Male Engagement in Family Planning

Gaps in Monitoring and Evaluation

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MEASURE Evaluation

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Cover photo: Tome Vidigal, with the Ogumaniha project in Zambezia Province, Mozambique, shares a moment with his newborn daughter.

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ABBREVIATIONS

CYP	couple-year of protection
DHS	Demographic and Health Survey(s)
FP	family planning
GEM	Gender Equitable Men [Scale]
IGWG	Interagency Gender Working Group
IUD	intrauterine device
KII	key informant interview
M&E	monitoring and evaluation
NGO	nongovernmental organization
PRH	Office of Population and Reproductive Health
PSI	Population Services International
RH	reproductive health
SRH	sexual and reproductive health
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

EXECUTIVE SUMMARY

Organized family planning (FP) programs have traditionally focused primarily on women. With gender equity gaining recognition as a prerequisite for better health, more attention is being placed on deliberately engaging men, including male youth, in learning about, supporting, and using FP services and products. Efforts to expand constructive male engagement are evolving from encouraging men to be supportive partners of women's reproductive health (RH), to focusing on meeting men's own RH needs and engaging them as contraceptive users and agents of change in families and communities.

Although male engagement is becoming more common in FP strategies and interventions, effective monitoring and evaluation (M&E) of this approach lags. This review contributes to the understanding of how male engagement in FP is defined, monitored, and evaluated. Specifically, we sought to identify gaps in M&E of male engagement and to make recommendations to address the gaps.

We obtained information on the successes and challenges of M&E of male engagement in FP interventions through a desk review of peer-reviewed articles and gray literature, including national FP strategies and policies. To supplement information from the desk review, the study team conducted key informant interviews (KIIs) with staff from organizations that are currently implementing or have recently implemented activities involving male engagement in FP. We used the KIIs to obtain more in-depth knowledge about how these activities are monitored and evaluated.

We investigated how male engagement in FP is defined and operationalized by projects, organizations, and countries. The approaches to male engagement in FP mentioned most commonly align with a male engagement framework (Greene, et al., 2006) that depicts men's roles through three overlapping areas:

- Men as clients and beneficiaries: Those receiving FP services and using male FP methods
- Men as supportive partners: Those actively engaging as a full partner in FP issues, and communicating and negotiating fertility desires and FP use with their partners
- Men as agents of change: Those acting as leaders in shifting societal norms, attitudes, and behaviors toward women and girls, and their place in families, communities, and societies at large

Although there is no universal definition of male engagement in FP, we found consensus on and adoption and use of this framework in FP programming. From this, we determined that the most common definition of male engagement in FP is the inclusion of men in FP programming as clients of FP services, supportive partners, and agents of change in the family, community, and society. The desk review revealed that the most common approach was engaging men as clients exclusively, followed by engaging men as partners. Few papers reported on programs that engaged men only as agents of change or across the full spectrum of the framework.

We found significant variation in the degree to which male engagement in FP is included in M&E, planning, and approaches. Our review found that few programs—particularly those that relied on routine national data—reported findings disaggregated by sex and by contraceptive method, making it difficult to determine the effect of programming on male use of methods.

Despite our research yielding 103 indicators related to male engagement in FP, a gap in M&E of male engagement is the dearth of indicators, overall, for measuring male engagement in FP in national strategies and policies. This result is consistent with the findings from the peer-reviewed literature and KIIs, which revealed few commonly used indicators specifically capturing male engagement in FP. Other gaps are a lack of identification of core indicators for male engagement, a lack of qualitative indicators, and missing indicator reference sheets for many commonly used indicators.

This review makes several recommendations on how to improve the M&E of male engagement in FP programs: using a standardized definition of male engagement in FP; including male engagement in national FP and RH strategies; using strong, high-quality indicators; and making better use of existing data collection approaches and methods.

INTRODUCTION

Background

For more than two decades, gender equity has been widely recognized as a prerequisite for better health and has been integrated in global development goals. A prominent shift occurred at the 1994 International Conference on Population and Development, in Cairo, with the global call to action for a broader and more rights-based health agenda that included both women and men to address harmful gender norms and values, RH for all, and shared responsibility for FP (United Nations, 2014; United Nations Population Information Network, 1994). Following the International Conference on Population and Development , the Interagency Gender Working Group (IGWG) was established in 1997 by the U.S. Agency for International Development (USAID), USAID-funded cooperating agencies, and nongovernmental organizations (NGOs) with the goal of improving sexual and reproductive health (SRH) and HIV/AIDS outcomes, by promoting the integration of gender approaches in population, health, and nutrition programming (Caro, Schueller, Ramsey, & Voet, 2003). In 2000, the United Nations' Millennium Development Goals set time-bound global development targets that included a specific gender equality and women's empowerment goal (goal 3) (Kabeer, 2005; Sachs & McArthur, 2005). The succeeding Sustainable Development Goals, adopted in 2015, include a broad gender equality goal (Goal 5) that highlights the importance of SRH and reproductive rights (Magar, 2015; Fredman, Kuosmanen, & Campbell, 2016).

