into one of the six segments and then tailor messages that speak to the specific motivators and barriers of that segment. This helps ensure that the real needs of the men are efficiently and effectively addressed in the one-on-one and small-group interactions.

**Results:**

Community mobilizers report that the new segmentation tool helps them better understand the profile of the men they are talking to and they are better able to tailor their messages to address the barriers and concerns most relevant to that segment. Previously, community mobilizers provided all men with the same key messages and often counseled on issues that were not pertinent to the individual. Community mobilizers report that they are now more time efficient and effective in their counseling as they are able to quickly tailor messages and identify clients who are more likely to uptake the service and can therefore spend more effort counseling those clients.

**Contact:**

For more information, contact PSI at [www.psi.org](http://www.psi.org).

**Human-Centered Design**

HCD consists of three phases:

1. **Inspiration Phase:** Here program staff learn directly from the people they're designing for as they immerse in the audiences lives and come to deeply understand their needs
2. **Ideation Phase:** Here program staff make sense of what they've learned, identify opportunities for design, and prototype possible solutions
3. **Implementation Phase:** Here program staff will bring the solution to life, and eventually, to market.

Throughout all steps of the process, program staff keep the very people they are looking to serve at the heart of the process.

For more information on HCD, see the IDEO.org's Design Kit at <http://www.designkit.org/>.

**Resources**

For more information and guidance on audience segmentation, see:

- [How to Do Audience Segmentation Guide](#)

Figure 6: Segmentation of men aged 15 to 29 into six audience groups

	VMMC Enthusiasts	VMMC Champions	VMMC Neophytes	Scared Rejecters	Embarrassed Rejecters	Highly Resistant
Independent vs. socially driven	Socially driven	Independent	Independent	Independent	Socially driven	Socially driven
Level of social support	High	Moderate	Moderate	Low	Low	Low
Motivations and messages	<ul style="list-style-type: none"> <li>- STIs/ HIV protection</li> <li>- Better sexual relationships</li> <li>- Helps feel closer to partner</li> <li>- Sexually appealing</li> </ul>	<ul style="list-style-type: none"> <li>- Protection for future generations</li> <li>- Slowdown the spread of HIV</li> <li>- HIV/ STIs protection</li> </ul>	<ul style="list-style-type: none"> <li>- To get sons circumcised</li> <li>- HIV/ STIs protection</li> <li>- Clean and smart</li> </ul>	<ul style="list-style-type: none"> <li>- STIs protection</li> <li>- HIV/STIs protection</li> <li>- Slowdown the spread of HIV</li> <li>- HPV protection</li> </ul>	<ul style="list-style-type: none"> <li>- Hygiene</li> <li>- HIV/ STIs protection</li> </ul>	<ul style="list-style-type: none"> <li>- Hygiene</li> <li>- Protection from HIV/ STIs (know, but mostly don't believe)</li> <li>- Negative beliefs</li> </ul>
Barriers /concerns /issues	<ul style="list-style-type: none"> <li>- Around erection and pain during healing</li> <li>- Time off (work, etc.)</li> <li>- HIV testing</li> <li>- Increase of promiscuity</li> </ul>	<ul style="list-style-type: none"> <li>- Around erection and pain during healing</li> <li>- Injections</li> <li>- Possible complications and loss of sensitivity</li> </ul>	<ul style="list-style-type: none"> <li>- Possible complications</li> <li>- Surgery and safety</li> <li>- Pain during healing</li> <li>- Lack of info</li> <li>- Quality of service</li> </ul>	<ul style="list-style-type: none"> <li>- Safety of the procedure, fear of complications, surgery, pain, injections, pain during healing, too long</li> <li>- Healing, service</li> </ul>	<ul style="list-style-type: none"> <li>- Fear and embarrassment</li> <li>- Concerns about pain, surgery, injections, healing process &amp; healing time</li> <li>- Service, privacy</li> </ul>	<ul style="list-style-type: none"> <li>- Believe in all possible negative consequences of MC</li> <li>- Need acceptance of the community</li> <li>- Are not open to info</li> </ul>
Channels	<ul style="list-style-type: none"> <li>- 'Word of mouth' (everyone, including males and females)</li> <li>- Friends</li> <li>- Mobilizers</li> <li>- HCPs</li> </ul>	<ul style="list-style-type: none"> <li>- Mobilizers</li> <li>- Partner and family members</li> <li>- Friends (especially if circumcised friends share experience)</li> <li>- HCPs</li> </ul>	<ul style="list-style-type: none"> <li>- Media</li> <li>- Mobilizers</li> <li>- Advocates among friends and brothers</li> <li>- HCPs</li> </ul>	<ul style="list-style-type: none"> <li>- HCP (more credible source of information)</li> <li>- Mobilizers</li> <li>- Partners</li> <li>- Friends</li> </ul>	<ul style="list-style-type: none"> <li>- Need more social support: especially from male peers, network of advocates</li> <li>- Media</li> <li>- Mobilizers</li> </ul>	<ul style="list-style-type: none"> <li>- Wide campaign in the community, community leaders</li> <li>- A lot of advocates around</li> <li>- Mobilizers</li> </ul>

### Tailor Messages to the Life Stages of Men

When developing communication strategies to increase demand for and use of SRH products and services for men, the **life stage approach** can be successful. Programs using the life stage approach reach men with the information and skills that are relevant to their stage in life (i.e., adolescence, young adult or adult), in the belief that providing men with the information they need when they need it increases the likelihood of its use. A life stage approach can also allow programs to design interventions to address specific attitudes and social and gender norms that act as barriers during a particular life stage.

Men have different SRH needs based on their life stage, which will influence which SRH products and services should be promoted, as well as how they are promoted. The positioning, channel selection and messaging should all be informed by and tailored to the life stage of the men being reached. For example, vasectomy programs typically do not focus on adolescent males as they are not at a life stage in which this information would be used or potentially acted on for many years.

If an SRH product or service is applicable across multiple life stages, then the approach to positioning, channel selection and messaging will be different across the life stages. **Table 6** illustrates one example of how the life stage approach may influence a VMMC program.

**Table 6: Example of Life Stages Approach for VMMC**

Life Stage	Positioning	Channel Selection	Messaging
<b>Adolescent Men (13 to 18 years old)</b> <ul style="list-style-type: none"> <li>Time of sexual debut and exploration</li> </ul>	VMMC will help protect you from HIV and help you get where you want to go.	<ul style="list-style-type: none"> <li>School-based programs (secondary level)</li> <li>Social media</li> <li>Radio</li> <li>Community outreach with parents and caregivers of adolescent men</li> </ul>	<ul style="list-style-type: none"> <li>HIV-prevention benefits of VMMC</li> <li>Hygiene benefits of VMMC</li> </ul>
<b>Young Adult Men (19 to 25 years old)</b> <ul style="list-style-type: none"> <li>Most men are unmarried or in non-committed relationships</li> </ul>	VMMC is an effective, modern way to reduce your risk of HIV, and women find a circumcised man more appealing.	<ul style="list-style-type: none"> <li>School-based programs (tertiary level)</li> <li>Social media</li> <li>TV</li> <li>Community outreach to men</li> </ul>	<ul style="list-style-type: none"> <li>HIV-prevention benefits of VMMC</li> <li>Hygiene benefits of VMMC</li> <li>VMMC is modern</li> <li>Women prefer circumcised men</li> </ul>
<b>Adult Men (Aged 26 and older)</b> <ul style="list-style-type: none"> <li>Most men are married and have children</li> </ul>	Responsible husbands and fathers get VMMC to better protect and provide for their families.	<ul style="list-style-type: none"> <li>Employer-based programs</li> <li>TV and radio</li> <li>Community outreach to men and wives/female partners</li> </ul>	<ul style="list-style-type: none"> <li>Hygiene benefits of VMMC</li> <li>Health benefits to wives or female partners (reduced risk of transmitting HIV and HPV)</li> </ul>

### Engage Women as Partners and Mothers

While the utilization of an SRH product or service by a man is ultimately the man's decision, it is important to acknowledge the role women can play in influencing a man's use of SRH products and services. Whether as a female partner, wife or mother, women are important sources of information, encouragement, support and discussion. An effective communication strategy should incorporate women as secondary audience, as well as a primary audience, when applicable.<sup>51,52,53</sup>

Communication to women should be based on the role women play in the lives of men. In most cases, wives and female partners are secondary audiences, whereas mothers and caregivers may be a primary audience, as they often make health decisions on behalf of men under 18 years of age.

When developing a communication strategy to engage women, it is important to understand the gender dynamics in the community. Research should be done on what role men want their wives and female partners to play in the decision to utilize an SRH product or service. While women are often cited as the number one influencer on a man's decision to use an SRH product or service, in some instances men do not want women to bring up the topic or pressure them to use a product or service. Instead, men may want to discuss their options with their wives or female partners, and receive their support and encouragement.

### **Promote Couple Communication**

Improving couple communication can strengthen joint decision-making in relation to FP use, HIV and STI prevention and other SRH needs. By encouraging couples to discuss their FP intentions, HIV status and other important SRH topics, couples are better able to make decisions for their individual health, as well as the collective health of their family.



*Image 18: A couple receives FP counseling in India*



*Image 19: Couple discusses FP options in Mali*

### **Couple Communication Example: Couple Communication Campaign Increased HIV Testing and Counseling**

#### **Program Description:**

In Uganda, the **Health Communication Partnership**, in collaboration with the MOH and AIDS Information Center, designed and implemented a national, multi-channel campaign to encourage couples to go for HIV testing and counseling services together. The campaign, known as “Go Together, Know Together,” encouraged couples who did not know their HIV status to go for couples HIV testing services (CHTS) to benefit their relationship.

#### **Intervention:**

The campaign, launched in 2009, employed intense community mobilization activities, including interactive radio shows, community drama and video-taped testimonials from couples who had undergone CHTS. These activities were reinforced by radio and TV spots, billboards, posters, media coverage and branding sites offering CHTS.

#### **Results:**

The Go Together, Know Together campaign was highly successful at influencing individuals exposed to the campaign to take action. A survey conducted found that 53 percent of respondents exposed to the campaign took some form of action, including talking to a partner about his/her HIV status (19 percent), talking to a partner about going for CHTS (25 percent) or going to CHTS with a partner (14 percent).

#### **Contact:**

For more information, contact CCP at [www.ccp.jhu.edu](http://www.ccp.jhu.edu).



*Image 20: Go Together Know Together campaign poster*

## **Couple Communication Example: Couples Campaign Promotes Vasectomy in India**

### **Program Description:**

Couple communication has also been promoted to increase knowledge and awareness of and uptake of modern FP methods, including non-scalpel vasectomy (NSV). The **Innovations in Family Planning Services Technical Assistance Project (ITAP)**, led by Futures Group International, was a USAID funded project that primarily focused on developing, demonstrating, documenting and leveraging the expansion of public-private partnerships for provision of high quality FP and RH nationally and, more specifically, in three states of northern India, Uttar Pradesh, Uttarakhand and Jharkhand. As the communication partner on the consortium, CCP used a multi-channel integrated approach to improve demand for FP in largely rural areas, using mass media, community mobilization and capacity strengthening of health workers and IPC agents.

### **Intervention:**

The campaign tagline was “Pati Patni Karein Vichaar, Swasth Nari Swasth Parivar,” (“Interspousal interaction leads to a healthy woman and child,”). The campaign highlighted the impact that male participation, couples communication and joint decision-making in FP has on the health of the entire family.



*Image 21: Couple in India*

In 2009-2010, TV and radio spots were developed under this integrated campaign for the National Rural Health Mission, Ministry of Health and Family Welfare, including a TV spot promoting vasectomy as an effective, safe and permanent FP method for couples who have completed their families. The spot featured a man taking responsibility to have a vasectomy after he and his wife mutually decide to use this method after completing their family. Watch the TV spot here: [https://www.youtube.com/watch?v=hfyaAymL\\_To](https://www.youtube.com/watch?v=hfyaAymL_To).

CCP also provided capacity strengthening and technical assistance to develop:

- Fifty-two-episode radio program promoting reproductive, maternal, newborn and child health and adolescent (RMNCH+A) health behaviors with community listener groups;
- Twenty-six-episode distance learning radio program for service providers to improve service communication;
- Innovative and interactive communication materials with audience participation; and
- Training tools and skills building workshops for outreach workers.

### **Contact:**

For more information, contact CCP at [www.ccp.jhu.edu](http://www.ccp.jhu.edu).

## USE GENDER-TRANSFORMATIVE PROGRAMMING

In order to increase men’s demand for and use of SRH products and services, SBC strategies and activities should strive to be gender transformative.<sup>54</sup> Gender-transformative programming seeks to address and change gender norms that create unequal access to and utilization of SRH products and services by men. Programs that apply a gender transformative approach identify gender norms that hinder men’s use of SRH products and services and actively work to change those norms to be more gender equitable. For example, in many societies, men are expected to be strong and not show physical weakness or pain. In such societies, men may not seek out health care for the symptoms of an untreated STI, as this may be interpreted as a sign of weakness. A gender-transformative program would acknowledge this gender norm and then seek to address it by repositioning health-seeking behavior as a sign of strength for both men and women.

