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Are We Getting Any Closer to Including Men and Boys in Sexual and Reproductive Health? A Multi-Country Policy Analysis on Guidance to Action in East and Southern Africa

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ABSTRACT

There has been growing recognition of the need to address the sexual and reproductive health (SRH) needs of men and boys, including a need for more explicit guidance in domestic health policy and plans. This paper reports on a policy analysis, covering five East and Southern African countries, and discusses the extent and ways in which male clinical and non-clinical needs, and their roles in SRH are currently being reflected. It draws attention to the policy discourse, trends, and gaps in including men in the region as clients, partners and change agents to inform a way forward.

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Introduction

Men and boys have a variety of sexual and reproductive health needs, including contraception, HIV and other sexually transmitted infections (STIs), sexual dysfunction, infertility, male reproductive health cancers, and how to provide support during pregnancy and child-related care. However, these needs are often unfulfilled due to several barriers, such as male stoicism, reluctance to admit ill health, restrictive access to health facilities, negative stereotypes of male clients among providers and services that do not cater to their needs, and a lack of agreed-upon standards for delivering SRH clinical and preventative services to men and boys (Baker et al., 2014; Heise et al., 2019; Kågesten et al., 2016; O'Brien et al., 2005; Rovito et al., 2017).

In recent years, there has been a growing recognition of the need to address the SRH needs of men and boys. In 2017, UNFPA and IPPF issued the Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys to help standardize male SRH care, as well as increase the range and quality of these services for men and boys in all their diversity. The package consists of clinical and non-clinical components and follows a gender-transformative approach whereby the provision of services to men and boys—whether in the health facility, at school, or in the community—actively integrates information on gender norms and roles, and the importance of men to take responsibility for their own, and their partner's and family health and wellbeing (United Nations Population Fund [UNFPA] and International Planned Parenthood Federation [IPPF], 2017).

Aligning with these policy and programming efforts, there have also been attempts to expand the definition of male involvement to include men and boys as clients of SRH services and to encourage their role as agents of change within families and communities. In fact, almost three decades ago, signatories of the International Conference on Population and Development (ICPD) Programme of Action committed to crafting policies and strategies that would more actively involve men in sexual and reproductive

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health programmes and family life. As part of a larger vision of the social changes and multi-sectoral activities required to stabilize population growth and improve people's quality of life and that of future generations, the declaration stated that:

> Men play a key role in bringing about gender equity since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of Government. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life. (paragraph 4.24)

The Programme of Action emphasized early action to instill respectful attitudes toward women and girls and shared family responsibilities in boys before their sexual debut (para. 4.29).

During early childhood, boys develop their gender identity and begin to understand what it means to be male (Martin & Ruble, 2004), after which they begin to internalize and apply gendered stereotypes propagated by parental figures and other socializing agents, such as schools and religious institutions (Hines, 2015). Timely intervention can prevent gendered health inequities that follow from gender norms which, for boys, tend to emphasize the need to prove themselves, take (sexual) risks and dominate in heterosexual relationships (Greene & Patton, 2020; Heise et al., 2019) and improve the health and (sexual) wellbeing of both girls and boys (Casique, 2019; Levy et al., 2020).

In the East and Southern African region, with a young demographic profile, key regional commitments on sexual and reproductive health and rights (SRHR) have begun to more intentionally consider the needs of adolescent boys and young men. For example, the East Africa Ministerial Commitment for the ICPD +25 expresses concern at the limited involvement, access, and uptake of services by men and boys, and commits to ensuring that all children, women and men have access to preventative, health, legal and psychosocial services, and to reducing gender-based violence (GBV) and harmful practices (EAC, 2019). The Southern African Development Community (SADC) Regional Strategy for SRHR (2019–2030) calls for Member States to engage men and boys as partners, and as individuals with their own SRHR needs. It also urges Member States to ensure that services meet the specific SRHR needs of men and boys (Southern African Development Community [SADC], 2019). Furthermore, guiding frameworks such as the East African Community minimum package for Reproductive, Maternal, Newborn, Child and Adolescent Health and HIV Integration, have become more explicit on the needs of boys and men. For example, HIV service points in East African countries are expected to conduct advocacy campaigns on male involvement, while voluntary male medical circumcision is regarded as part of an integrated package of SRH services for men and boys, covering information and screening for sexually transmitted infections (STI), HIV, male reproductive health cancers and counseling on contraceptive services, and harmful gender norms relating to sexual and gender-based violence (EAC, 2020).

Despite these efforts, the scope of male involvement in ESA policies and strategies has been insufficient, with the consideration of men and boys as clients of SRHR services and encouraging their role as change agents within families and communities significantly lagging (Shand & Marcell, 2021). Several scholars critiquing the post-ICPD approach to male involvement as being reductionist and instrumentalist have called for greater clarity within SRHR-related policies on how the involvement of men is anticipated to change gender influences on health outcomes (Barker & Das, 2004; Comrie-Thomson et al., 2015; McLean, 2020; Montgomery et al., 2011). It is asserted that the post-ICPD interpretations of male involvement in SRHR policy have tended to focus on drawing men into SRH services as supportive partners, without addressing the gendered power dynamics and patriarchal structures that are impediments to involving men in sexual and reproductive health programmes and family life. This has led to implementation that has not been as gender-transformative as envisioned in the Programme of Action (Ruane-McAteer et al.,

2019). Additionally, there is very limited published data on how these strategic commitments and frameworks have since been translated into national policy and guidelines on the SRHR for men and boys in the ESA region (Galle et al., 2019; Gopal et al., 2020).

This paper reports on a policy analysis of five ESA countries where UNFPA is implementing its SRHR programmes. The analysis sought to assess how (if at all) the SRH needs, rights and roles of men and boys in all their diversity have been addressed in national policies and strategies, and whether these policies and strategies align with regional commitments to strengthen boys'/men's inclusion and advance SRHR for all.