The focus on addressing gender inequalities to optimize health outcomes resounds in the field of FP. However, global FP initiatives, including Family Planning 2020, continue to concentrate primarily on women, with less attention to men (Hardee, Croce-Galis, & Gay, 2016). Although some FP programs include men as an integral part of their intervention strategy, men are more commonly involved as gatekeepers or decision makers for women's health or as "add-ons" in activities that focus on providing information and services to women (Geleta, Birhanu, Kaufman, & Temesgen, 2015; Raj, Ghule, Ritter, et al., 2016).

Efforts to expand the vision of strategically engaging men in FP and RH have been slow, but steady (Dunn & Gage, 2010). Gender experts agree that men should be encouraged to be supportive partners of women's RH while also meeting their own RH needs, and engaged as agents of change in families and communities (Greene, et al., 2006). Constructive male engagement in FP entails a thoughtful, gender-sensitive approach that places gender equality and women's empowerment on equal footing with other desired outcomes (Gilles, 2015). Constructively engaging men, including adolescent boys, to be users of RH services themselves, shifting gender norms, and improving communication and joint decision making in couples can be challenging and require long-term efforts. Moreover, it is resource-intensive to demonstrate the impact of these efforts. In this report, the term "male engagement" is used synonymously with "constructive male engagement."

Although male engagement is becoming more common in FP strategies and interventions, effective M&E of this approach lags. Previous research on male engagement found the following M&E challenges: lack of clear behavioral objectives, limited data on men in RH and FP, lack of a common set of indicators on male engagement in FP, difficulty in capturing the complexity of gender, and complications in identifying or measuring gender outcomes (Dunn & Gage, 2010). A gap remains in how to address these M&E challenges to move the field of male engagement in FP forward.

Research Objectives

The purpose of our research was to identify gaps in M&E of male engagement in FP, which we accomplished by implementing the following activities:

- Establishing a uniform framework for defining male engagement in FP programs, with clear behavioral objectives for each level of male engagement
- Identifying existing indicators to track male engagement in FP, such as male FP service use, use of male FP methods, and other aspects of constructive male engagement (e.g., involving men as partners in FP decision making in behavior change communication activities and including men in efforts to address harmful gender norms)
- Identifying areas of male engagement for which there are measures and where appropriate measures are lacking
- Analyzing existing indicators and systematically identifying strong indicators for M&E of male engagement

We sought to review the landscape of M&E of male engagement in FP, identify gaps, and make recommendations to address the gaps in measuring male engagement across the male engagement framework. Our findings contribute to the goal of improving and applying methods, tools, and approaches to address RH information challenges and gaps.

METHODS

We expected information on male engagement in FP to vary based on the type of documentation reviewed (e.g., journal article versus program documentation). To understand how male engagement in FP is defined and measured, and the successes and challenges of M&E of such engagement, the study team conducted a desk review of peer-reviewed articles, gray literature, and national FP strategies and policies. We also conducted KIIs with staff from organizations that are currently implementing or have recently implemented activities involving male engagement in FP to obtain more in-depth knowledge about how these activities are monitored and evaluated, including successes and challenges. We collected indicators from both the desk review and KIIs.

Desk Review

We conducted a document review of published peer-reviewed and gray literature on male engagement in FP. Materials were identified through a literature search that included articles written in English and published between January 1996 and April 2016. The search was not bound by geographic location so that the widest possible range of sources could be captured. The gray literature included reports, working papers, research briefs, but not conference abstracts or posters, webinars, or presentations. Databases searched were PubMed, Scopus, Web of Science, Popline, USAID's Development Experience Clearinghouse, and Google Scholar. The term "family planning" was searched in combination with "male/men's engagement," "male/men's participation." and "male/men's involvement."

The initial search yielded 293 publications. After eliminating those whose titles and abstracts did not meet our search criteria, 118 publications were extracted and entered in an Excel spreadsheet on a SharePoint website specifically created for this activity. Two members of the four-member study team reviewed the publications and excluded those that did not include: FP; an intervention; did not explicitly mention male involvement, engagement, or participation; or were redundant (i.e., another article covering the same intervention, study, or evaluation appeared in the database). The analysis resulted in a total of 72 relevant publications. (See Appendix A for the full list of publications in our study.)