Throughout design and implementation, programs should routinely analyze and assess whether messages, approaches and activities are gender transformative or if they are reinforcing inequitable relationships, dynamics or gender norms. It is important that in the interest of getting men to use products and services, programming does not erode women’s autonomy in their own decision-making around SRH.

When developing SBC materials, the questions included in Gender Transformative SBC Materials Checklists (see **Table 7**) can assist in ensuring gender is incorporated in a meaningful way to move strategies towards gender transformation approaches.

**Table 7: Gender Transformative SBC Materials Checklist<sup>55</sup>**

Questions	Gender Neutral	Gender Sensitive	Gender Transformative
<i>Does the material show women and men involved in traditional practices (i.e., bride price, etc.) which could be interpreted to promote gender inequality?</i>	<i>Are the traditional roles/ traditional practices essential to the message being communicated? If not, can other images/ situations be used instead?</i>	<i>Avoid depicting traditional practices unless they are the focus of the intervention (e.g., prevention of female genital mutilation/cutting).</i>	<i>Think of how you can challenge traditional roles. Can you represent men and women actively questioning and reflecting on rigid gender roles?</i>
<b>Note:</b> Presenting traditional practices simply to “set the scene” can end up legitimizing these same practices. An example could be including a traditional practice like “lobola,” where women are presented as “property.” Avoiding these traditional practices is not meant as a condemnation of the practice. However, some of them can promote inequity, and there is often no benefit to including them.			
<i>Are the messages and images in health-care materials primarily targeting women?</i>	<i>Begin to include images of men or of couples (as well as women) whenever appropriate.</i>	<i>Include images and messages for men (as well as women) which promote male involvement in SRH whenever appropriate.</i>	<i>Create materials which target men specifically and challenge gender norms keeping men from seeking health services.</i>
<b>Note:</b> Many men see SRH, and health care in general, as a primarily female arena. Images which feminize health in general can reaffirm an impression that caring for oneself and using health services is a feminine trait.			
<i>Are men and women primarily represented in traditional gender roles (i.e., women caring for children and doing housework, men making the main decisions, men being the provider or women being submissive)?</i>	<i>Avoid using images of men and women in traditional gender roles.</i>	<i>If you must use messages which relate to traditional gender norms, include others which are more equitable. For example, a message asking men to financially support their partners’ use of FP (men as providers) can be mixed with messages asking men to discuss and participate in FP and to respect their partner’s decisions regarding FP.</i>	<i>Actively challenge traditional gender norms and ask men (and women) to equitably share responsibility for SRH, as well as caregiving, decision-making and household chores.</i>
<b>Note:</b> Presenting these traditional gender roles, especially in the context of health or other social programming, can end up legitimizing them.			

Questions	Gender Neutral	Gender Sensitive	Gender Transformative
<i>Does the way in which gender is integrated into programming or messaging inadvertently promote inequitable norms?</i>	<i>Avoid using gender norms to highlight a perceived health risk unless you are able to spend time analyzing their interaction and are able to communicate the complexity of those gender norms.</i>	<i>Only mix in gender issues which are relevant to the goals of the specific campaign, and even then conduct qualitative research to understand the relationship between gender and the desired behavior change.</i>	<i>Actively identify and analyze gender issues and challenge inequitable gender norms broadly.</i>
<b>Note:</b> For example, a campaign to reduce women’s alcohol consumption referred to sexual violence as a consequence of drinking. (It was subsequently removed after backlash.) While this reasoning is intended to serve as a deterrent to alcohol abuse, it creates serious harm by leaving the impression that women who drink are in part responsible for any sexual violence they may experience.			
<i>Do you ask men or women to behave like “real” men or women?</i>	<i>Avoid any reference to “real” men or women.</i>	<i>Avoid any reference to “real” men or women.</i>	<i>Avoid any reference to “real” men or women. Ideally a gender-transformative project will instead question the notion that there are “real” men or women and will promote gender equality more broadly.</i>
<b>Note:</b> A strategy in which the term “real men” or “real women” is being used as an attempt to turn the issue on its head and question traditional gender norms can (at times) be effective. Though some campaigns use this strategy, it has to be done with extreme care, as the perceived need to prove manhood (or womanhood) is in and of itself a norm which needs to be questioned. Also, the concept of a specific category of real men or women excludes many men or women.			
<i>Are you using simplistic or overly generalized representations of masculinities or femininities?</i>	<i>If using representations of traditional masculinities, do not use caricatures. Many men can hold very inequitable views while holding more equitable views at the same time. For example, a man may believe that women and men should have equal opportunities and pay at work, but he may also believe that women should provide the majority of caregiving for their children.</i>	<i>Hold focus group discussions to better understand masculinities and femininities in the project area and develop positive examples of gender-equitable men and women.  If using representations of traditional masculinities, do not use caricatures.</i>	<i>Use images of positive deviants (i.e., men who are equitable in their relationships or women who are empowered) to demonstrate that gender roles can be flexible if we so choose, and that you do not have to fit into a “gender box.” If you choose to portray a negative gender norm, do not use a caricature of a “traditional” man or woman and provide an alternative to this negative norm.</i>
<b>Note:</b> There is no one version of masculinity or femininity in any society. Oversimplifying can make it hard for the audience to identify with the messages you create.			



## **Gender Transformative Example: Address Gender Norms to Increase Knowledge and Use of SRH Products and Services for Men**

### **Program Description:**

In Uganda, the **Learning Center Initiative (LCI)** used a gender transformative approach to address men as clients, partners and advocates for social change.<sup>56</sup> The project, managed by Sonke Gender Justice and implemented by Reproductive Health Uganda from 2011 and 2013, sought to increase men's access to SRH services, challenge unequal gender roles that harm men and women and engage men as agents for social change (see **Figure 7**).

### **Intervention:**

To accomplish these objectives, LCI used a mix-channel approach, including:

- Educating men on SRH through churches, football tournaments, community outreach, drama performances, posters, monthly radio programs, bi-weekly community sensitization meetings and media briefs to journalists;
- Establishing a SRH resource center staffed by program staff;
- Using peer educators to address misinformation and encourage men to access SRH services;
- Conducting workshops to challenge unequal gender roles that harm men and women, highlighting the benefits of more gender equitable alternatives;
- Encouraging men to improve communication with their female partners regarding sexual decision-making, sexuality and to support their female partners' needs and share in domestic duties ;
- Encouraging men to act as agents or advocates of change by participating in the promotion and delivery of SRH information in their community; and
- Urging religious and community leaders to publicly support gender equality and cultivate positive attitudes towards men's involvement in SRH.

To complement these activities, LCI hosted Saturday clinic days every week that targeted male attendance, offering VMMC, reproductive planning and testing and treatment of STIs, including HIV, free of charge. Providers and clinic staff were trained on how to make SRH services friendlier and more accessible to men. The initiative also offered HTS and STI testing at men's workplaces.

### **Results:**

LCI successfully raised men's awareness and knowledge of SRH issues. Program staff reported an increased demand for and utilization of SRH services by men. Men also reported more shared sexual decision-making and participation in domestic duties.

For more information on the implementation and results from LCI, read an article on the program evaluation here: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4706030/>.

### **Contact:**

For more information, contact Sonke Gender Justice at <http://www.genderjustice.org.za/>.

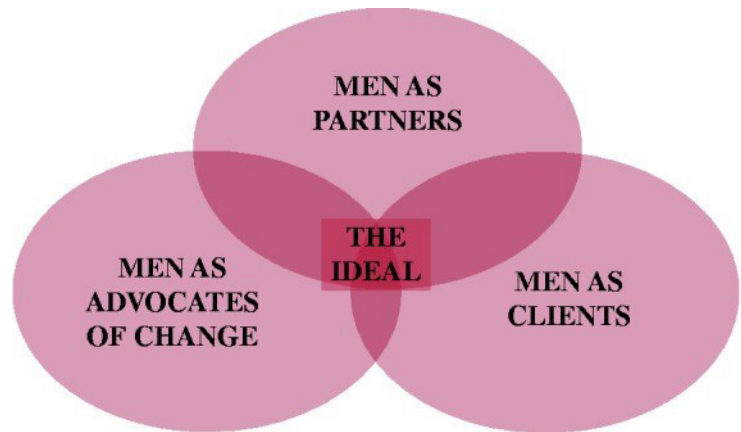


Figure 7: LCI three pronged matrix for engaging men to change gender norms

## Resources

For more information and guidance on gender transformative programming, see:

- [Gender Transformative Programming](#)
- [Engaging Men and Boys in Gender Equality and Health Toolkit](#)
- [Program H: Working with Young Men](#)
- [Engaging Boys and Men in Gender Transformation: The Group Education Manual](#)
- [Addressing the Role of Gender in the Demand for RMNCH Commodities: A Programming Guide](#)
- [Communicating Gender for Rural Development](#)
- [African Transformation Toolkit](#)

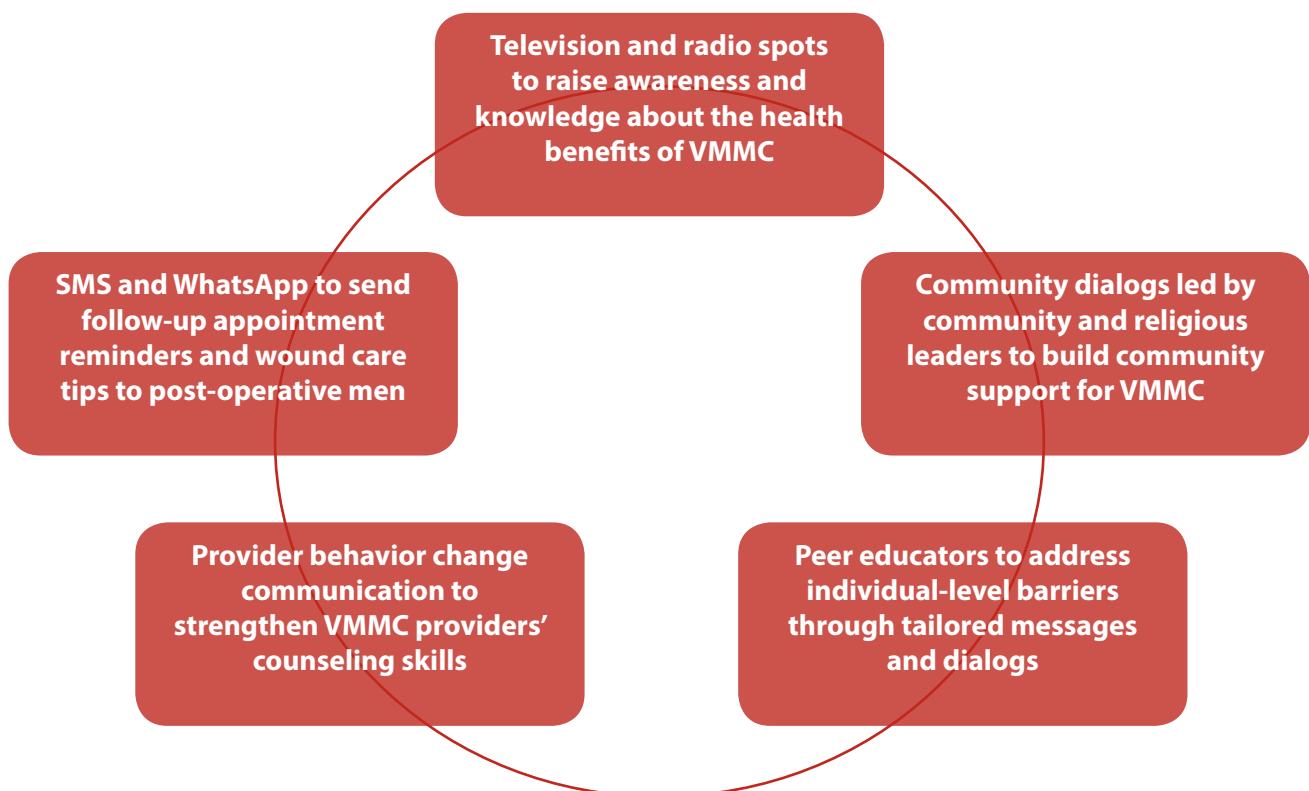
## SELECT EFFECTIVE COMMUNICATION CHANNELS

A well-designed communication strategy for promoting SRH products and services for men includes activities across a range of different communication channels to reinforce messages and reach the intended audiences where and when they are most receptive to messages. According to a review of interventions by WHO and [Promundo](#), integrated programs and programs that incorporate community outreach, mobilization and mass-media campaigns are more effective at changing behavior among boys and men.<sup>57</sup>

The process of aligning channels and messages means selecting the right communications channels for the message and the intended audience. Determining the right channel mix will be informed by the program objectives, the local context and the audience analysis.

Each communication channel has advantages and disadvantages; therefore, it is most effective to use a combination of different channels to increase the effect on changing behavior. Using multiple channels will lead to greater reach and allow the intended audience to receive the same message in multiple ways, facilitating retention and comprehension. An example of how a communication strategy for VMMC may use multiple channels is illustrated in **Figure 8**.