Material and methods

In looking at public policies, our approach focused on the intentions of formal institutions of government in the five countries, that provide the framework in which public policy processes take place. Five countries were selected based on their participation in the 2gether 4 SRHR programme, a Joint UN Regional Programme that aims to improve the sexual and reproductive health and rights of all people in East and Southern Africa. The focus of the analysis was on the contents of these policies and did not include an enquiry into the policy making process itself, its actors or the context in which influence was exercised to get boys'/men's (sexual and reproductive) health and rights issues onto the policy agenda. Reviewed sources of documentation included legislative pieces, policies and strategies, guidelines and school curricula, where available, covering aspects of sexual and reproductive health in part or in full. For example, this included sections within criminal law referring to sexual behavior or national health and development policies outlining the direction or prioritization of programmatic foci on SRH, as well as a full appraisal of national SRH policies and strategy documents on adolescent SRH. The review covered 8 regional and 73 country policy documents (see Table 1). Relevant policy documents were identified through electronic and manual searches, in collaboration with the research teams and UNFPA country offices in each country. Resources were obtained online from websites hosted by national Ministries of Health, Education or Youth and civil society organizations, as well as via direct contact with Ministry employees. The majority of documents could be easily retrieved, except for country in-school guidance for comprehensive sexuality education to primary and secondary learners. The team was able to obtain these curricula in only three of the five countries.

The policy analysis was carried out by the lead author between February and May 2022, with the second author providing feedback on drafts of the analysis during this period. The policy analysis used content analysis and discursive thematic analysis (Weber, 1990; Yardley, 1997). Content analysis identified boys'/men's SRH needs/roles in each policy or strategy document. Here, the review was guided by an assessment framework composed of different criteria to index the textual data (see box 1). Data were entered compactly into an excel spreadsheet, while more expansive notes concerning specific pieces of data were compiled in a separate document, and organized around a priori and emerging issues to support in-country and cross-country comparisons. The Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys served as an important analytical unit for the assessment framework, as the package encapsulates the diverse needs of men and boys as clients of and supportive partners in SRHR services. Greene et al.'s (2006) conceptualization of men's involvement in SRH services, which focuses on men as clients, men as partners and men as agents of positive change on SRHR within families and communities also informed the analysis.

The discursive thematic analysis, then critically examined how concepts such as gender, health behavior and agency were strategically deployed in current policies and strategies to produce particular thematic meaning units, with subsequent reflections on potential gaps and opportunities for action. Gender dynamics were taken into account in policy intentions using the framework of the Interagency Gender Working Group (IGWG, 2017). The framework is organized along a continuum that ranges from gender-blind,

Table 1. Overview of policy documents included in the analysis.

Name of document	Date of issue or period of implementation
Regional documents	
SADC Regional Strategy on SRHR	2019–2030
EAC Minimum Standards for RMNCAH and HIV Integration and Linkages	2020
HIV declaration	2016–and 2025 targets
Maputo Plan of Action	2016–2030
Africa Health Strategy	2016–2030
African Union Policy on SRHR	2006
Abuja Declaration on AIDS, malaria and TB	2013
Ministerial Commitment on Comprehensive Sexuality Education and SRH services for Adolescents and Young People in ESA	2013
Country documents	
Uganda	
Uganda Penal Code	1950, updated version 2020
Constitution	1995, 2017
Adolescent Health Policy	2012
SRHR policy	2022 (to be formally approved)
Adolescent Health Policy	2021–2025 (to be formally approved)
School Health Policy	2021 (to be formally approved)
Safe Male Circumcision policy	2010
Health Sector Development Plan	2015–2020
Ministry of Health Strategic Plan	2020–2025
National HIV/AIDS Strategic Plan	2020–2025
National Plan of Action SGBV and Violence against Children	2019–2030
National Strategy for Male Involvement/participation in reproductive health, maternal, child, adolescent health and rights nutrition, including HIV/TB	2019
HIV Prevention roadmap to 2030	2018
UHC Roadmap	2020–2030
Policy Guidelines to Male Involvement in SRH service delivery	2019
National SRHR guidelines and standards	2006
National Guidelines on PMTCT and infant feeding	2011
National Standards for improving MCH quality	2018
Revised guidelines for Prevention and Management of Pregnancy in school settings	2020
Presidential Initiative on AIDS Strategy for Communication to Youth: Helping pupils to stay safe. Handbook for Teachers, P5-P7	undated
National Sexuality Education framework	2018
Lesotho	
Criminal Procedure and Evidence Act	1981
Marriage Act	1974
School Health and Nutrition policy	undated
Prevention and Management of learner pregnancy policy	2021 (draft)
National Health Strategic Plan	2017–2022
National HIV Strategic Plan	2018–2023
National Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategic Plan	2021–2025 (final draft)
National Health Strategy Adolescents & Young People	2015–2020
Social and Behavior Change Communication strategy for SRHR and HIV	2020 – 2023
National Health Quality standards for Young People Friendly services	2012
ART guidelines	2016
Life Skills based Sexuality Education Syllabi, Grade 8-11	2021
Malawi	
Penal code	1930, amendment 2016
Marriage, Divorce and Family Relations Act	2015
National SRHR policy	2009 and 2017–2022
National Health Policy	2017
National Gender Policy	2015
Malawi National Youth Policy	2013
Health Sector Strategic Plan	2017–2022
National Community Health Strategy	2017–2022
National Strategic plan HIV and AIDS	2020–2025
National Youth Friendly Health Services Strategy	2015–2020
VMMC communications strategy	2012–2016
Malawi Clinical HIV Guidelines	2018
Zambia	
Penal code	1931, revised 2007
Marriage Act	1918, revised 1964
HIV Policy Education Sector	2004
National Health Policy	2012
National Gender Policy	2014
Community Health Strategy	2019–2021
Child Marriage Strategy	2016–2021
National Health Strategic Plan	2017–2021
HIV/AIDS Strategic Framework	2017–2021

(*continued*)

Table 1. Continued.

Name of document	Date of issue or period of implementation
VMMC strategy	2010–2020
Roadmap MNCH	2013–2016
Operational plan VMMC	2016–2020
HIV consolidated guidelines	2020
Adolescent National Operation Plan	2017–2021
National Standards and Guidelines for Adolescent Friendly health services	undated (developed >2011)
Peer Education Programme Standards	2010
Comprehensive Sexuality Education Framework, Grade 5–12	2014
Zimbabwe	
Criminal Law	2004
National Gender Policy	2013–2017
Gender Policy National AIDS Council	undated
National Adolescent Sexual and Reproductive Health Policy	2016–2020
National Development Strategy (Chapter Health)	2021–2025
National Health Strategy	2016–2020
National AIDS Strategic Plan	2015–2020
National HIV Communications Strategy	2019–2025
VMMC Implementation Plan	2019–2021
ART guidelines	2016
BRO2BRO peer educator manual	2018
School-based Life Skills Empowerment and Support Programme	2018–2022

which means there is no consideration of gender-related outcomes of factors in policies or programmes, to gender-aware which entails a deliberate examination and addressing of gender-related issues, and then to the accommodation of gender-related issues and challenging and reflection on unequal power relationships and harmful gender norms, termed gender-transformative.