We abstracted the following information for each of the peer-reviewed and gray literature publications:

- Title, author, and publication year
- Organization
- Country and region
- How men are addressed (partners, clients, and/or agents of change)

- Intervention description
- Description of M&E methods identified (e.g., service statistics, focus group discussions, client-provider observations)
- Indicators or measures
- Type of indicators (qualitative/quantitative)

Using the Google search engine, we searched national FP or RH strategies to find mention of male engagement and, if it was found, how male engagement was being measured, if at all. "Strategy," "policy," and "framework" were included in the search terms as was the term "RH," because many countries include FP in their RH strategies. All USAID Population and Reproductive Health (PRH) priority countries were searched individually, yielding 18 available FP/RH policies, representing 75 percent of the PRH priority countries. We found an additional five strategies through a general (Google) search, bringing the total to 23 national FP/RH policies, strategies, and frameworks (Appendix B). Only policies produced in the past decade (2006 to 2016) were included. When the search yielded multiple FP strategies for a country, we included only the most recently approved strategy. However, at the time of writing, six strategies had expired, based on the time frame covered by the strategy.

We created an Excel spreadsheet to collect the following information from the national FP strategies/policies:

- Country
- Name of document and year, or years the policy or strategy covers
- How male engagement in FP is addressed
- Indicators pertaining to male engagement in FP

Key Informant Interviews

We conducted KIIs to compare with the information we obtained from the literature review, and to gather in-depth information on male engagement indicators and M&E challenges.

We used the snowball sampling strategy to recruit interview participants. First, we developed a list of nine organizations to contact from the desk review of programs and organizations, based on whether they had published on male engagement in FP in the past decade. We identified key informants from the publication authors. Additional names were obtained by drawing from our professional connections, and in-person contacts at the May 2016 Women Deliver conference. Next, we contacted 14 key informants by email to explain the activity and schedule a time for the KII.

One person did not reply. Two contacts referred us to a colleague (who was already listed as one of our original 14 contacts) whom they felt would be better suited to provide the needed information. Two others showed interest in being interviewed but did not respond to our emails for setting up a time for an interview. We interviewed a total of nine people from eight different organizations. (Appendix C provides the list of organizations involved in the KIIs.) Interviews were conducted by phone or Skype. The interviews lasted between 30 and 60 minutes. After conducting the eight interviews, we reached a point of information redundancy.

The KIIs covered three areas:

- Information on how the organization or project defines male engagement in FP
- How the organization or project monitors male engagement in FP activities, including what indicators are used
- How the organization or project evaluates male engagement in FP programs, including what indicators are used and the challenges, best practices, or lessons learned

(Appendix D provides the key informant interview guide.)

Data Analysis

We conducted a thematic analysis of the KIIs, reviewing how the organization/project monitors and evaluates its male-engagement-in-FP activities/programs, with a focus on the indicators used and the data sources. We entered the indicators provided from the KIIs in a master Excel spreadsheet, which also contained all the indicators related to male engagement extracted from the literature review.

Human Subjects Approval

The study team applied to the University of North Carolina at Chapel Hill's Office of Human Research and Ethics for approval to conduct the KIIs. The Office of Human Research and Ethics determined that this study did not constitute human subjects research as defined under federal regulations, and therefore, did not require institutional review board approval. Participants were informed of the purpose of the KII, including an overview of the topics to be covered, how the data would be used, and how names/organizations would be referenced in the report. Verbal consent was obtained before each interview.

Identifying and Collating Indicators for Male Engagement in Family Planning

Based on the desk review and KIIs, we compiled 103 output, outcome, and impact indicators currently used for measuring male engagement in FP and RH (Appendix E). We organized the indicators in a three-dimensional matrix according to the male engagement framework (i.e., men as clients, men as partners, and men as agents of change), the level of intervention (i.e., individual, community/facility, structural) and type of indicator (input, output, outcome, or impact). The individual level relates to men's personal knowledge, attitudes, and practices. The community/facility level pertains to data collected at the health facility and/or community level, or to data that apply to health providers specifically. Indicators for the structural category measure changes at the larger, systemic level, such as guidelines, policies, laws, and the media. For the purposes of simplification, we list each indicator once. However, we recognize that some indicators may fit into multiple categories of interventions or approaches.