**Figure 8: Example of Using Multiple Channels for Before, During and After VMMC Use**



When selecting communication channels, it is important to remember that not all channels are appropriate for all messages. Some messages and new behaviors require a lot of interaction, information or time, particularly when introducing a new skill or addressing deeply held beliefs, misinformation or social and gender norms. The message requirements will determine the appropriate format: interpersonal, small group, mass media or social media. For example, addressing a man's fear of pain and the period of sexual abstinence following a vasectomy may be best addressed through a one-on-one or small group session with a peer educator or community outreach agent. Alternatively, promoting couple communication and joint decision-making regarding FP, including the decision to undergo a vasectomy, may be best addressed through modeling behavior during a community drama event.

## Resources

For more information and guidance on media selection and an appropriate channel mix plan, see:

- [A Theory-Based Framework for Media Selection in Demand Generation Programs](#)
- [How-to Guide: How to Develop a Channel Mix Plan](#)

## Utilize Peer Educators and Mentors

Peers play a key role in motivating men to utilize SRH products and services. Many studies have demonstrated that peers, especially those who already use the SRH product or service, can positively influence other men by providing credibility to health messages and leveraging the power of role modeling.<sup>58,59,60,61</sup> Peers can also support the development of positive group norms by providing support for deviations from social and gender norms.

Communication strategies often engage peer educators and mentors in an effort to address beliefs and misinformation, build knowledge and address social and gender norms that negatively impact men's willingness to use SRH products and services. Since peers educators and mentors typically come from the same communities as the men they reach, they can relate to the barriers other men face in accessing and utilizing health products and services, and provide realistic solutions.

Peer mentors provide an additional benefit of being able to share their own experience using the SRH product or service being promoted. Many men have fears and misinformation about side effects, pain and periods of sexual abstinence that can be uniquely addressed by men who already use the product or service.

## Engaging Community and Religious Leaders

In order to create an enabling environment for men to seek and use SRH products and services, it is often necessary to engage community, traditional, political and religious leaders. Community, traditional and religious leaders play a key role in shaping and maintaining social and gender norms. As leaders in their civic and religious communities, they are uniquely positioned to normalize men's use of SRH products and services as community gatekeepers and thought leaders.

Examples of how community, traditional, political and religious leaders can be engaged to create change for men's use of SRH products and services are explained in **Table 8**.



Image 22: Male champions of FP engage in community mobilization in Kenya

**Table 8: Suggestions of how leaders may be used to promote SRH products and services for men**

Community/Traditional Leader	Political Leader	Religious Leader
<ul style="list-style-type: none"> <li>• Frame men’s use of SRH products and services as being in-line with being a responsible member of society</li> <li>• Promote the idea that men should share the responsibility for SRH with their wives and female partners</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate for the provision of SRH products and services for men</li> <li>• Ensure SRH products and services for men are included in national guidelines</li> <li>• Ensure SRH products and services for men receive adequate funding</li> </ul>	<ul style="list-style-type: none"> <li>• Frame men’s use of SRH products and services as being in-line with religious text or beliefs (e.g., Christianity, Islam or Judaism)</li> <li>• Promote the idea that men should share the responsibility for SRH with their wives and female partners</li> </ul>

In Bangladesh, the **ACQUIRE Project** sought to increase the availability, quality and use of facility-based reproductive health and FP services among couples. In order to reach couples and promote the use of modern FP methods, including vasectomy and male condoms, the project enlisted the help of religious leaders to demonstrate the acceptability of FP with their congregations. The project produced a book entitled *Family Planning in the Eyes of Islam*, which was designed to engage imams in the promotion of FP by demonstrating the acceptance of FP in the Qur’an. The project also conducted community forums with imams, teachers, business leaders, political leaders and FP providers to discuss FP, with a special emphasis on permanent methods.<sup>62</sup>

***The ACQUIRE Project***

In Bangladesh, the ACQUIRE Project successfully addressed supply and demand side issues to increase the perception and utilization of vasectomy. The project used a combination of mass media, community outreach, telephone hotlines and male champions, including religious leaders, to address misinformation regarding vasectomies and increase demand for vasectomy services. For more information regarding this and similar programs in Honduras and Ghana read the following country case studies:

- [Bangladesh](#)
- [Honduras](#)
- [Ghana](#)

***Use Technology: Hotlines and Social Media***

Program experience in numerous countries has found that men, especially adolescent and younger men, are receptive to accessing and receiving SRH information for themselves and their partners via hotlines and social media.<sup>63,64,65</sup> Accessing information remotely via hotlines and social media allows men to receive the SRH information they need when they need it. These mHealth channels provide men with a confidential space in which to discuss taboo topics they may feel unable to discuss in other settings.

## **Hotline Example: Hotline Increased Men's Access to Accurate Information on HIV and HIV Prevention**

### **Program Description:**

In Ethiopia, stigmatization of PLHIV and reticence to talk openly about sex and sexuality present barriers to HIV testing, disclosure of a positive status and seeking services and treatment for related illnesses. To combat stigma and address these barriers, CCP launched the **Wegen AIDS Talkline**, a toll-free hotline, as an alternative communication channel where people felt safe to discuss HIV and related illnesses.



Image 23: Wegen AIDS Talkline logo

### **Intervention:**

Since 2004, the Wegen AIDS Talkline has provided Ethiopians with a confidential and discreet channel through which to receive:

- Up-to-date information on HIV, AIDS, ART, tuberculosis and STI related health issues;
- Supportive counseling to promote HIV prevention and low risk behaviors;
- Promotion of treatment adherence and healthy living among those infected/affected by HIV or AIDS; and
- Referrals to clinical and social support services.

The hotline is staffed by professional counselors 16 hours a day, seven days a week. Counselors received extensive training on primary HIV prevention as well as how to address fears related to HIV testing, coach individuals on how to disclose a positive HIV result to a sexual partner, coach individuals on how to discuss and negotiate safe sex practices with a sexual partner and address questions related to PMTCT, ART, tuberculosis, opportunistic infections and STIs.

### **Results:**

The hotline currently receives approximately 300,000 calls per month, of which counselors are able to answer 120,000. The vast majority of the callers (89 percent) are between the ages of 15 and 29, and more than 90 percent have never been married. The hotline has particularly been effective at reaching men, as 80 percent of the callers are men.

### **Contact:**

For more information, please contact CCP at [www.jhu.ccp.edu](http://www.jhu.ccp.edu).

## Social Media Example: Facebook Used to Promote Vasectomy in Guatemala

### Program Description:

In Guatemala, the **Women's International Network for Guatemalan Solutions (WINGS)** began offering vasectomies at a static clinic in Antigua in 2015. Initial uptake of vasectomy services was low, with only one or two procedures a month due to limited public knowledge about the service and its availability.

### Intervention:

In response to the low uptake of services, WINGS used Facebook™ to promote information about vasectomy and the availability of its vasectomy services in Antigua and at partner clinics in Cobán, Chimaltenango, Escuintla, Mazatenango, Sololá, Santiago Atitlán and Totonicapán.

### Results:

In the months following the intervention, the majority of men (55 percent in the first campaign and 98 percent in the second campaign) who received vasectomies at the clinic reported finding out about vasectomy services from the Facebook campaign.

The Facebook campaign has been especially useful in helping men locate affordable, local vasectomy services.

By 2017, WINGS's vasectomy Facebook campaign received over 77,500 views. The monthly vasectomy clinics are now almost always completely booked (10 to 15 spots per clinic day) and WINGS is scheduling patients two months out.

### Contact:

For more information, contact WINGS at [www.wingsguate.org](http://www.wingsguate.org).

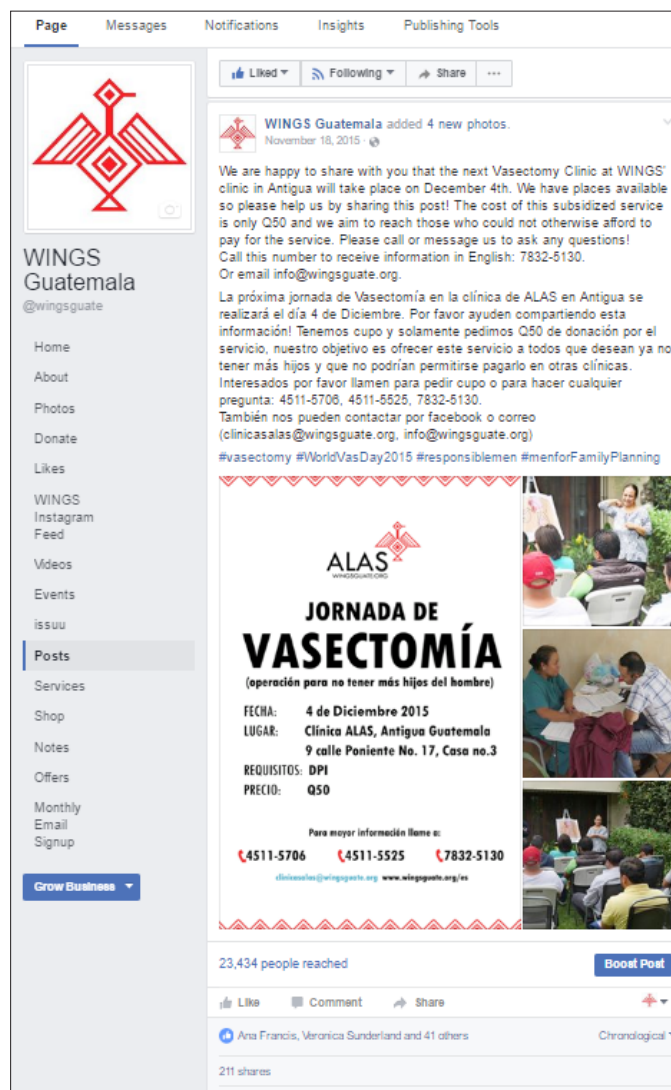


Image 24: Facebook post from WINGS vasectomy campaign

## Provide High Quality, Comprehensive Counseling

When promoting SRH products and services to men, it is important for men to receive high-quality, comprehensive counseling regarding the product or services being promoted or utilized. Whether through IPC agents<sup>66</sup> and community outreach workers during demand generation efforts, or through providers and other health workers during service delivery, messaging to men must openly and honestly address side effects, pain or discomfort during and after a SRH service, abstinence periods (if applicable) and other identified concerns.<sup>67,68</sup>

For example, fear of pain and abstaining from sex following VMMC and vasectomy are often cited as key concerns and barriers to men's uptake of these SRH services. Issues of pain and abstinence are best addressed through channels which allow for two-way communication, such as IPC with peer educators and mentors,

health providers and community outreach workers. All program staff who provide counseling to men should be trained to answer questions about the level of pain associated with the SRH service being promoted. The expectation that some pain will be associated with VMMC or vasectomy should be set during counseling. Counseling should also emphasize that pain during and after the procedure is manageable, common and that the benefits from the procedure outweigh the temporary pain experienced. Ignoring or minimizing the subject of pain could turn a client into a powerful opponent of the SRH service among his peers. Similarly, all program staff should be trained to answer questions about the length of the abstinence period following VMMC and vasectomy. During the VMMC wound healing process for example, it is essential for men to abstain from sexual activity in order to allow for proper healing. The length of the abstinence period should be communicated clearly to clients and their wives and female partners before, during and after the procedure. Health providers should discuss the abstinence period during pre- and post-procedure appointments.

### ***Comprehensive Counseling Example: Innovative Tool Assists Providers in Managing Expectations and Alleviating Fears of Pain Associated with VMMC***

#### ***Program Description:***

In Zimbabwe, research showed that messages had minimized discussions of the pain associated with VMMC. Men reported being surprised when they felt pain during and after the procedure and felt deceived.

#### ***Intervention:***

To address this issue and enhance counseling on expectations during and after the procedure, PSI Zimbabwe used a HCD approach to create and prototype counseling job aids with men. Using men's feedback and input, the *Pain-O-Meter* job aid (see image) was developed in 2016.



*Image 25: Pain-O-Meter Job Aid*

The *Pain-O-Meter* describes the typical pain associated with the VMMC procedure and recovery period using easy to understand terms and references. For example, the pain associated with the injection of local anesthesia for the VMMC procedure is described as an Acacia thorn prick. The discomfort on Day 2 of the recovery period is described as a cut on the finger. The removal of the bandages on Day 3 is described as a band-aid being pulled away quickly.

#### ***Results:***

The *Pain-O-Meter* allows mobilizers and providers to talk honestly about pain so potential clients have clearer expectations about pain during and after VMMC.

#### ***Contact:***

For more information, contact PSI at [www.psi.org](http://www.psi.org).

## EXPLORE UNIQUE OPPORTUNITIES

In designing a communication strategy for promoting SRH products and service for men, it is often beneficial to capitalize on unique opportunities and approaches for addressing barriers and motivating men to take action.

### *Brand SRH Products and Services for Men*

Branding enhances the recognition of the product or service and over time builds trust with the intended audience as to its quality and performance. Trust in a brand can lead to brand loyalty. When done correctly, branding of SRH products and services for men helps men and other key secondary audiences develop favorable associations with the product or service being promoted.