Results

Our analysis looked at how policies and strategies positioned men's health in the five countries and within this distinguishes five broader themes and four subthemes.

Locating gender within SRHR policies and health strategic plans

In the preambles of most country policies and strategies, we found that equitable access to health care was promulgated as a key guiding principle for policy implementation, based on an understanding that all citizens are entitled to quality health services, irrespective of their ability to pay. Policy narratives of overarching health strategic plans and SRHR policies point to differences between men and women in access to health care, health needs and outcomes related to their gender and biological sex, which necessitate a diversified health system response. All countries made a conceptual link to the social determinants of health approach (Solar & Irwin, 2010), the life course approach to health (WHO, 2015; Mishra et al., 2009, 2010), or a combination thereof, to situate their understanding of gender in relation to health.

In the social determinants of health approach, gender is considered one of the most important mechanisms that gives rise to health inequities between individuals, as someone's gender (alongside income, education, occupation, social class, and race/ethnicity) determines the position of that individual within hierarchies of power, prestige and access to resources in society. The life course approach equally considers the contribution of gender to health outcomes, whereby negative physical, psychological, and social exposures in someone's early life (e.g during gestation or adolescence) may have long-term effects on health and disease risk later in life. The prominent relation between gender and health was most explicitly captured in the SRHR policy from Malawi.

> SRHR needs increase during youth, but for women they particularly increase during the reproductive years. In old age, the general health of men and women reflect the earlier reproductive life events. Although individual SRHR needs differ at different stages of life, events at each phase have important implications for future wellbeing. Malawi National SRHR policy 2017-2022, p. 10.

In Health Strategic Plans, gender was found to be subsumed under the social determinants of health as the excerpts demonstrate below:

> To develop an effective health system, the determinants of health, that is the social, economic, environmental and cultural factors which influence health, will be taken into account. People's age, sex, and hereditary characteristics inherited from parents are the basic determinants of health status. These are factors over which individuals have no control. Lesotho National Health Strategic Plan 2017-2022, p. 7.

> "To further improve health outcomes, there is need to focus more on quality of health care, there is need for action on social determinants, like wealth and education, hence the importance of the Sustainable Development Goals agenda" and "The HSSP II is designed to contribute to the sustainable development goals through interventions in the essential health package and action on social determinants of health". Malawi Health Sector Strategic Plan II 2017–2022, pp. 24–25 & 27.

> The NHSP uses a model that incorporates underlying socio-economic factors impacting health behaviours. The socio-economic determinants model postulates that poor social and economic factors impact health throughout an individual's life. Zambia National Health Strategic Plan 2017–2022, p. 9.

> The major determinants of health in Uganda include levels of income and education, housing conditions, access to sanitation and safe water, cultural beliefs, social behaviours and access to quality health services. Uganda Ministry of Health Strategic Plan 2020/21-2024/25, p. 18.

> The Constitution further provides, in Section 77 that every person has a right to safe, clean and potable water, and sufficient food. These rights are directly related to peoples' health as it not possible to divorce the living conditions of people from their health risks and status. National Health Strategy for Zimbabwe (2016–2020), p. 1.

In the application of the social determinants of health, three countries (Uganda, Malawi, Zambia) emphasize the relationship between ill-health, social structure, and context and do not refer to people's ability to exercise power and to adopt practices to improve their health, including under very difficult economic and social circumstances. Within these strategy documents, we observed how this resulted in a tendency to position men (and women) as recipients of health care (served by a system equally constrained by poverty), and to interpret the concept of engagement in health as 'getting men (and women) to a health facility'. Two countries (Lesotho and Zimbabwe) have an eye for the influence of both structure and agency on men's (and women's) health and health behavior.

> Social and community networks, including families and households, have a considerable role to play in the health of individuals. It is often through local structures that services are delivered or that individuals and communities get information about health and health services and get the support they need to take an active role in improving their own health. Lesotho National Health Strategic Plan 2017–2022, p. 7.

> Communities need not be seen only as beneficiaries of health services but also as co-producers of those services […] The involvement of other community cadres and traditional leadership will enhance demand for services, and also community and individual responsibility for their health status. National Health Strategy for Zimbabwe (2016–2020), pp. 56–57.

Meanings of gender responsiveness

Commitments to a health care system that is responsive to gender differences in access, health care needs and outcomes were routinely embedded in health strategic plans across the five countries, with an observation that policy action was mostly directed toward the disadvantaged position of women and girls. Only the National Health Strategic Plan from Lesotho made explicit reference to men.

> Special consideration shall be accorded to women due to their culturally constructed lower status in the society and their special role in reproduction. Where men have been disadvantaged, special effort will be made to support them. Lesotho National Health Strategic Plan 2017–2022, pp. 7 & 38.

> Gender considerations are important for both health service delivery and also for assessing the health sector outcomes. Some of the pernicious manifestations of gender inequality in Zambia include the disproportionately high ratio of educated men to women and low representation of women in politics and formal employment. In addressing issues of gender and health, the NHSP in the next five years will stress the inclusion of gender mainstreaming in planning, design, and M&E of health programmes and policies. Zambia National Health Strategic Plan 2017–2022, p. 10.

> This strategy, as described in the SDG framework, seeks to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. National Health Strategy for Zimbabwe 2016–2020, p. 2–3.

It was further observed that the term gender mainstreaming was widely used but only scarcely defined or elaborated on in health strategy documents. As a result, the utility of the term for and actual in-country practice to ensure a gender-responsive health system remains unclear for the most part.

> Gender mainstreaming shall be central in the planning and implementation of all health policies and programmes. Malawi Health Sector Strategic Plan II 2017–2022, p. 28.

> Principle vi: "*A gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programmes*". Uganda, Ministry of Health Strategic Plan, 2020/2021–2024/2025, p. 56.