Although several input[1] and process indicators were similar across projects, many were closely tied to specific program activities. These indicators were not included because they were designed for a specific project or NGO and were therefore too varied for the scope of this report. For monitoring purposes, we included a select number of output indicators that are common in male engagement programs but focused mainly on outcome indictors. For evaluation purposes, we included impact indicators. Myriad indicators on SRH and FP programs and services in general are described elsewhere (for example, MEASURE Evaluation's FP/RH Indicators Database); however, they were not relevant enough for this research. We included general SRH indicators only if they directly affect or are affected by men's involvement.

The indicators were copied verbatim from the desk review and indicator documents provided by the KIIs. For reasons of confidentiality, we did not indicate the sources of individual indicators. Some indicators are broadly applicable, whereas others can pertain to a specific intervention. Although we acknowledge that the format and wording of the indicators vary, it was important to present them in their original form, because this provides a snapshot of the breadth and quality of the indicators that are being

[1] We defined input indicators as the human and financial resources, physical facilities, equipment, and operational policies that enable programs to be implemented. Process indicators refer to the activities (e.g., meetings or trainings) carried out to achieve the objectives of the program. Output indicators refer to the immediate results of activities at the program level. Outcome indicators measure behaviors of interest to determine if change is occurring, in what direction, and to what extent. Impact indicators measure the attribution of the intervention to the change in outcomes in the general population.

used to measure male engagement in FP. Appendix E provides the full list of male engagement in FP indicators.

Although we state in Appendix E what each type of indicator is (output, outcome, or impact), depending on the activity and approach, indicators may vary as to whether they are output, outcome, or impact.

Following the compilation of the indicators in an Excel spreadsheet, the study team systematically analyzed each one based on eight standard criteria, and scored each indicator based on a scale (Table 1). For the binary scales, only indicators that met the criteria were assigned a point. For the criteria with a scale of one to three, indicators were assigned one point if the indicator did not meet the criteria, two points if the indicator somewhat met the criteria, and three points if the indicator met the criteria. Because of the subjectivity of the scales, three reviewers in the study team scored each indicator based on the eight criteria and an average score was calculated.

Table 1: Indicator criteria, definitions and scales

Criteria	Explanation	Scale
Specific	The indicator is specific to the change being measured. It is precisely formulated, not vague.	0, 1
Measurable	The indicator is easily monitored, and amenable to independent validation.	0,1
Attainable	The indicator requires data and information that can be collected.	0,1
Relevant	The indicator is appropriate to the subject of male engagement in FP and evaluation.	0,1
Commonly used	The indicator is frequently used by programs to monitor or evaluate male engagement in FP.	1, 2, 3
Validated and/or already collected in routine data collection	The indicator is already validated and/or used in routine data collection, such as DHIS 2, Demographic and Health Surveys (DHS), or other validated surveys.	0, 1
Generalizable	The indicator can be used across multiple types of FP interventions and is not specific to a method or process.	1, 2, 3
Applicable to FP programs sponsored by a variety of funding agencies, governments, or NGOs worldwide	The indicator can be used by any program/project regardless of implementing or funding agency.	1, 2, 3

Following our individual reviews, the study team met to analyze and compare the indicator rankings based on the average scores. Looking particularly closely at the indicators that received higher scores, the team analyzed and discussed each indicator with the indicator criteria in mind.

Based on this analysis, we identified 18 that would be considered strong, high-quality indicators for male engagement in FP. We collected available indicator reference sheets for these indicators. For indicators without indicator reference sheets, we adapted similar available sheets (e.g., we referenced the indicator reference sheets for female sterilization for the vasectomy indicators, none of which had existing indicator reference sheets). Appendix F contains the 18 indicators and indicator reference sheets.

RESULTS

Defining and Operationalizing Male Engagement in Family Planning

We began this investigation by asking how male engagement in FP is defined and operationalized by projects, organizations, and countries, by conducting a desk review of peer-reviewed journals, gray literature, and country documents. Early program publications (primarily from the 1990s) varied widely in how male engagement was defined and approached, showing preference for engaging men as partners and gatekeepers to women's health, or as clients by providing vasectomy services. More recent publications reveal increased uniformity in specifying what male engagement in FP entails, with the most commonly mentioned approaches to male engagement in FP aligning with a framework (Table 2) that depicts men's roles in three overlapping areas (Greene, et al., 2006):