**Branding Products:** Experience promoting male condoms has shown a preference for branded condoms over generic condoms. In studies conducted in South Africa and Malawi, researchers found that youth (defined as 18 to 30 years old in South Africa and 15 to 24 years old in Malawi) had unfavorable perceptions of generic, public-sector condoms.<sup>69,70</sup> In both countries, generic, public-sector condoms were equated with poor quality and reduced safety compared to other brands. In response to this research the MOH in both countries branded their public sector condoms to be more appealing to youth. In South Africa, the MOH also introduced colored, flavored condoms in response to audience insights showing youth wanted more innovative condoms and a variety of choices.

### *Branding Example: Branding Condoms in Malawi Favored by Youth*

#### **Program Description:**

Research in Malawi revealed that youth (aged 15 to 24) perceived free unbranded condoms to be poorly made, less safe and more likely to break than other brands, as well as capable of causing allergic reactions.

#### **Intervention:**

To improve brand appeal and increase access to free public sector condoms for youth, **PSI Malawi**, with funding from the National AIDS Commission, developed the Silvertouch™ brand for both male and female condoms in 2012. The brand slogan “Tsoyolo lokhwana,” which translates to “a hopeful brighter future.”



*Image 26: Silvertouch male condom packaging from Malawi*

#### **Results:**

A year after the brand was launched, PSI Malawi conducted a study to assess acceptability and uptake of the branded Silvertouch condoms among youth. The study used a cross-sectional and multi-stage household survey with 1,214 households and in-depth interviews with 20 key informants from selected facilities that distributed Silvertouch condoms.

Key findings from the study revealed:

- The majority (85.7 percent) of youth liked the brand name Silvertouch. More male (92.3 percent) compared to female (88.7 percent) youth liked the brand name.
- Most of the youth (92.4 percent male and 85 percent female) reported they liked the Silvertouch packaging.
- Twenty percent of the youth reported they use free condom brands on a regular basis, with 90 percent of these youth indicating Silvertouch was their regular condom brand.

A young man in the research study said, “Young people identify themselves with Silvertouch and they often say, ‘this is our brand, the other brands are for adults.’” A health worker at a clinic distributing Silvertouch said he has “observed that the condom replenish rate is so high, unlike in the past. A majority of the youth rush for Silvertouch condoms.”

**Contact:** For more information, contact PSI at [www.psi.org](http://www.psi.org).



**Branding Health Services:** Branding can go beyond the branding of products to also include health services. Branding is often used to convey high-quality, safe SRH services. PSI, Marie Stopes International (MSI), International Planned Parenthood Federation (IPPF) among others have used social franchising to promote and deliver SRH services to men, including vasectomy, HTS and VMMC, through branded clinics. In Cambodia, IPPF provides STI testing and treatment, HTS and vasectomy services to men through its network of 15 Reproductive Health Association of Cambodia clinics (see **Figure 9**).



*Figure 9: Reproductive Health Association of Cambodia logo*



*Figure 10: Zambia VMMC National Program logo*

Branding has also been used by MOHs in national programs to identify sites offering high-quality vasectomy, VMMC and HTS. In Zambia, for example, the MOH developed a national quality icon for the National VMMC Program (see **Figure 10**). The icon, which featured the colors of the Zambian flag as well as a confident-looking man, was used on posters, signs and billboards to identify locations where VMMC services were available. Clinics using this icon had to meet national standards, thus all clinics displaying this icon were associated with high-quality VMMC services.

## Resources

For more information and guidance on branding, see:

- [How-to Guide: How to Develop a Brand Strategy Part 1: Using Audience Insights to Drive Your Brand](#)
- [How-to Guide: How to Develop a Brand Strategy Part 2: Developing Positioning for a Branded Product, Service or Behavior](#)
- [How-to Guide: How to Develop a Brand Strategy Part 3: Developing the Personality and Look of the Brand](#)
- [Brand Strategy Worksheet](#)

## Use of Testimonials and Personal Stories

In addressing barriers to SRH products and services, the use of client testimonials and personal stories can be a powerful tool for encouraging men to use an SRH product or service.<sup>71</sup> Men who have already used the SRH product or service and who promote its use are often referred to as male champions. Male champions differ from peer mentors in that male champions are not necessarily, but can be, peers with the men they reach.

Male champions have been successfully used to promote men's use of VMMC and vasectomy services. By sharing personal testimonials of their own journeys towards VMMC or vasectomy, male champions are able to build the self-efficacy of other men who face similar concerns and barriers, such as social norms, stigma or unsupportive partners. Male champions can honestly



*Image 27: Miners in Zambia receive HIV/AIDS counseling at work*

address concerns related to fears about pain and side effects, as well as explain what to expect during and after the procedure.

Similarly, the personal stories of men and couples can also be leveraged to promote couples communication and joint decision-making regarding men's use of SRH products and services. By sharing their experience with other men and women in the community, couples are able to address not only men's concerns and barriers, but also those of their wives and female partners.

### **Testimonial Example: Male Champions Increase VMMC Among Adolescents**

#### **Program Description:**

In 2014, **Grassroot Soccer** developed an intervention called Make the Cut Plus (Make the Cut+), designed to increase demand for and utilization of VMMC services among male adolescents, aged 14 to 19.<sup>72</sup>

#### **Intervention:**

Make the Cut+ used soccer and activity-based social learning to increase adolescent males' knowledge about VMMC, address beliefs and misinformation and to build social support and self-efficacy for VMMC.

The intervention, targeting in-school adolescent males, recruited circumcised men from the community between the ages of 18 and 30 to act as "coaches" and share their testimonials on undergoing VMMC. Each coach received five days of in-depth training on HIV, VMMC, facilitation skills and how to conduct the intervention and engage adolescents, their parents and the school community.

The Make the Cut+ intervention consisted of:

- A single 60-minute session delivered at schools;
- Follow-up texts, phone calls or home visits with adolescent males who expressed interest in receiving VMMC;
- Coordination of transportation for small groups of adolescent males to attend VMMC clinics; and
- Accompaniment of small groups of adolescent males during VMMC services.

#### **Results:**

The effectiveness of Make the Cut+ at increasing VMMC uptake among adolescent males was tested in 26 secondary schools in Bulawayo, Zimbabwe, between March and October 2014, using a randomized control trial.<sup>73</sup> Half of these schools, the intervention group, were randomized to receive Make the Cut+ for the first four months of the trial. The remaining half of the schools (the control group) were included in the intervention during the last four months of the trial.

Overall, Make the Cut+ increased the odds of VMMC uptake among adolescent males in Bulawayo schools during the four-month trial period by approximately 250 percent (OR, 2.53, 95 percent CL, 1.21 to 5.30). Forty-



*Image 28: Adolescent boy and coach joking around during interactive soccer game to promote VMMC*

#### **The schedule for the 60-minute session is as follows:**

- Soccer warm up (five minutes)
- Coach's Introduction (five minutes)
- Cut & Cover interactive penalty-shootout game (20 minutes)
- Coach's story (10 minutes)
- Group Question and Answer session (10 minutes)
- Cool Down (five minutes)
- Coach's Corner for one-on-one

one intervention participants (7.3 percent) and 19 control participants (2.9 percent) were circumcised during trial follow-up (OR, 2.46; 95 percent CI, 1.20 to 5.04; P = 0.01).

The success of Make the Cut+ depended on the use of male coaches, who present strong, positive role models for adolescent males considering VMMC. Coaches were able to build a trusted rapport with adolescent males by sharing their personal story and relating to participants on a personal level. In communities where adults do not traditionally share personal fears and experiences with adolescents, this model can be especially strong in building a safe space where adolescents can openly and honestly express their concerns. By having coaches accompany participants to clinics in groups, the intervention built upon the motivation of this trusted relationship, as well as the power of positive peer pressure.

Read more about the Make the Cut+ evaluation at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5054964/>.

**Contact:**

For more information, contact Grassroot Soccer at [www.grassrootsoccer.org](http://www.grassrootsoccer.org).

## Testimonial Example: Using Satisfied Clients as Community Mobilizers to Increase VMMC in Mozambique

### Program Description:

In Mozambique, the CCP-led HC3 Project began communication support for VMMC in Manica and Tete provinces in late 2015, aimed at generating increased demand for services among 15-to-29-year-old men, and improving quality of in-service communication and counseling. While the younger adolescents were accessing VMMC services, uptake of services was much lower among the older priority age group.

A needs assessment found that the communication was not effectively addressing the fears and concerns of these men, such as fear of pain during and after the procedure and concerns that circumcision could cause infertility, among others. At the same time, data gathered at the VMMC sites revealed the critical role of the community mobilizers as the number one source of referral to VMMC.

### Intervention:

HC3 developed a multi-pronged approach to increase demand for VMMC using community mobilizers, including:

- Hiring satisfied clients as community mobilizers so men could hear first-hand from someone who had been through VMMC;
- Training mobilizers on the use of SBC materials, including a frequently asked questions tool that was developed with their input;
- Recording and videotaping client testimonials and leveraged these testimonials via multiple channels, including community radio discussions with call-in, televisions in health waiting areas, mobile video units and live testimonials during mobilization events, as well as videos on community mobilizer's phones shared via WhatsApp;
- Distributing personal invitations to men during festivals, sporting events and concerts with the mobilizer's personal contact information so that men could follow up individually to ask questions or book appointments more privately; and
- Mobilizers and supervisors sharing experiences and discussing barriers they've encountered and possible approaches to overcome them during monthly meetings.



Image 29: Poster promoting VMMC in Mozambique

center

### Results:

While a site-capacity/site-utilization analysis of the VMMC sites in Manica and Tete in late 2015 revealed that sites were only being used at about 30 percent of their capacity—meaning that staff were being paid to wait around with no clients coming for services—an analysis in January 2017 found most sites operating at near 100 percent capacity. Uptake of services has increased significantly in the priority age segments from 2015 to 2016 in both Manica and Tete provinces (without turning away the younger boys) as illustrated in **Figures 11 and 12** on the next page.

### Contact:

For more information, contact CCP at [www.ccp.jhu.edu](http://www.ccp.jhu.edu).