The adoption of gender-neutral policy language was also observed to obscure the meaning and practice of health system responsiveness to adolescents as a group with specific health needs in the population. Across all five countries, age-appropriate and comprehensive (sexual and reproductive) health services were promoted as a 'blanket approach' for this age band and, as a result, tailored strategies and guidance in response to the differing needs of boys, girls and non-binary youth at different developmental phases of life do not come to the fore. For example, it is noted that while the Uganda Adolescent Health Policy Guidelines and Service Standards (2012) acknowledges that adolescents are a heterogenous group with different needs for health information, education and services, it provides no further guidance on this in the policy itself. It relegates the actual assessment and responsiveness to adolescent health needs to the health actors who come in direct contact with the adolescent by indicating that through training and retraining: "*relevant services* [are] *provided as per specific needs and circumstances of adolescents based on age, sex, marital status and socio-economic situation*" (p. 34) – a stance which did not alter in the latest iteration of the country's Adolescent Health Policy (2021).[1]

Problematizing boys'/men's behavior

The discourse on health behaviors in policy and school learner documents was found to be largely negative of men, depicting them as individuals who take sexual and other health-related risks and jeopardize the health of others, and as individuals who avoid seeking health care. Problem analyses contextualize the range of behaviors listed (e.g. promiscuity, excessive alcohol consumption, violence against and sexual dominance over women, or inter-generational sex at the initiative of men) within the strong patriarchal societies of the five countries, as well as how the patriarchal system dictates the transference of gender and sex roles to new generations. In one of these analyses, the pivotal task of shifting such deeply entrenched social and cultural norms starting at the policy level, was succinctly described:

> Male dominance has traditionally also been entrenched into some of the domestic policies. According to this cultural trait, men are heads of households and thus, they have decision making-powers on all critical matters including those concerned with fertility, household size, family planning and individuals' participation in social, political and economic activities. Though achievements have been made to change male supremacy through policy and legislation, the practical situation on the ground relating to the suppression of women by men remains the same as in traditional times. Lesotho National Health Strategy Adolescents & Young people (2015–2020), p. 13.

Adolescence and emerging adulthood are specific periods in which men are characterized as risk-taking, irresponsible and lacking control in relation to their own health and the health of girls, as illustrated by the following policy documents.

> Girls report experiencing stress, shame, embarrassment, confusion and inability to manage their menstruation. Boys report feeling low self-esteem and feeling out of control of events in their lives, which manifests itself through unhealthy behaviours. Lesotho School Health and Nutrition Policy, undated, p. 11.

> Youth cannot expect government to diligently undertake programmes to empower them when they are busy doing the opposite - abusing themselves through alcohol and drug abuse. Therefore, in order to get maximum benefits from the implementation of this youth Policy, it is expected that youth, as important stakeholders in the implementation of this policy, would also develop and promote an appropriate mindset and the necessary self-discipline

that goes with it. Malawi National Youth Policy, 2013, p V.

As inferred in the Malawi Youth Policy, there is an expectation nonetheless that the adolescent can exert self-control, while social and economic inequalities that influence behaviors are ignored. In Zambia and Uganda, a more punitive approach is promoted where learners are told to abstain from sex and given multiple warnings against sexual stimulation (e.g., watching porn, being in the same room as the opposite sex) and deviant sexual behavior which "*may lead into harmful or self-destructive behaviors*". (Comprehensive Sexuality Education curriculum for 13 to 16-year-old learners Uganda, p. 31). By contrast, in Lesotho, teachings are seen to move beyond the placement of boys'/men's sexuality in a value and/or risk frame. Both girls and boys are expected to engage in activities (e.g., role plays) that challenge gender stereotypes and are encouraged to solicit views on traditional gender practices (e.g., early marriage) outside of the school setting as homework assignments. In grade 11, learners need to conduct research on gender stereotypes in their community, formulate their own interview or questionnaire questions and suggest how to make positive changes in their community based on their findings.

Men's (sexual and reproductive) health concerns are being overshadowed by HIV

It was observed that policy and strategy documents contained limited information on the health status of men and linked priorities to address men's health concerns in each country, except in reference to HIV and AIDS. HIV sections within the national health strategics plans of Uganda, Lesotho and Zimbabwe and strategies and guidelines specifically designed for the management of HIV and AIDS across the five countries presented gender-disaggregated data on both the burden of disease and service utilization.

We observed how this data informed strategic priorities and actions specific to men or subgroups of men in the population. Plans included actions to address the problem of lower uptake and retention of men in HIV care, for example by engaging traditional and religious leaders in the promotion of boys'/men's health seeking behavior in their communities, or reaching specific groups of men with outreach services. Examples of male target groups included adolescent boys and young men, middle-aged men, young boys herding livestock in remote areas, prisoners, and men who have sex with men. It was this set of disease-specific directives which spoke of men belonging to sexual and gender minority populations. Very few health policies and strategies covered men in all their diversity, and if country documents made mention of it, it was under the guise of the right to health, as illustrated by the following quote from the Zambian Adolescent Health Strategy.

> The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics. Zambia Adolescent Health Strategy - National Operation Plan 2017–2021, p. 15.

While some documents present male prevalence and incidence data for certain health conditions (e.g., leading causes of death in men), only a few dedicate a paragraph to the most salient health concerns for men, as is observed in the Health Strategy of Zimbabwe (2016–2020) or make the male excess disease burden insightful such as in the Ugandan Adolescent Health Policy quoted below:

> Some causes of death have a high ranking only among males (e.g. drowning) or females (e.g. maternal conditions), or among younger adolescents (e.g. lower respiratory infections) or older adolescents (e.g. interpersonal violence and self-harm). Similarly, some causes of DALYs lost only have a particularly high ranking among males (e.g. road injury) or females (e.g. anxiety and maternal conditions), or among younger (e.g. lower respiratory infections) or older adolescents (self-harm and depression). These differences illustrate that disaggregation of health information is vital to identify and act upon the special needs of different sexes and age groups. Adolescent Health Policy (draft 2021) Uganda.

Data presentation on conditions specific to men was also missing in the documents. This gap on, for example, prostate cancer and male infertility, is noted in the preamble of the SRHR policy from Malawi:

> For some thematic areas, such as reproductive cancers (especially prostate and breast cancers), infertility, obstetric fistula, domestic violence/harmful practices and male involvement in maternal health of their spouses, there is scanty data for the baseline and targets for the key indicators. For effective monitoring of the policy, there is a need to collect data that will be used to update these statistics during the implementation of this policy. Malawi National SRHR policy 2017–2022, p. 11.

As a consequence, boys'/men's health priorities are not well reflected in overarching health strategic plans and SRHR policies and, as we will present later, even fewer priorities are supported by a budget and monitoring framework.