Figure 11: VMMC by Age Group and Year – Tete Province

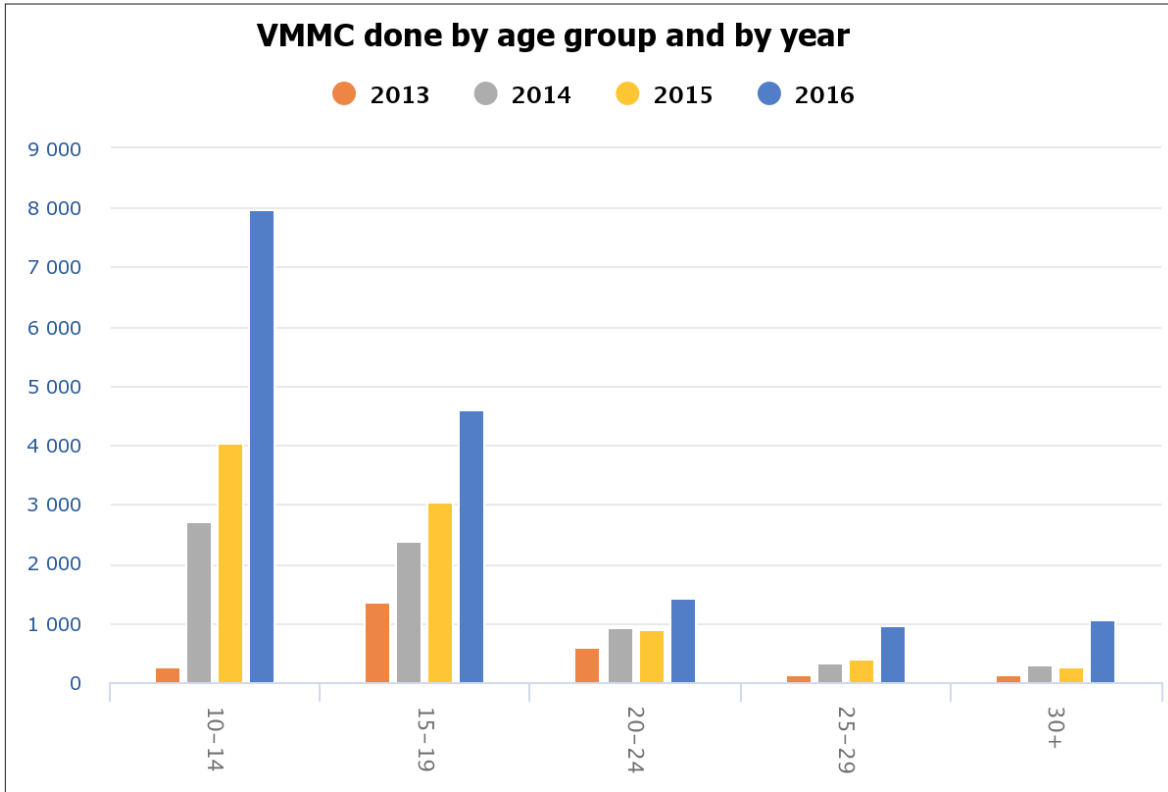
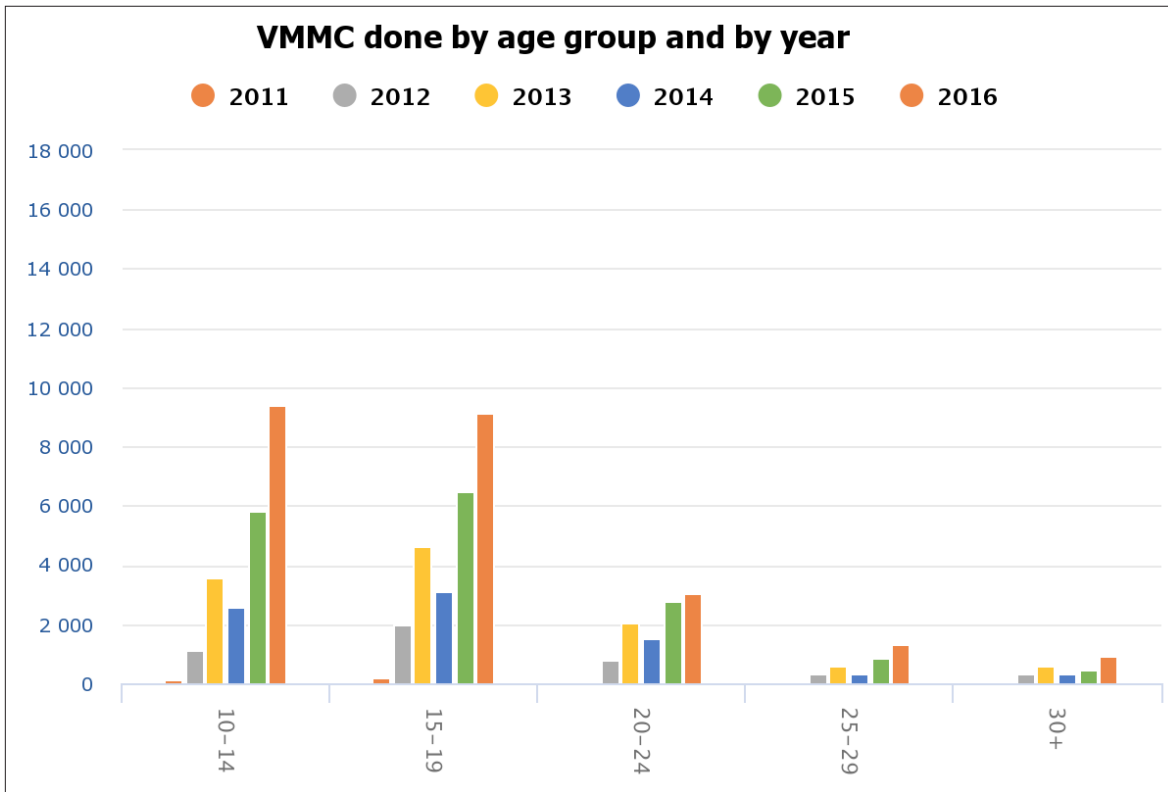


Figure 12: VMMC by Age Group and Year – Manica Province



## Couple's Personal Story Example: Happy Dampatti

### Program Description:

In India, the **Urban Health Initiative** (UHI) implemented the *Happy Dampatti* ("Happy Couples") initiative to promote the use of FP, including male condoms and vasectomy, using model couples from the community to serve as positive role models. A consortium of partners, led by FHI360, implemented the program from 2010 to 2014. As the core demand generation partner of the consortium, CCP supported the project's communication initiatives which included a mass-media campaign, communication materials and outreach activities implemented in urban slums that brought together consumers, clinics, providers, businesses and civil society to model and support new social norms in FP.



Image 30: Women enroll in the Happy Dampatti competition

### Intervention:

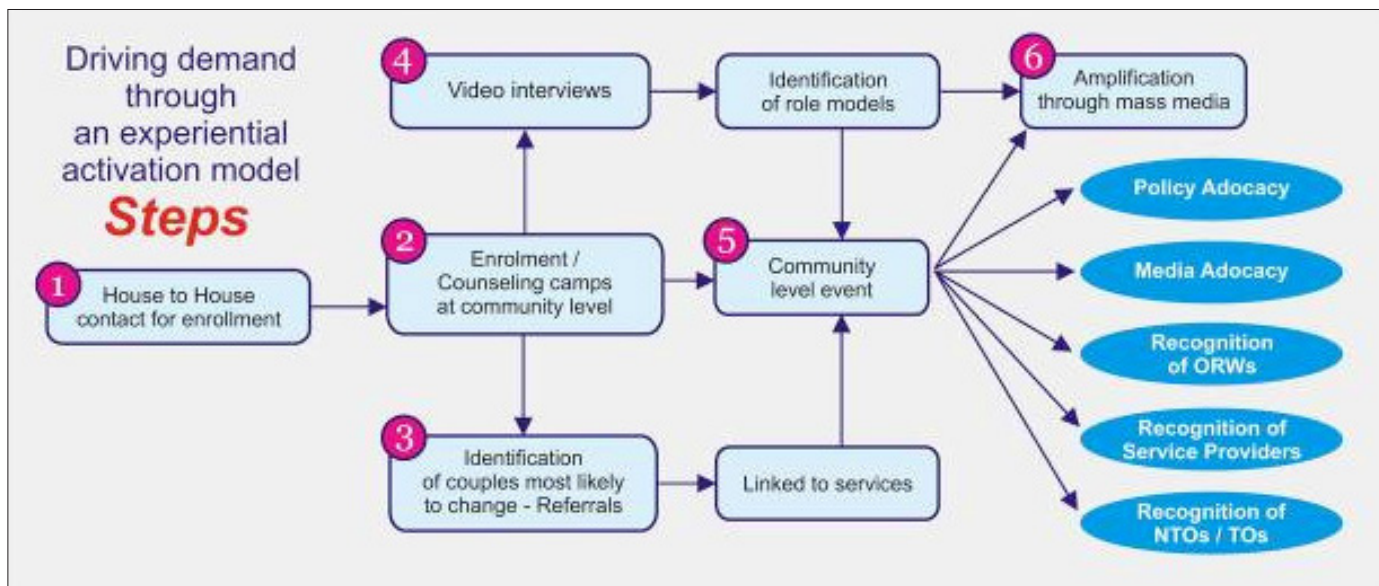
Under the UHI project, CCP used a community-based activation model to empower couples and embed change agents within the community, thereby creating a strong positive social environment for sustainable FP use.

Designed as a week-long program, the *Happy Dampatti* model used branded mid-media (posters, banners and audio recordings from rickshaws) and mass media (newspapers, radio and television) to surround and engage the communities. The initiative used a six-step community engagement model (see **Figure 13**), including:

1. Orientation of community-level workers and house-to-house contact to meet with eligible couples;
2. Couples attended enrollment camps in their communities where they receive personalized FP counseling;
3. Model couples who effectively integrated FP into their lives according to their life stage were selected from couples attending enrollment camps;
4. Selected model couples shared stories on camera of how they overcame barriers to FP use and the motivating reasons for accepting FP;
5. Winners of the contest were announced at a large community-level event; and
6. Positive deviant stories were amplified through local mass and print media.

At the enrollment camps, several kiosks were set up where couples received counseling for limiting or spacing methods, and they could either take condoms or a referral card for an intrauterine device (IUD) or other FP services. The culminating, large community-level event used entertainment education to reinforce key FP behavioral messages through interactive couple games and role-plays. Community workers and private- and public-sector health providers were also introduced to the public during the event.

Figure 13: Happy Dampatti Activation Model



**Results:**

The initiative was first piloted in the city of Agra, where 909 couples enrolled for the contest, 320 couples were counseled on life stage-specific FP methods and 151 couples received referrals for an IUD or condom packets. In Aligarh the intervention was scaled up to include more slum clusters, where 11,500 couples enrolled in the contest, 2,988 couples received counseling on FP, 132 couples immediately accepted FP methods and 286 received referrals. In the city of Gorakhpur, 3,686 couples enrolled and were counseled on FP, 300 referral cards were issued and 750 received referrals for an IUD. A total of 400 positive deviant couples in Aligarh and Gorakhpur had their stories recorded, and the winning stories were amplified during the live community-level event and on other media.

The *Happy Dampatti* initiative successfully brought together varied stakeholders with the government, NGOs and the private sector actively participating and sponsoring rewards for the winning couples. Since the initiative focused on couples, it attracted a large number of men who participated in the couple contest, attended the community-level event and engaged in discussions on FP.

To learn more about the *Happy Dampatti* initiative, read more here: <http://www.thehealthcompass.org/project-examples/experience-change-happy-dampatti>.

**Contact:**

For more information on UHI, contact FHI360 at [www.fhi360.org](http://www.fhi360.org). For more information on the Happy Dampatti Program, contact [www.ccp.jhu.edu](http://www.ccp.jhu.edu).

### **Timing of Communication Campaigns**

The timing of communication campaigns for SRH services can have an impact on men’s ability to use the service being promoted. Since SRH services, such as VMMC and vasectomy, often require men to take time off from school or work to have the procedure and abstain from rigorous physical activity immediately following, programs should take into consideration seasonal opportunities or barriers based upon the agricultural calendar and harvest season, school year and cultural beliefs.

VMMC programs often run communication campaigns in the weeks immediately preceding school holidays in an effort to increase uptake of VMMC among adolescent males. These breaks in the school year provide an opportune time for adolescent men to undergo VMMC by minimizing the number of adolescent males who have to take time off from academic work or school activities for the procedure and/or immediate recovery period.

Cultural beliefs regarding the effects of temperature on healing can also play a role in the timing of campaigns for SRH services. For example, in some cultures in Southern and East Africa, it is often believed that healing is better during the colder months. Programs should take such beliefs into consideration when determining the timing of campaigns to maximize on when men are most receptive to taking action.

### **Design Innovative Campaigns**

Special events, such as national sporting championship events, can present an innovative opportunity for promoting SRH services. In the United States, numerous health clinics across the country have capitalized on data showing an increase in vasectomies coinciding with major sport championship events, most notably the National Basketball Association (NBA) Finals.

In 2008, the Oregon Urology Institute, a private clinic specializing in male reproductive health, ran a radio spot titled *Snip City*, encouraging men to undergo vasectomy during the NBA finals and then follow doctor’s orders to “sit back and watch nonstop basketball,” during the recovery period. The campaign was so successful that other doctors and clinics throughout the United States began running similar ads the next year, many offering special pricing or packages on the cost of vasectomies during the NBA finals.



*Image 31: Snip City campaign advertisement*

In Washington, D.C., a sports radio show holds an annual Vasectomy Madness contest, where three men compete for a free vasectomy. Each man comes onto the show and makes a case for why they deserve to win the vasectomy. Listeners then vote for their favorite to receive a vasectomy during the March Madness playoffs.

While this type of campaign has not been implemented in a LMIC setting, major international sporting events, such as the Fédération Internationale de Football Association (FIFA) World Cup, may present opportunities.



## SECTION 4: RESOURCES AND TOOLS

This section provides links to additional guidance, resources and tools to assist in developing an SBC strategy to increase men's demand for and utilization of SRH products and services. The section is organized alphabetically, with a brief description of each resource or tool.

### ***LITERATURE REVIEWS ON SRH PRODUCTS AND SERVICES FOR MEN***

The following literature reviews conducted by the Evidence Project informed the development of this Guide.

#### ***[Recent Experience and Lessons Learned in Vasectomy Programming in Low-Resource Settings: A Document Review](#)***

**Citation:** Perry, B., Packer, C., Chin Quee, D., Zan, T., Dulli, L., & Shattuck, D. (2016). *Recent Experience and Lessons Learned in Vasectomy Programming in Low-Resource Settings: A Document Review*. Durham, NC: FHI 360 and Washington, DC: Population Council, the Evidence Project.

This review summarizes recent studies exploring the knowledge of, attitudes toward and acceptability of vasectomy among individuals in many low-resource settings around the globe. At the same time, it summarizes the common characteristics and motivations for vasectomy among the early adopters in these societies. Finally, it describes the various ways in which vasectomy services have been promoted and provided over the last decade, including descriptions of program implementation models, promotional and provider training costs and lessons learned from recent programs.

#### ***[Men as Contraceptive Users: Programs, Outcomes, and Recommendation](#)***

**Citation:** Hardee, K., Croce-Galis, M., & J. Gay. (2016). *Men as Contraceptive Users: Programs, Outcomes, and Recommendations, Working Paper*. Washington, DC: Population Council, The Evidence Project.

This paper reviews 47 current activities, programs and evidence that affect men's use of contraceptive methods. The review draws from published and grey literature, as well as from interviews with organizations and institutions, which focused on men as users of contraception in LMIC.

#### ***[Adolescent Sexual and Reproductive Health Services and Implications for the Provision of Voluntary Medical Male Circumcision: Results of a Systematic Literature Review](#)***

**Citation:** Kaufman, M. R., Smelyanskaya, M., Van Lith, L. M., Mallalieu, E. C., Waxman, A., Hatzhold, K., ... & Ncube, G. (2016). Adolescent sexual and reproductive health services and implications for the provision of voluntary medical male circumcision: results of a systematic literature review. *PLoS one*, 11(3), e0149892.

This paper reveals barriers to and gaps in SRH and VMMC service provision to adolescents, including structural factors, imposed feelings of shame, endorsement of traditional gender roles, negative interactions with providers, violations of privacy, fear of pain associated with the VMMC procedure and a desire for elements of traditional non-medical circumcision methods to be integrated into medical procedures. The review also summarizes factors linked to effective adolescent-focused services, including the engagement of parents and the community, an adolescent-friendly service environment and VMMC counseling messages sufficiently understood by young males.

## **DEVELOPING A SBC STRATEGY**

### **Developing a Communication Strategy**

#### ***Designing a Social and Behavior Change Communication Strategy***

##### **HC3 Project**

This I-Kit provides practical step-by-step guidance on developing a communication strategy for SBCC.

<https://sbccimplementationkits.org/courses/designing-a-social-and-behavior-change-communication-strategy/>

#### ***How-to Guide: How to Develop a Communication Strategy***

##### **HC3 Project**

This guide provides step-by-step guidance on how to develop a communication strategy.

<http://www.thehealthcompass.org/how-to-guides/how-develop-communication-strategy>

#### ***The P-Process***

##### **CCP**

The P Process™ is a step-by-step roadmap for designing an SBCC strategy. This updated version of the P Process incorporates lessons learned and acknowledges the real-time, dynamic nature of the strategic process as well as new technologies and the constantly changing nature of communication, social norms, individual behavior and decision-making.

<http://www.thehealthcompass.org/sbcc-tools/p-process>

### **Conducting Formative Research**

#### ***How-to Guide: How to Conduct Qualitative Formative Research***

##### **HC3 Project**

This guide provides step-by-step guidance on how to conduct qualitative research to gain insights to inform the design of a communication strategy, including insights on the health issue or behavior the project intends to address; relevant characteristics of primary and secondary audiences; communication access, habits and preferences; and the main drivers of behavior. Includes links to tools and additional guidance.

<http://www.thehealthcompass.org/how-to-guides/how-conduct-qualitative-formative-research>

#### ***Understanding Formative Research: Methods, Management, and Ethics for Behavior Change Communication***

##### **Chemionics**

This facilitator guide provides detailed information on the management of a formative research study, including defining formative research and its role in strategic SBCC plans, describing the components of a formative research plan, explaining qualitative and quantitative methodologies for formative research (and their applications) and discussing challenges and approaches to managing formative research processes.

<http://www.thehealthcompass.org/sbcc-tools/understanding-formative-research-methods-management-and-ethics-behaviour-change>

#### ***Guide for Selecting a Formative Research Method***

##### **Chemionics**

This guide provides an algorithm to assist program managers and researchers in selecting the right formative research method. The guide helps managers decide between qualitative and quantitative methods and then offers specific methods that match the needs of a program.

<http://www.thehealthcompass.org/sbcc-tools/guide-selecting-formative-research-method>

## **Audience Segmentation**

### ***How-to Guide: How to Do Audience Segmentation Guide***

#### **HC3 Project**

This guide provides step-by-step guidance on how to divide intended audiences into segments who have similar needs, values or characteristics as part of the audience analysis, including links to tools and additional guidance.

<http://www.thehealthcompass.org/how-to-guides/how-do-audience-segmentation>

### ***Audience Segmentation Template***

#### **CCP**

This template can be used when analyzing the characteristics of an audience to decide how to segment the intended audience when designing an SBCC strategy.

[http://www.thehealthcompass.org/sites/default/files/strengthening\\_tools/Audience\\_Segmentation\\_Template.pdf](http://www.thehealthcompass.org/sites/default/files/strengthening_tools/Audience_Segmentation_Template.pdf)

### ***Audience Segmentation Checklist***

#### **CCP**

This checklist can be used to assess proposed audience segments for an SBCC strategy. It describes seven audience characteristics that a segment should have, including heterogeneous, homogeneous, measurable, substantial, accessible, actionable/practical and responsive.

<http://www.thehealthcompass.org/sbcc-tools/audience-segmentation-checklist>

## **Channel Selection**

### ***A Theory-Based Framework for Media Selection in Demand Generation Programs***

#### **HC3 Project**

This guide provides step-by-step information and practical tools to guide media selection (i.e., communication channels) using a theory-based approach. The guide provides a theoretical foundation to guide the design, implementation and evaluation of media selection, with a specific focus on information communication technology (ICT) and new media channels, commonly referred to as e- or mHealth.

<https://sbccimplementationkits.org/demandrmnch/ikitresources/media-selection-demand-generation/>

### ***How-to Guide: How to Develop a Channel Mix Plan***

#### **HC3 Project**

This guide provides step-by-step guidance on how to developing a channel mix plan, including links to tools and additional guidance.

<http://www.thehealthcompass.org/how-to-guides/how-develop-channel-mix-plan>

## **Branding**

### ***How-to Guide: How to Develop a Brand Strategy Part 1: Using Audience Insights to Drive Your Brand***

#### **HC3 Project**

This guide provides step-by-step guidance on how to use audience insights to drive the development of a brand, including links to tools and additional guidance.

<http://www.thehealthcompass.org/how-to-guides/how-create-brand-strategy-part-1-using-audience-insight-drive-your-brand>

### ***How-to Guide: How to Develop a Brand Strategy Part 2: Developing Positioning for a Branded Product, Service or Behavior***

#### **HC3 Project**

This guide provides step-by-step guidance on how to developing positioning for a brand, including links to tools and additional guidance.

<http://www.thehealthcompass.org/how-to-guides/how-create-brand-strategy-part-2-developing-positioning-branded-product-service-or>

***How-to Guide: How to Develop a Brand Strategy Part 3: Developing the Personality and Look of the Brand***

**HC3 Project**

This guide provides step-by-step guidance on how to develop the personality and look of a brand, including links to tools and additional guidance.

<http://www.thehealthcompass.org/how-to-guides/how-create-brand-strategy-part-3-developing-personality-and-look-brand>

***Brand Strategy Worksheet***

**CCP**

This worksheet is designed to help a branding team determine and define the brand execution, personality and position.

<http://www.thehealthcompass.org/sbcc-tools/brand-strategy-worksheet>

***BEFORE – PRODUCT PURCHASE OR SERVICE DELIVERY***

**Community Mobilization**

***How to Mobilize Communities for Health and Social Change***

**CCP**

This field guide contains illustrative examples and lessons learned in community mobilization experiences from around the world, focusing on working with disadvantaged or marginalized groups in developing countries. Includes links to tools and additional guidance.

<http://www.thehealthcompass.org/sbcc-tools/how-mobilize-communities-health-and-social-change>

**Community Outreach**

***Community-Based Family Planning Toolkit***

**FHI360**

This toolkit is a platform for sharing reliable and relevant information about community-based FP programs (CBFP) and for strengthening the capacity of agencies and organizations to plan, implement, evaluate, promote and scale up CBFP programs. The toolkit presents a collection of carefully selected resources for health policy makers, program managers, service providers, information officers and others, and includes experience and tools from dozens of countries.

<https://www.k4health.org/toolkits/communitybasedfp>

**Interpersonal Communication**

***How-to Guide: How to Plan an Interpersonal Communication Intervention***

**HC3 Project**

This guide provides step-to-step guidance on how to plan for an IPC intervention, including links to tools and additional guidance.

<http://www.thehealthcompass.org/how-to-guides/how-plan-interpersonal-communication-intervention>

***IPC Methods and Tools Template***

**CCP**

This template helps the user chart out what the audience needs are, what IPC method would be appropriate, what tools will be necessary to support the IPC method and whether new tools need to be developed or existing tools adapted.

<http://www.thehealthcompass.org/sbcc-tools/ipc-methods-and-tools-template>

## **Mass Media**

### ***How-to Guide: How to Develop SBCC Creative Materials***

#### **HC3 Project**

The guide provides general steps for developing creative materials and draws on results from the message design and channel mix guides.

<http://www.thehealthcompass.org/how-to-guides/how-develop-sbcc-creative-materials>

### ***Tips for Creating Print, Video, and Radio Materials***

#### **CCP**

These tip sheets offer basic information about creating print, video and radio materials. Included are tips about readability, images, content and care of equipment.

<http://www.thehealthcompass.org/sbcc-tools/tips-creating-print-video-and-radio-materials>

### ***How to Design and Produce Radio Serial Drama for Social Development: A Program Manager's Guide***

#### **CCP**

This practical manual helps program managers guide the process of developing entertainment education programs for radio with a focus on drama serials and series. The manual includes chapters on the use of serial drama, design documents, the design team and the design workshop, as well as the writing process, the pre-production phase and the production phase.

<http://www.thehealthcompass.org/sbcc-tools/how-design-and-produce-radio-serial-drama-social-development-program-managers-guide>

## **mHealth**

### ***The mHealth Planning Guide: Key Considerations for Integrating Mobile Technology into Health Programs***

#### **CCP**

This guide provides a thorough orientation to the mHealth planning process; outlines key considerations and resources for planning an mHealth intervention, from concept development and technology design to preparation for implementation; and helps you build a strong foundation for your mHealth activity, laying out the many facets of program planning that the mHealth pioneers wish they had known when they were starting out.

<http://www.thehealthcompass.org/sbcc-tools/mHealth-planning-guide-key-considerations-integrating-mobile-technology-health-programs>

## ***DURING – PRODUCT PURCHASE OR SERVICE DELIVERY***

### **Client Counseling**

#### ***Men's Reproductive Health Curriculum: Counseling and Communicating with Men***

##### **EngenderHealth**

This three-part curriculum is designed to provide a broad range of health care workers with the skills and sensitivity needed to work with male clients and provide men's reproductive health services. The curriculum contains sections on: an introduction to men's reproductive health services, counseling and communicating with men and management of men's reproductive health programs. Each section is comprised of a participant's handbook and a trainer's resource book.

[https://www.engenderhealth.org/files/pubs/gender/mrhc-2/participant/mrh\\_2p.pdf](https://www.engenderhealth.org/files/pubs/gender/mrhc-2/participant/mrh_2p.pdf)

### **Provider Behavior Change**

#### ***Provider Behavior Change Implementation Kit***

##### **HC3 Project**

This I-Kit is designed to help programmers understand factors that influence provider behavior, design an assessment to understand the specific barriers providers face and develop an SBCC intervention to address those barriers.

<https://sbccimplementationkits.org/provider-behavior-change/>

### ***Provider Behavior Change Toolkit***

PSI

This toolkit provides step-by-step guidance on using SBCC to positively influence providers' behaviors by designing individualized solutions to address needs and barriers to behavior change, and thereby improve client outcomes. The toolkit was developed in partnership between PSI and Pfizer, Inc., and follows best practices from the pharmaceutical industry.

<http://www.psi.org/publication/provider-behavior-change-toolkit/>

### ***Strategies for Changing the Behavior of Private Providers***

**Strengthening Health Outcomes through the Private Sector (SHOPS) Project, Abt Associates**

This primer is designed for use as a resource for field staff who implement private PBC programs. Informed by professional experience and a literature review, the primer covers behavior change theories and an adoption model. A review of the four forces that influence provider decision-making draws on examples from developing countries. It concludes with essential information for program design and implementation.

[http://pdf.usaid.gov/pdf\\_docs/PA00M11N.pdf](http://pdf.usaid.gov/pdf_docs/PA00M11N.pdf)

### **Service Delivery**

***Service Communication Implementation Kit***

HC3 Project

This I-Kit aims to help service delivery project managers effectively use service communication to enhance the impact of their project. It can be used to help increase demand for and uptake of services, and improve consistent long-term maintenance of healthy behavior.

<https://sbccimplementationkits.org/service-communication/>

### **Supportive Supervision**

***Supportive Supervision Guidance***

AED and John Snow Inc.

This guide provides an overview of supportive supervision, including key considerations for designing and implementing a supportive supervision program and links to additional resources.

<http://www.ngoconnect.net/documents/592341/749044/Human+Resources+-+Supportive+Supervision>

### ***Making Supervision Supportive and Sustainable: New Approaches to Old Problems***

University Research Company

This paper distills lessons learned from experiences of approximately 16 field programs to improve the supervision of FP and health programs in developing countries and identifies approaches that may be more effective and sustainable.

<https://www.k4health.org/sites/default/files/maqpapersupervision.pdf>

### ***Sample IPC Supportive Supervision Form and IPC Supervision Intended Audience Questionnaire***

PSI

Sample supportive supervision tools for evaluating the effectiveness of IPC from the community agent and intended audience perspective.

[http://www.psi.org/wp-content/uploads/2014/09/VMMC\\_Demand\\_Creation\\_Toolkit.pdf](http://www.psi.org/wp-content/uploads/2014/09/VMMC_Demand_Creation_Toolkit.pdf)

## **CROSS-CUTTING TOPICS**

### **GENDER**

#### ***Gender Transformative Programming***

##### **UNFPA**

Step-by-step guidance and facilitation resource for developing gender transformative media campaigns and programs.