Aligning policy to continental and regional frameworks on (sexual and reproductive) health and rights

All five countries committed to a number of continental and regional guiding frameworks on health and SRHR, and these frameworks speak in varying degrees to the inclusion of men. The African Union Policy on SRHR (2006, p. 25), for example, refers to the need for policies, strategies and policies that address men's own health needs as well as their shared responsibility as husbands, partners and fathers, and the SADC regional strategy on SRHR (2019-2030) also speaks to the inclusion of men as change agents in sexual and reproductive health, as illustrated below:

> Policies, strategies and programmes should be developed that work with men and boys as partners, SRHR clients, and as agents of change to challenge and change unhealthy dominant norms of masculinity and patriarchy, and turn the tide on maternal mortality, HIV incidence, GBV and other poor SRH health outcomes across SADC. Addressing gender inequality as a fundamental driver of poor SRHR outcomes is central to boldly accelerating the regional SRHR agenda. SADC SRHR strategy 2091–2030, p. 28.

The Maputo Plan of Action (2016–2030) highlights the importance of the role of men in enabling access for women and girls to SRH services:

> The revised Plan learns from best practices and high impact interventions and responds to vulnerability in all its forms, from gender inequality, to rural living and the youth, to specific vulnerable groups such as displaced persons, migrants and refugees to ensure nobody is left behind. It recognizes the importance of creating an enabling environment and of community and women's empowerment and the role of men in access to SRH services. Maputo Plan of Action 2016–2030, p. 4.

However, other documents tend to overlook men and their role in health. For example, the Africa Health Strategy (2016–2030) prioritizes women, children and adolescents and does not make the role of men in health explicit in its strategy.

> Ensure long and healthy lives and promote the well-being for all in Africa in the context of "Agenda 2063: The Africa We Want" and the Sustainable Development Goals. This goal will be people driven with a particular focus on the most productive segments of society as well as on women, youth, adolescents, children and persons in vulnerable positions. Africa Health Strategy (2016–2030), p. 17.

The Ministerial Commitment on Comprehensive Sexuality Education (CSE) and SRH services for Adolescents and Young People in ESA adopts a gender-neutral stance, but with a clear direction toward domestic SRH policy and service provision. The latter document affirms it is "*the responsibility of the State to promote human development, including good quality education and good health, as well as to implement effective strategies to educate and protect all children, adolescents and young people, including those living with disabilities, from early and unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs) including HIV, risks of substance misuse and to combat all forms of discrimination and rights violations including child marriage*" (2013, p. 1). While the Ministerial commitment had been signed by all five countries in 2013, only four (Uganda, Lesotho, Zambia and Zimbabwe) renewed their commitment to CSE and SRH in 2021.

We will discuss the three areas of focus, as jointly articulated within these frameworks and in the boys'/men's inclusion literature (Greene et al, 2006: Shand & Marcell, 2021) in the next three subthemes.

Including men as clients of sexual and reproductive health services

Out of the clinical care package of SRH services for men (UNFPA & IPPF, 2017), the provision of

HIV services was the most frequently mentioned of all in national policy and strategy documents. Country strategies largely focussed on bringing more male clients into voluntary medical male circumcision (VMMC) programmes, and identifying and enrolling HIV-positive men on antiretroviral treatment. They spoke to a lesser extent of the provision of pre-exposure prophylaxis and post-exposure prophylaxis to specific groups of men, and the role of male partners in the prevention of mother to child transmission (PMTCT) of HIV.

> Redesign, fund and scale up a sustainable national VMMC programme as part of overall SRHR for men, boys and male infants. Lesotho National HIV Strategic plan 2018–2023.

> Expand the availability of quality VMMC services for males 15-49 in public facilities, private sector facilities, and other institutions. Malawi National Strategic plan HIV and AIDS 2020–2025

> Breaking the HIV transmission cycle by identifying people who are HIV-positive, with particular attention on finding missing men, members of key populations and other HIV-exposed individuals likely to test positive for HIV and initiating them on treatment. Uganda National HIV and AIDS Strategic Plan 2020/2021–2024/2025.

While VMMC was promoted as an entry-point for men to access a broader package of SRH services according to need, our analysis found that the policies and strategies that would need to underpin and operationalize this service package were not well articulated for male clients, as we will discuss below. It was also observed that in countries where specific VMMC policy documents had been conceived a decade or more ago, current national health strategic plans no longer referred to VMMC as a health service. For example, the Essential Health Package, as presented in the Health Sector Strategic Plan of Malawi (2017–2022), speaks of HIV testing services and treatment for men but not of VMMC.

Attention to and provision of STI prevention, screening and treatment services was mostly referred to in gender-neutral terms, with an exception for men belonging to key populations within HIV-related policies and standards.

In terms of boys'/men's choices and provision of contraceptive services to boys and men, the male condom was more often than not presented as a singular option. Even the policies that iterated a broad, inclusive stance on family planning service provision (for example, the Lesotho NHSP 2017-2022 which aims to "*ensure access to safe, effective, affordable and acceptable RH services including family planning services to youth, women and men,*" p. 40, the Ugandan SRHR Policy 2022[2] which commits to "*provide all sexually active individuals access to Quality Family Planning information and services whenever they need them,*" p. 11, or the Malawian SRHR policy 2017–2022 which seeks to "*broaden the range of family planning methods offered at both health facility and community levels*", p. 25.) were not seen to further expand on male contraceptive methods, such as vasectomy or involving men in the contraceptive choice of a female partner.

In addition, discrepancies between noting contraception as a SRH need on the one hand and actioning it for men and boys on the other hand were found in several policy documents, such as in the National Youth friendly health services strategy (2015–2020) of Malawi which directs all of its attention to female contraceptive services, despite problematizing the low contraception uptake in boys in the introduction of the document.

Attention to and clinical services for male reproductive disorders and dysfunction, infertility, and cancers were largely absent from national policy documents. The only exceptions were the Ugandan male involvement policy guidelines, and strategy (both 2019), which promote screening for prostate cancer, infertility, and screening for sexual dysfunction and benign prostatic hypertrophy in older men. The SRHR policy of Uganda (2022, draft) integrates infertility and sexual dysfunction services within existing SRH services and at various levels of health care, and underlines the need to "*counter prevalent myths and misconceptions about causes and treatments of infertility and sexual dysfunction*" (p. 11). And Malawi's SRHR policy (2017–2022) covers screening for infertility for individuals and couples and referral to appropriate care, and diagnostic screening for prostate cancer at the primary health care level and referral for cancer patients.