<https://www.unfpa.org/sites/default/files/pub-pdf/tools.pdf>

#### ***Engaging Men in Sexual and Reproductive Health and Rights***

##### **EngenderHealth**

This toolkit is designed to assist program designers or managers in constructively engaging men as clients of SRH services, as supportive intimate partners and as agents of change to address gender norms in their communities.

<https://www.engenderhealth.org/pubs/gender/gender-toolkit/toolkit.html>

#### ***Engaging Men and Boys in Gender Equality and Health Toolkit***

##### **Promundo, MenEngage and UNFPA**

This toolkit addresses strategies and lessons learned for engaging men and boys in diverse themes, such as SRH; maternal, newborn and child health; fatherhood; HIV; gender-based violence; advocacy; policy; and addressing issues around monitoring and evaluation of this work. It includes tools and activities from organizations and programs from around the world that can be adapted and utilized by other organizations.

<http://promundoglobal.org/resources/engaging-men-and-boys-in-gender-equality-and-health-a-global-toolkit-for-action/>

#### ***Program H: Working with Young Men***

##### **Promundo**

This manual includes approximately 70 activities to carry out group work with young men (aged 15 to 24) on gender, sexuality, reproductive health, fatherhood and caregiving, violence prevention, emotional health, drug use and preventing and living with HIV and AIDS.

<http://promundoglobal.org/resources/program-h-working-with-young-men/>

#### ***Gender and Social and Behavior Change Communication Implementation Kit***

##### **HC3 Project**

This I-Kit provides a step-by-step approach to integrate gender into an existing SBCC strategy. It is designed to help users understand gender concepts, theories and frameworks, assess the current level of gender integration in a project and use a series of tools to uncover new information that can be applied to programming.

<https://sbccimplementationkits.org/gender/courses/gender-and-social-and-behavior-change-communication/>

#### ***Engaging Boys and Men in Gender Transformation: The Group Education Manual***

##### **EngenderHealth and Promundo**

This 11-chapter manual offers trainers an array of participatory experiential exercises to reach men (and their partners), exploring gender socialization and its impact on HIV prevention and care.

<http://www.thehealthcompass.org/project-examples/engaging-boys-and-men-gender-transformation-group-education-manual>

### ***Addressing the Role of Gender in the Demand for RMNCH Commodities: A Programming Guide***

#### **HC3 Project**

This guide provides information and practical tools to help program managers determine how gender norms and roles may limit demand for RMNCH commodities, and how to address these norms and roles to ultimately increase the demand for and utilization of these commodities.

<https://sbccimplementationkits.org/demandrmnch/ikitresources/addressing-the-role-of-gender/>

### ***Communicating Gender for Rural Development: Integrating Gender in Communication for Development*** **Food and Agriculture Organization**

This document is designed to promote the introduction of a gender perspective into communication for development initiatives in rural areas, and suggests practical ways of incorporating gender.

<http://www.unwomen.org/en/docs/2011/8/communicating-gender-for-rural-development>

### ***African Transformation Toolkit***

#### **BRIDGES II Project**

This toolkit includes a set of participatory activities designed to foster gender equity in communities and societies. Sessions enable women and men to explore how gender norms and roles operate in their lives, and transform those they determine to have a negative effect while reinforcing those they deem positive, particularly in terms of HIV prevention.

<https://www.k4health.org/toolkits/bridge-ii-project-toolkit/african-transformation>

### **Youth**

#### ***Urban Adolescent Social and Behavior Change Communication Implementation Kit***

#### **HC3 Project**

This I-Kit provides a selection of essential elements and tools to guide the creation (or strengthening) of SRH SBCC programs for urban adolescents aged 10 to 19.

<https://sbccimplementationkits.org/urban-youth/>

### ***HIV Testing and Counseling for Youth: A Manual for Providers***

#### **FHI360**

This manual is a guide to best practices for offering and improving HTS for youth, functioning as an easy-to-use reference tool on youth and HIV/AIDS; a guide to counseling young clients about HIV testing, prevention, care and treatment; a reference tool on related services, including contraceptive options and other STIs; and a convenient place to record local referral networks.

<http://www.fhi360.org/sites/default/files/media/documents/HIV%20Counseling%20and%20Testing%20for%20Youth.pdf>

### **Human-Centered Design**

#### ***Design Kit: The Human-Centered Design Toolkit***

#### **IDEO.org**

This online portal provides an overview of HCD and the methods it employs, case studies and links to additional resources.

<http://www.designkit.org/>

#### ***The Field Guide to Human-Centered Design***

#### **IDEO.org**

This guide reveals IDEO.org's HCD process with the key mindsets that underpin how and why they think about design for the social sector; 57 design methods that are clear and ready-to-use for both new and experienced practitioners; and from-the-field case studies of HCD in action. The guide has everything a program needs to understand the people they are designing for, to have more effective brainstorming, to prototype their ideas and to ultimately arrive at more creative solutions.

<http://www.designkit.org/resources/1>



## **RESOURCES FOR SPECIFIC SRH PRODUCTS OR SERVICES**

### **VMMC**

#### ***Voluntary Medical Male Circumcision Demand Generation Toolkit***

**PSI and RTI**

This toolkit provides implementing partners and organizations with step-by-step guidance and the tools needed to conduct communication and outreach activities to drive demand for VMMC services.

<http://www.psi.org/publication/voluntary-medical-male-circumcision-demand-creation-toolkit/>

#### ***PEPFAR's Best Practices for VMMC Site Operation***

**PEPFAR**

Developed for use at facilities or other sites where VMMC will be offered, this guide provides implementing partners with a comprehensive and consistent process for establishing VMMC services for HIV prevention.

[https://www.usaid.gov/sites/default/files/documents/1864/pepfar\\_best\\_practice\\_for\\_vmmc\\_site\\_operations.pdf](https://www.usaid.gov/sites/default/files/documents/1864/pepfar_best_practice_for_vmmc_site_operations.pdf)

#### ***VMMC Counseling Training Packet***

**PSI and the Zambia MOH**

This training package consists of modules, a participant's manual and a facilitator's manual. It is designed to develop the knowledge and skills of VMMC counsellors to guide and support men, women and parents considering the procedure.

<https://www.malecircumcision.org/resource/vmmc-counseling-training-package>

### **Vasectomy**

#### ***No-Scalpel Vasectomy Curriculum: A Training Course for Vasectomy Providers and Assistants***

**EngenderHealth**

This curriculum is designed to help providers of FP services learn how to offer high-quality vasectomy services that ensure clients' voluntary, fully informed and well-considered decision-making in a context that is medically safe. This clinical training course presents all the information both trained providers and their assistants need to be able to provide safe and effective NSV services.

[https://www.engenderhealth.org/files/pubs/family-planning/nsv\\_curric\\_participant\\_final.pdf](https://www.engenderhealth.org/files/pubs/family-planning/nsv_curric_participant_final.pdf)

#### ***The Family Planning Handbook***

**WHO and CCP**

This handbook, one of WHO's Family Planning Cornerstones, provides evidence-based guidance on FP methods. It offers clinic-based health care professionals the latest guidance on providing clients with the full range of contraceptive methods, including vasectomy. The vasectomy section includes information on health benefits and side effects, correcting misunderstandings, ensuring informed choice and detailed information on the procedure.

[https://www.fphandbook.org/sites/default/files/chap\\_12\\_eng.pdf](https://www.fphandbook.org/sites/default/files/chap_12_eng.pdf)

## ENDNOTES

1. United Nations, Department of Economics and Social Affairs, Population Division. (2013). World Contraception Patterns 2013. Retrieved from: <http://www.un.org/en/development/desa/population/publications/family/contraceptive-wallchart-2013.shtml>
2. Staveteig, S., Wang, S., Head, S. K., Bradley, S. E. K., & Nybro, E. (2013). *Demographic Patterns of HIV Testing Uptake in Sub-Saharan Africa. Demographic and Health Survey Comparative Reports No. 30*. ICF International. Calverton, Maryland, USA.
3. Hoffman S, Wu Y, Lahuerta M, Kulkarni SG, Nuwagaba-Biribonwoha H, El Sadr W, et al. (2014). Advanced disease at enrollment in HIV care in four sub-Saharan African countries: change from 2006 to 2011 and multilevel predictors in 2011. *AIDS*. 28. 2429–38.
4. Mukolo, Abraham, et al. (2013). Predictors of late presentation for HIV diagnosis: a literature review and suggested way forward. *AIDS and Behavior* 17(1). 5-30.
5. Bor, J., Rosen, S., Chimbindi, N., Haber, N., Herbst, K., Mutevedzi, T., ... & Bärnighausen, T. (2015). Mass HIV treatment and sex disparities in life expectancy: demographic surveillance in rural South Africa. *PLoS Med*, 12(11), e1001905.
6. Kikaya, V., Skolnik, L., García, M. C., Nkonyana, J., Curran, K., & Ashengo, T. A. (2014). Voluntary medical male circumcision programs can address low HIV testing and counseling usage and ART enrollment among young men: lessons from Lesotho. *PLoS one*, 9(5), e83614.
7. Bor, J., Rosen, S., Chimbindi, N., Haber, N., Herbst, K., Mutevedzi, T., ... & Bärnighausen, T. (2015). Mass HIV treatment and sex disparities in life expectancy: demographic surveillance in rural South Africa. *PLoS Med*, 12(11), e1001905.
8. United National Population Fund (UNFPA). (2016). *Sexual and reproductive health: Overview*. Retrieved from <http://www.unfpa.org/sexual-reproductive-health>
9. Centers for Disease Control and Prevention (CDC). (2016). *Condoms and STDs: Fact Sheet for Public Health Personnel*. Washington, DC: CDC.
10. Pinkerton, S. D., & Abramson, P. R. (1997). Effectiveness of condoms in preventing HIV transmission. *Social science & medicine*, 44(9), 1303-1312.
11. National Institute of Allergy and Infectious Diseases (NIAID). (2001). *Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention*. Washington, DC: NIAID.
12. Centers for Disease Control and Prevention (CDC). (2016). *Effectiveness of Family Planning Methods*. Washington, DC: CDC.
13. World Health Organization (WHO), Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, INFO Project. (2011). *Family Planning: A Global Handbook for Providers*. CCP and WHO. Baltimore, USA and Geneva, CH.
14. Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., & Puren, A. (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLoS med*, 2(11), e298.
15. Gray, R. H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., ... & Sewankambo, N. K. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *The lancet*, 369(9562), 657-666.
16. Bailey, R. C., Moses, S., Parker, C. B., Agot, K., Maclean, I., Krieger, J. N., ... & Ndinya-Achola, J. O. (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *The lancet*, 369(9562), 643-656.
17. Tobian, A. A., Kacker, S., & Quinn, T. C. (2014). Male circumcision: a globally relevant but under-utilized method for the prevention of HIV and other sexually transmitted infections. *Annual review of medicine*, 65, 293-306.
18. World Health Organization (WHO). (2012). *Voluntary Medical Male Circumcision for HIV Prevention Fact Sheet*. Retrieved from: [http://www.who.int/hiv/topics/malecircumcision/fact\\_sheet/en/](http://www.who.int/hiv/topics/malecircumcision/fact_sheet/en/)
19. The Joint United Nations Programme on HIV/AIDS (UNAIDS). (2015). *2015 Estimates from the AIDSinfo Online Database*. Retrieved from: <http://www.aidsinfoonline.org/devinfo/libraries.aspx/Home.aspx>