Also part of the SRH clinical service package for men is Sexual and Gender Based Violence (SGBV) support. This service took up a prominent place in policy documents with a recognition that both women and men can be a victim. In several documents, this was also supported by quantitative data on sexual/emotional abuse among boys, such as in Zimbabwe's Adolescent Health Strategic plan (2016–2020), the National Plan of Action SGBV and violence against children (2019–2030) from Uganda, and Malawi's National Youth friendly health services strategy (2015–2020). However, recognition of this problem for boys was not seen to lead to further policy action. For example, the National Plan of Action SGBV and violence against children (2019–2030) points to the exposure of boys and young men to violence in juvenile detention centres/prisons in Uganda, but does not contain a subsequent intervention for this group.

In other countries, service provision is formulated in gender neutral terms, as illustrated by the Lesotho National Health Strategic Plan (2017–2022, p. 41) which commits to providing "*comprehensive services for victims/survivors of abuse/violence and promote reduction of all forms of gender-based violence.*" Whilst a key role is assigned to men in the elimination of SGBV, only a few policy documents were observed to subsequently translate this role into programmatic interventions. These included male forums for GBV discussions and integration of GBV issues in the educational curriculum (Zimbabwe), anger management as part of male-oriented package of SRH services (Uganda), and the involvement of male prisoners in SGBV reduction strategies (Lesotho). None of the policies on SGBV contained specific interventions or psycho-social support for perpetrators of SGBV.

Provision of information on sexual health and CSE to men primarily centered on the adolescent and young age band, and stretched across facility-, community- and school-based strategies[3]. The strategies which promoted facility-based health education and counseling services were not observed to single out the male client but, as a guiding policy principle, strongly emphasized youth-friendliness and privacy within these services. Attention to adolescent boys and young men was pronounced via specific and intersectoral strategies, intended to bring them into SRH care and reduce risk behaviors and harmful attitudes and practices concerning HIV and STI transmission, alcohol and drug use, and GBV. The Uganda male involvement strategy (2019) took this a step further by its suggestion to "*integrate boys and men's interests in the health service delivery that will foster physical, emotional and social development of boys and men as a way of adopting health-promoting behavior*" p. 18. Sexual pleasure was not mentioned as a topic to include in the provision of sexual health information and counseling in national health guidance documents and the CSE curricula, as is recommended in the clinical care package of SRH services for men.

There was attention to the necessity of tailor-made messaging on SRHR for men and boys within policy documents. A number of countries produced a stand-alone communication strategy to help guide this process for particular SRH issues, notably for HIV in Zimbabwe, SRH and HIV in Lesotho, and VMMC in Malawi. In the HIV communication strategy of Zimbabwe (2019–2025) adolescent boys and young men were marked as a priority group. While the strategy describes a number of pressing issues for this group (such as low risk perception, experimental sexual behavior, lack of comprehensive SRH, and low adherence to anti-retroviral treatment), it remained unclear from the document which particular SRH needs were identified for this priority group and could potentially serve as cue(s) to action and help refine messaging.

Including men as supportive partners

The clinical package also covers boys'/men's support to pre- and post-natal care and safe motherhood, and safe abortion care. While we observed that the inclusion of men as partners and expectant fathers in maternity care is encouraged through policy in all five countries, the degree of attention was found to vary considerably between countries. The inclusion of men in abortion care was not well articulated in any of the five countries. Only a previous version of Uganda's

National SRHR policy (2006) referred to the latter (i.e. "*this is health care provided to a woman or a couple seeking advice and services either for terminating a pregnancy or managing complications arising from an abortion,*" p. 45); the new country policy no longer mentions the male partner in the provision of post abortion care. Only one document contained a working definition of the term 'male involvement' to help guide policy implementation.

> In this document, male involvement refers to the fulfilment of roles and responsibilities of men and boys in sexual and reproductive health and rights including HIV/TB prevention, care and support. Boys and men will take responsible decisions to realize their full potential in their sexual and reproductive health and rights. It will also mean that men and women's full enjoyment of their sexuality and realization of their reproductive health goals and rights in a responsible manner. It will further mean that males participate effectively in the health and well-being as well as respecting rights of their partners and children. Uganda National Strategy for male involvement/participation, 2019, p. 9

The National SRHR policy of Malawi (2017–2022) has a dedicated section on male involvement in reproductive health, consisting of four strategies. The policy positions male involvement as a relatively new approach in the country, even though the previous SRHR policy (2009–2016) already included one male involvement strategy. The emphasis is placed on awareness raising, bringing men into the facility, making them feel welcome and empowering them to promote the services.

> Male involvement in maternal and neonatal health care touches on sensitive gender roles related to culture, social norms, values and beliefs. Therefore male involvement should be viewed as a new health or social and behavioural change activity. Malawi SRHR Policy, p. 32

In the other three countries, we did not come across the same degree of operationalization of the term: either in making explicit the approach or strategies to secure male involvement or in listing related activities within the appending workplan. The (draft) National Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategic Plan 2021–2025 from Lesotho, for example, makes minimal note of male involvement[4]. Furthermore, the role of boys in the prevention of teenage pregnancy and as an expectant father in school health and learner policies was missed in all countries, except Uganda. Its revised guidelines for prevention and management of pregnancy in school settings (2020) was found to dedicate a section on the expectant father, who is expected to take part in childcare after his child is born. To deter other learners, policy directives include suspension for all boys, who find themselves in this situation together with their pregnant partner, three months into the pregnancy and allowing boys to reenter school only after the delivery.

Including men as change agents

The inclusion of men as change agents in SRHR was observed to receive the least attention in country policy and strategies. Male support groups, as one of the non-clinical services proposed by UNFPA & IPPF, were not incorporated as a conventional strategy within national documents, except when it concerned people, including men and boys, living with HIV. Only in the Ugandan Male Involvement Strategy (2019), male action groups and a psychosocial peer support model feature as key strategies to equip men to become agents of change in their family and community. In all other policy documents, the strategic emphasis lies more on reaching men and boys with SRHR information and services than on building a (supportive) community. The inclusion of men in SRHR advocacy was equally overlooked by the vast majority of policy documents.

In fact, we found very few policy documents incorporating the terms 'transformation' and 'positive masculinity' to steer policy implementation around the change agent role of men, and these originated primarily from Uganda. Elements that align with gender transformative practices, as it is defined by the Interagency Gender Working Group (IGWG, 2017), were for example reflected in the articulation of the role of the male action groups (MAGs). The MAGs, according to the Male Involvement strategy (2019), are intended "*to stimulate the necessary critical consciousness on men and boys' involvement/participation in SRHR*" (p. 17) and "*to*

discuss the roles and responsibilities of men in child health, SRHR including HIV/TB in a culturally, politically and religious sensitive manner however, without compromising the rights of women and children" (p. 19). A brief section within Uganda's HIV prevention roadmap (2018) also speaks of the male agency role.

> Engaging community, cultural, religious and political leaders will build community resilience to infection and challenge stereotypes, norms, values and practices that fuel stigma. If behaviour patterns are to be changed in a lasting way, traditional culture institutions are indispensable: catalysing meaningful and longer-term shifts in social norms and behaviour requires working with traditional cultural leaders to implement culturally grounded interventions that are family-centred and that engage men as agents of positive change. HIV Prevention Roadmap 2018, p. 34

National Gender Policies were also not found to embrace gender transformative work as a key pillar of the policy. There was a strong tendency to inform rather than to transform communities, as illustrated by the following strategies under the section on gender and health from various national policies:

> Promote awareness on the benefits of sexual and reproductive health services among women, men, girls and boys. National Gender Policy Malawi, 2015, p. 29

> Increase the number of counselling and testing centres, and provide adequate ARTs (encouraging both women and men). National Gender Policy Zambia, 2014, p. 23

> Popularise and conscientize women and men on the new constitutional provisions for rights to health, food and shelter and other provisions that impact on efforts to achieve gender equality in health and HIV and AIDS treatment. National Gender Policy Zimbabwe, 2013–2017, p. 16

Indication of gender transformative intentions within the CSE country curricula of the three countries from which these were available, was only observed in Lesotho where, as indicated before, learners engage in role play scenarios that challenge gender stereotypes and, as homework, are encouraged to make positive changes in their communities. While the country syllabi for in-school CSE have the potential of equipping boys with the skills, attitudes and knowledge to become an agent of change early on in life, such skills-oriented and reflective approach to gender and SRHR issues was not seen to be carried through in other policies and strategies from Lesotho, which may affect the intended outcomes of the CSE programme.

Harmonization, resourcing and monitoring of policy intentions

A closer look into the alignment between the policy intentions in overarching health and SRHR policies, and those of national community health strategies and roadmaps to UHC, when these were available, revealed that intentions on including men in SRHR were not at par. In none of these documents, men's health was discussed and in the case of Malawi, only the components contraception (male condoms), and HIV were reflected in the essential health package (EHP), leaving a significant part of the SRH service provision outside the EHP.

Another large gap observed during the analysis of all documents was that the attention paid to boys'/men's SRH issues in problem statements and/or actionable terms within policies were not or only marginally represented in the budget lines and service/programme indicators of these documents. This was also noted for HIV and AIDS, which received the most prominent focus within men's health. For example, the Lesotho National Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategic Plan (2021–2025) signals an increasing trend in HIV prevalence among men, but its proposed set of indicators to monitor HIV service uptake include female clients only. Another example is Malawi's Gender Policy (2015), which seeks to mainstream gender issues in HIV and AIDS programmes and tracks progress for female programme clients, and the National HIV/AIDS Strategic Plan (2020–2025) of Malawi which budgets for activities with adolescent girls and young women, and not with adolescent boys and young men. It thus remains unclear to what extent boys'/men's service needs, and their participation in SRH activities are being resourced and outputs and outcomes are being tracked to inform the next policy cycle.

Discussion

Our findings from selected countries in the ESA region indicate there has been a shift in the policy landscape over the past five years with increased attention to boys'/men's sexual and reproductive health. While the attention is highly skewed to a few medical conditions and to the male support role in maternity care, the commitments to reaching men with these services align broadly with regional strategies and are now more visibly anchored in domestic health policy. However, important gaps remain which include the lack of policy guidance, finance and concerted push for gender transformative interventions, and the protracted silence on sexual and gender diversity in health policy and education across the male life course.

Key legal barriers, such as the criminalization of same-sex sexuality and conflicting and restrictive age of consent policies guiding the provision of SRH services, have long been pointed out as detrimental to (male) health outcomes in the region (Govender et al., 2018; Mantell et al., 2020; Plesons et al., 2019; Sam-Agudu et al., 2020). Nonetheless, strong opposition against legal change (Currier, 2018; Muparamoto, 2021; Van Klinken, 2017), and even further retreat with outright rejection and penalization of queer identities in one of the five study countries (Jerving, 2023), imply that policy-makers' attention to men is severely distorted along the line of age, sexual orientation and gender identity. As the policy analysis shows, the maneuvering space in serving the SRH needs of male key populations resides (almost) exclusively with HIV and AIDS programmes, and to an extent, adolescent boys also depend on them as the age threshold for HIV testing is generally lower than for other medical procedures[5]. While these services must be made available to them within an otherwise restricted setting for SRHR, the programme does not offer the breadth of services outlined in the global package for men and boys, and as a consequence, key opportunities to intervene both early and timely in the life course of men are being lost.

The provision of integrated health care held promise, but almost two decades of effort to integrate basic health and SRH services with HIV did not yield the systemic change that was needed to overcome the fragmented state of health service delivery in the region and bring such care to scale (Mayhew et al., 2017; Warren et al., 2017). Expectations have since been trimmed back to realizing policy- and service linkages between HIV and other units/programmes providing SRH care (Akatukwasa et al., 2019; Martin et al., 2021; Smit et al., 2012), which, given the current disconnect in mandate and scope between HIV and broader (sexual and reproductive) health policies, is unlikely to bring solace for adolescent boys and male key populations in need of information and services that are not directly related to HIV or VMMC in Uganda, Lesotho, Malawi, Zambia and Zimbabwe.

Apart from a policy disconnect, there is also the marked issue of underrepresentation of boys'/men's SRH needs in current national (sexual and reproductive) health policy and strategies, which not only affects adolescent boys and male key populations but also adult cisgender heterosexual men. Moving forward, policy-makers need to include as well as articulate clearly at what level(s) men can access which services for reproductive disorders and dysfunction, infertility, and male cancers. Several scholars have pointed out the need for robust data on these conditions to inform policy action and, more specifically, treatment guidance that is in line with how these conditions manifest in sub-Saharan African men and the options available to them in an under-resourced health systems' context (Akang et al., 2023; Cassell et al., 2019; Ombelet & Onofre, 2019; Shiferaw et al., 2020).