20. World Health Organization (WHO). (2012). *Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC policy framework*. Geneva, Switzerland: WHO.
21. Newman, L., Rowley, J., Vander Hoorn, S., Wijesooriya, N. S., Unemo, M., Low, N., ... & Temmerman, M. (2015). Global estimates of the prevalence and incidence of four curable sexually transmitted infections in 2012 based on systematic review and global reporting. *PloS one*, 10(12), e0143304.
22. World Health Organization (WHO). (2016). *Factsheet: Sexually transmitted infections (STIs)*. Retrieved from: <http://www.who.int/mediacentre/factsheets/fs110/en/>.
23. Eng, T. R., & Butler, W. T. (Eds.). (1997). *The hidden epidemic: Confronting sexually transmitted diseases*. Washington, DC: National Academies Press.
24. Eng, T. R., & Butler, W. T. (Eds.). (1997). *The hidden epidemic: Confronting sexually transmitted diseases*. Washington, DC: National Academies Press.
25. Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.
26. Kincaid, D.L., Figueroa, M.E., Storey, D., & Underwood, C. (2007). *A social ecology model of communication, behavior change, and behavior maintenance (working paper)*. Baltimore, MD: Johns Hopkins Center for Communication Programs.
27. Mosha, I., Ruben, R., & Kakoko, D. (2013). Family planning decisions, perceptions and gender dynamics among couples in Mwanza, Tanzania: a qualitative study. *BMC Public Health*, 13(1), 523. Retrieved from <http://www.biomedcentral.com/1471-2458/13/523>
28. Shattuck, D., Wesson, J., Nsengiyumva, T., Kagabo, L., Bristow, H., Zan, T., & Ngabo, F. (2014). Who chooses vasectomy in Rwanda? Survey data from couples who chose vasectomy, 2010-2012. *Contraception*, 89(6), 564-571.
29. Dageid, W., Govender, K., & Gordon, S. F. (2012). Masculinity and HIV disclosure among heterosexual South African men: implications for HIV/AIDS intervention. *Culture, health & sexuality*, 14(8), 925-940.
30. MacPherson, P., MacPherson, E. E., Mwale, D., Squire, S. B., Makombe, S. D., Corbett, E. L., ... & Desmond, N. (2012). Barriers and facilitators to linkage to ART in primary care: a qualitative study of patients and providers in Blantyre, Malawi. *Journal of the International AIDS society*, 15(2).
31. Bila, B., & Egrot, M. (2009). Gender asymmetry in healthcare-facility attendance of people living with HIV/AIDS in Burkina Faso. *Social science & medicine*, 69(6), 854-861.
32. Skovdal, M., Campbell, C., Nhongo, K., Nyamukapa, C., & Gregson, S. (2011). Contextual and psychosocial influences on antiretroviral therapy adherence in rural Zimbabwe: towards a systematic framework for programme planners. *The International journal of health planning and management*, 26(3), 296-318.
33. MacPherson, P., MacPherson, E. E., Mwale, D., Squire, S. B., Makombe, S. D., Corbett, E. L., ... & Desmond, N. (2012). Barriers and facilitators to linkage to ART in primary care: a qualitative study of patients and providers in Blantyre, Malawi. *Journal of the International AIDS society*, 15(2).
34. Lyimo, R. A., de Bruin, M., van den Boogaard, J., Hospers, H. J., van der Ven, A., & Mushi, D. (2012). Determinants of antiretroviral therapy adherence in northern Tanzania: a comprehensive picture from the patient perspective. *BMC Public Health*, 12(1), 716.
35. Wouters, E., Van Damme, W., Van Loon, F., Van Rensburg, D., & Meulemans, H. (2009). Public-sector ART in the Free State Province, South Africa: community support as an important determinant of outcome. *Social science & medicine*, 69(8), 1177-1185.
36. Lifson, A. R., Demissie, W., Tadesse, A., Ketema, K., May, R., Yakob, B., ... & Shenie, T. (2013). Barriers to retention in care as perceived by persons living with HIV in rural Ethiopia focus group results and recommended strategies. *Journal of the International Association of Providers of AIDS Care (JIAPAC)*, 12(1), 32-38.
37. Merten, S., Kenter, E., McKenzie, O., Musheke, M., Ntalasha, H., & Martin-Hilber, A. (2010). Patient-reported barriers and drivers of adherence to antiretrovirals in sub-Saharan Africa: A meta-ethnography. *Tropical Medicine & International Health*, 15(s1), 16-33.
38. Campbell, C., Scott, K., Nhamo, M., Nyamukapa, C., Madanhire, C., Skovdal, M., ... & Gregson, S. (2013). Social capital and HIV competent communities: the role of community groups in managing HIV/AIDS in rural Zimbabwe. *AIDS care*, 25(sup1), S114-S122.

39. Interagency Gender Working Group (IGWG). (2013). *The Gender Equality Continuum*. Retrieved from: <http://www.igwg.org/>.
40. Taylor, J. (2008). Revitalizing Underutilized Family Planning Methods: Using Communications and Community Engagement to Stimulate Demand for Vasectomy in Honduras. *Applying Lessons Learned to Strengthen FP/RH Services – Number 10*. New York, New York: The ACQUIRE Project.
41. Contraindication is a specific situation in which a drug, procedure, or surgery should not be used because it may be harmful to the person.
42. Wegs, C., Creanga, A. A., Galavotti, C., & Wamalwa, E. (2016). Community Dialogue to Shift Social Norms and Enable Family Planning: An Evaluation of the Family Planning Results Initiative in Kenya. *PloS one*, 11(4), e0153907.
43. Yahner, M., & Cisek, C. R. (2012). Using an Employer-based Approach to Increase Support for and Provision of Long-acting and Permanent Methods of Contraception: The India experience. *The RESPOND Project Study Series: Contributions to Global Knowledge—Report No. 7*. New York, New York: EngenderHealth.
44. Alford, S., Cheetham, N., and Hauser, D. (2005). *Science and Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV, & Sexually Transmitted Infections*. Washington, DC: Advocates for Youth.
45. Kincaid, D.L., Payne Merrit, A., Nickerson, L., de Castro Buffington, de Castro, M.P., & de Castro, B.M. (1996). Impact of a Mass Media Promotion Campaign in Brazil. *International Family Planning Perspectives*, 22, 169-175.
46. Subramanian, L., Cisek, C., Kanlisi, N., & Pile, J. M. (2010). The Ghana vasectomy initiative: Facilitating client-provider communication on no-scalpel vasectomy. *Patient education and counseling*, 81(3), 374-380.
47. Tumwikirize, S., Torpey, K., Adedokun, O., & Badru, T. (2015). The Value of Support Group Participation in Influencing Adherence to Antiretroviral Treatment among People Living with Human Immunodeficiency Virus (HIV). *World*, 5, 189-198.
48. Bateganya, M., Amanyeiwe, U., Roxo, U., & Dong, M. (2015). The Impact of Support Groups for People Living with HIV on Clinical Outcomes: a systematic review of the literature. *Journal of acquired immune deficiency syndromes (1999)*, 68(0 3), S368.
49. Odeny, T. A., Bailey, R. C., Bukusi, E. A., Simoni, J. M., Tapia, K. A., Yuhas, K., ... & McClelland, R. S. (2012). Text messaging to improve attendance at post-operative clinic visits after adult male circumcision for HIV prevention: a randomized controlled trial. *PloS one*, 7(9), e43832.
50. Odeny, T. A., Bailey, R. C., Bukusi, E. A., Simoni, J. M., Tapia, K. A., Yuhas, K., ... & McClelland, R. S. (2012). Text messaging to improve attendance at post-operative clinic visits after adult male circumcision for HIV prevention: a randomized controlled trial. *PloS one*, 7(9), e43832.
51. Sgaier, S. K., Baer, J., Rutz, D. C., Njehumeli, E., Seifert-Ahanda, K., Basinga, P., ... & Laube, C. (2015). Toward a systematic approach to generating demand for voluntary medical male circumcision: insights and results from field studies. *Global Health: Science and Practice*, 3(2), 209-229.
52. Price, J. E., Phiri, L., Mulenga, D., Hewett, P. C., Topp, S. M., Shiliya, N., & Hatzold, K. (2014). Behavior change pathways to voluntary medical male circumcision: narrative interviews with circumcision clients in Zambia. *PloS one*, 9(11), e111602.
53. Bunce, A., Guest, G., Searing, H., Frajzyngier, V., Riwa, P., Kanama, J., & Achwal, I. (2007). Factors affecting vasectomy acceptability in Tanzania. *International Family Planning Perspectives*, 13-21.
54. Refer to pages 11 to 14 for more about gender norms and gender transformative approach.
55. EngenderHealth and the United Nations Population Fund (UNFPA). (2016). *Engaging Men in Sexual and Reproductive Health and Rights, Including Family Planning*. Available at: <https://www.engenderhealth.org/pubs/gender/gender-toolkit/toolkit.html>.
56. Stern, E., Pascoe, L., Shand, T., & Richmond, S. (2015). Lessons learned from engaging men in sexual and reproductive health as clients, partners and advocates of change in the Hoima district of Uganda. *Culture, health & sexuality*, 17(sup2), 190-205.
57. Barker, G. T., Ricardo, C., & Nascimento, M. (2007). *Engaging Men and Boys in Changing Gender-based Inequity in Health: Evidence from Programme Interventions*. Geneva: World Health Organization (WHO).

58. Muhamadi, L., Ibrahim, M., Wabwire-Mangen, F., Peterson, S., & Reynolds, S. J. (2013). Perceived medical benefit, peer/partner influence and safety and cost to access the service: client motivators for voluntary seeking of medical male circumcision in Iganga District Eastern Uganda, a qualitative study. *Pan African Medical Journal*, 15(1).
59. Shattuck, D., Kerner, B., Gilles, K., Hartmann, M., Ng'ombe, T., & Guest, G. (2011). Encouraging contraceptive uptake by motivating men to communicate about family planning: the Malawi Male Motivator project. *American journal of public health*, 101(6), 1089-1095.
60. Price, J. E., Phiri, L., Mulenga, D., Hewett, P. C., Topp, S. M., Shiliya, N., & Hatzold, K. (2014). Behavior change pathways to voluntary medical male circumcision: narrative interviews with circumcision clients in Zambia. *PloS one*, 9(11), e111602.
61. Lalaharimanitra, H., Hurley, L., and Rafalimanana, A. (2016). *Images of Manhood Approach: How Changing Gender Norms with Young Men Increased FP Use in Madagascar*. Abstract at 2016 International Conference on Family Planning, 2016. Nusa Dua, Indonesia. January 25-28, 2016.
62. Taylor, J. (2008). Revitalizing underutilized family planning methods. Using communications and community engagement to stimulate demand for vasectomy in Bangladesh. *Applying Lessons Learned to Strengthen FP/RH Services – Number 9*. New York, New York: The ACQUIRE Project.
63. Joanita, K., Nankunda, B., and Achola, R. (2016). *Using an Integrated Media Approach to Prevent Teen Pregnancy in Order to Promote Delayed Marriage and First Pregnancy*. Abstract at 2016 International Conference on Family Planning 2016. Nusa Dua, Indonesia. January 25-28, 2016.
64. Kasongo, G., Makuta, A. (2016). *Ligne Verte: Outil d'informations sur la Planification Familiale en Republique Democratique du Congo*. Abstract at 2016 International Conference on Family Planning 2016. Nusa Dua, Indonesia. January 25-28, 2016.
65. Kohthari, S. (2016). *Using Social Media to Promote Family Planning Among Guatemalan Men*. Guatemala: Women's International Network for Guatemalan Solutions (WINGS). Unpublished.
66. IPC agents are individuals trained by a program to provide one-on-one and small group counseling and information regarding SRH products and services using an IPC approach.
67. Hatzold, K., Mavhu, W., Jasi, P., Chatora, K., Cowan, F. M., Tarubekera, N., ... & Njeuhmeli, E. (2014). Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: results from a mixed methods study. *PLoS One*, 9(5), e85051.
68. Evens, E., Lanham, M., Hart, C., Loolpapit, M., Oguma, I., & Obiero, W. (2014). Identifying and addressing barriers to uptake of voluntary medical male circumcision in Nyanza, Kenya among men 18-35: a qualitative study. *PloS one*, 9(6), e98221.
69. Mulwo, A. K., Tomaselli, K. G., & Dalrymple, L. (2009). Condom brands, perceptions of condom efficacy and HIV prevention among university students in KwaZulu-Natal, South Africa. *African Journal of AIDS Research*, 8(3), 311-320.
70. Mkandawire, P., et al. (2014). *Branding free condoms to increase acceptability and use among the youth of Malawi*. Melbourne, Australia: International AIDS Conference. Poster #MOPE 287
71. Muhamadi, L., Ibrahim, M., Wabwire-Mangen, F., Peterson, S., & Reynolds, S. J. (2013). Perceived medical benefit, peer/partner influence and safety and cost to access the service: client motivators for voluntary seeking of medical male circumcision in Iganga District Eastern Uganda, a qualitative study. *Pan African Medical Journal*, 15(1).
72. SKILLZ is comprehensive curriculum designed to educate male and female adolescents on the critical issues of gender, HIV and SRH and rights.
73. Kaufman, Z. A., DeCelles, J., Bhauti, K., Hershow, R. B., Weiss, H. A., Chaibva, C., ... & Ross, D. A. (2016). A Sport-based intervention to increase uptake of voluntary medical male circumcision among adolescent male students: results from the MCUTS 2 cluster-randomized trial in Bulawayo, Zimbabwe. *Journal of acquired immune deficiency syndromes (1999)*, 72(Suppl 4), S297.

## IMAGES AND FIGURES

- Cover Photo:** The Uganda Health Marketing Group (UHMG), in partnership with the Strengthening TB and HIV/AIDS Response in eastern-central Uganda (STAR-EC), with funding from USAID, conduct a condom promotion for the Protector brand at a rural fisher community. © 2012, Kim Burns Case/CCP, Courtesy of Photoshare.
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- Page 6: Image 4:** A nursing aide in Masaka, Uganda, administers an HIV test to a participant in a community HIV/AIDS awareness event. © 2012, Uganda National Volunteers Link, Courtesy of Photoshare.
- Page 7: Image 5:** An adolescent (with back to camera) receives counseling prior to HIV testing at Gulu Youth Centre in northern Uganda. The center, run by Straight Talk Foundation, a leading health and development communications NGO in the East Africa region, teaches life skills to young people so they can stay safe from HIV and avoid other impediments to their progress in life. © 2007, Gilbert Awekofua, Courtesy of Photoshare.
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