However, except HIV and AIDS, the analysis revealed the weak evidence base upon which policy-makers (have to) define their country's priorities in men's health and SRH interventions and proceed to make budget allocations. Moreover, the scant mechanisms to track the current performance of the health system in reaching men and with which SRH service impede routine updates and trend analyses at Ministerial level, leading to repeated cycles of less well-informed policies and possibly faulty policy designs (see also Aiyede & Quadri, 2021; Nabyonga-Orem et al., 2016). This is not to say that further research and comprehensive facility data alone

will close the policy-implementation gap, especially when it concerns policy responses that are complex and long-term in nature, such as male involvement in pregnancy and abortion care, which would require, at minimum, a two-way communication process between policy-makers, implementing agencies and recipients of such care during all stages of the policy cycle (Hudson et al., 2019).

Our finding on the need for greater clarity on the specific drivers of risk, vulnerabilities and (sexual and reproductive) health needs of men to inform policy was also recently underscored through the adoption of the SADC boys and young men vulnerability framework (SADC, 2022). Member States are advised to undertake gender analyses to identify common drivers and consequences of boys' vulnerabilities, and to put in effect a multisectoral coordination mechanism at Ministerial level as well as a "*standard referral pathway to ensure boys and young men receive the necessary support and services at all levels (national, district, local and community)*" p. 14. For Southern African countries, this may provide the push necessary to move the policy narrative beyond the observed acknowledgement of differential needs to the articulation of specific strategies and actions to address boys'/men's vulnerabilities.

The framing of men and male (sexual) behavior needs to be carefully thought through as part of the policy cycle and move to a more enabling stance that is supportive of men as opposed to solely problematizing or viewing them as 'dysfunctional' in their role as clients and partners of SRH services and programmes from the onset. While we strongly encourage such a shift, we also underscore there is a particularly delicate balance between tending to the male partner's needs and to the skewed power dynamics that are evident between men and women in different social contexts (described in more detail in a.o. Daniele, 2021). For example, one intervention that was introduced to attract men to antenatal care services—the ability to 'jump the queue' if you escort your partner—has long been criticized for its reinforcement of patriarchal norms and discrimination toward unaccompanied pregnant women but continues to be offered as one of the primary approaches to male involvement in the region, including in some of the countries that are central to this paper (Osaki et al., 2021; Mkandawire & Hendriks, 2018). Nevertheless, it is essential to acknowledge that even within patriarchal environments characterized by the reinforcement of traditional masculine traits like aggressiveness, risk-taking, emotional unresponsiveness, and dominance over others, especially women, the capacity for women to exercise agency and self-determination should not be disregarded. Therefore, before implementing any changes to the SRH policy environment pertaining to men, it is imperative to conduct a careful analysis of the context and engage in consultations with both men and women to ensure that the proposed measures align with local needs and preferences.

The limited attention given to the inclusion of men as agents of change in SRHR within national policies and strategies is of concern. While some policies reviewed in this paper acknowledge the need to challenge harmful norms rooted in traditional masculinities, they offer minimal guidance (except in Uganda) on how to involve men in shifting away from these misogynistic norms and behaviors and, more broadly, to address the patriarchal social structures through which these individual actions come to occur. This could be attributed to a combination of factors: inadequate awareness and a lack of theorization and understanding of the potential benefits of such approaches, deeply ingrained social and cultural barriers, and the ongoing challenge of engaging boys and men as agents of positive change in settings where programmatic conditions hamper longer-term and scalable commitments to gender transformation (Morrell et al., 2012; Comrie-Thomson et al., 2015; Heise et al., 2019; Ruane-McAteer et al., 2020). Based on the above analysis, it is suggested that existing policies should be reviewed to identify and remove any language or conceptual biases that exclude men in all their diversity and to clarify terminologies, such as gender mainstreaming, gender responsive health systems and gender transformation, and what it means for both men and women in practice. In addition to addressing policy biases, more research is needed to guide gender transformative

programming. The current availability of studies assessing the evidence on gender transformative interventions from the region is limited, however, some synthesis work has been conducted (Casey et al., 2018; Dworkin et al., 2015; Heymann et al., 2019; Hillenbrand et al., 2015; Ruane-McAteer et al., 2019; United Nations International Children's Emergency Fund [UNICEF], 2022) that sheds light on promising practices. By fostering a more inclusive environment and promoting evidence-based practices, we can create policies and programmes that advance SRHR for all members of society.

Study limitations

The policy analysis consisted of a rapid appraisal of documents over a short period, and with a focus on national-level policies and strategies. Hence, the findings are confined to a cross-section of documents that were accessible to the team within this timeframe and excludes any policies and programming strategies that may have been developed and used at a sub-country level, and which possibly contain more detail. An additional constraint of the analysis lies in its acknowledgment that policies and programmes addressing SRHR for men and boys are embedded within the overarching power dynamics between men (including other men) and women within a patriarchal societal framework. Our analysis is constrained by its limited exploration of this intricate interplay of power relations.

Conclusion

Almost three decades after the appeal in the ICPD Programme of Action, substantive challenges remain in devising sexual and reproductive health policies and programmes that will bring men on board and that will also keep them there. A critical window of opportunity during their formative years, e.g. by letting them engage with learning and teaching materials that promote gender equality, is missing from much of the policy guidance that was reviewed. Further, SRHR programming has become overly focused on the clinical aspects of disease treatment, prevention and reproduction, ignoring the broader context and needs of men in all their diversity. There is an urgent need for the region to accelerate investment in research and capacity-building initiatives. These targeted efforts should support the development and implementation of evidence-informed policies that foster the inclusion of men in SRHR interventions while simultaneously engaging them in a manner that contributes to the transformation of harmful patriarchal norms. This includes providing policy makers and programme implementers with the resources and knowledge they need to design and deliver effective programmes that engage men and boys as allies and partners in achieving SRHR goals.

Notes

1. This version of the policy was not yet been formally approved at the time this paper was written.
2. It is expected that the policy on SRHR will be integrated into one national health sector policy in due course.
3. Strategies included CSE for in and out of school youth.
4. As one of six priority actions under strategic objective 5, the plan seeks to: "Strengthen individual, family and community capacity to take necessary SRMNCAH-N actions at home and to seek health care appropriately including male involvement", p. 38. Two indicators are proposed under this priority actions, none of which measures male involvement.
5. The minimum age of consent for HIV testing is 12 years in Uganda and Lesotho, 13 years in Malawi and 16 years in Zambia and Zimbabwe (source: Barr-DiChiara et al., 2021). The minimum age of consent for medical treatment is 12 years in Lesotho, 18 years in Uganda, Zambia and Zimbabwe, and unspecified by law in Malawi (source: Kangaude, 2016; Kangaude et al., 2020).

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Data availability statement

Not applicable. The country documents that were analyzed are publicly available.

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