- Men as clients and beneficiaries: Those receiving FP methods or counseling on male-controlled and cooperative methods; addresses men's FP needs
- Men as supportive partners: Those actively engaging as a full partner in FP issues, and communicating and negotiating fertility desires and FP use; engages men as supportive partners
- Men as agents of change: Those acting as leaders in shifting underlying community and cultural norms, attitudes, and behaviors toward women and girls and their place in families, communities, and societies at large; promotes gender equality as a means of improving men's and women's RH as an end in itself

Although there is no universal definition of male engagement in FP, we found consensus, adoption, and use of this framework by multiple international organizations, bilateral agencies, and the IGWG (Population Reference Bureau, 2014; International Planned Parenthood Federation, 2014; Doggett & Herstad, 2008; United Nations Population Fund & International Council on Management of Population Programmes, 2011; IGWG, 2016). From this, we determined that the most common definition of male engagement in FP is the inclusion of men in FP programming as clients of FP services, as supportive partners, and as agents of change in the family and community. Whereas male engagement generally pertains to men, it also pertains to male youth.

Program reports and the KIIs revealed that each of the male engagement and FP approaches described was tied to specific, common programmatic objectives, as outlined in Table 2.

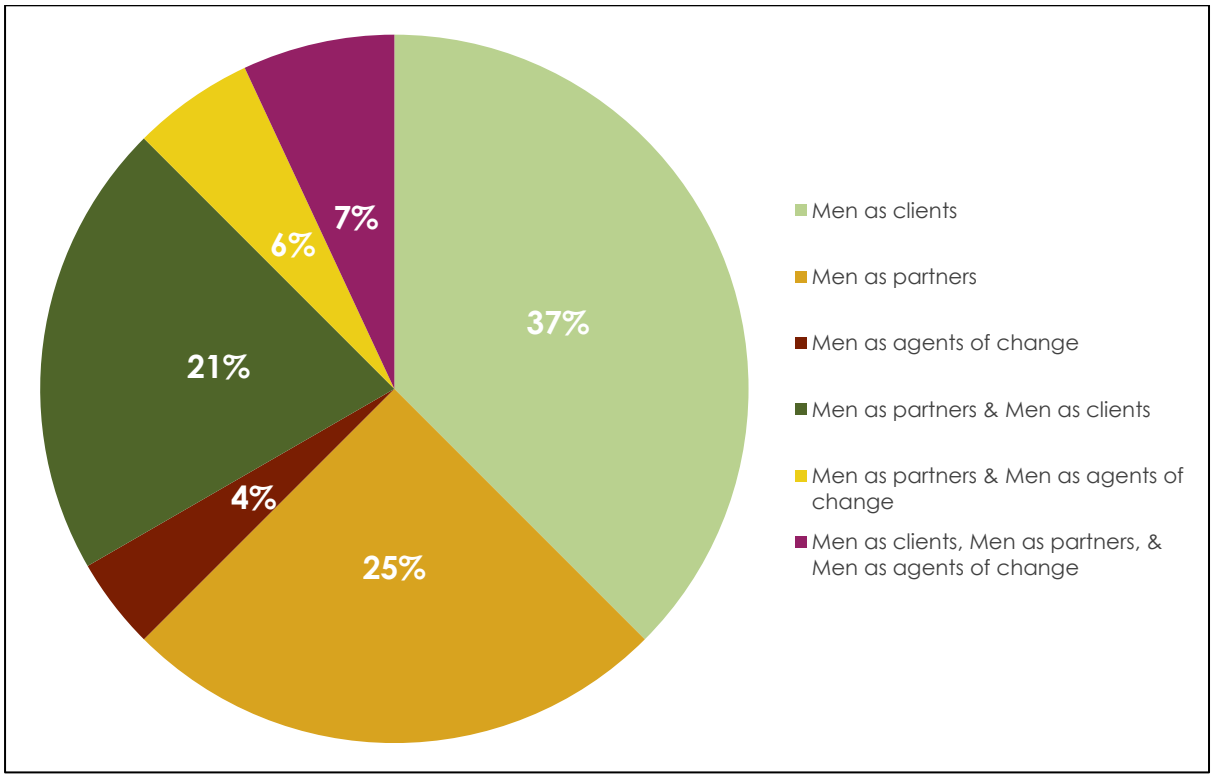
Table 2. Programmatic areas, descriptions, and objectives in the Constructive Male Engagement Framework

Area	Description	Programmatic Objectives
Men as Clients	Address men's FP needs	Increase knowledge of healthy timing and spacing of births, modern contraceptives, and FP options for men. Promote increased demand, accessibility, acceptability, and use of male-controlled FP options, such as condoms and vasectomy, as well as Standard Days Method, which requires men's active participation as a cooperative method. Ensure quality in provision of FP services to men.
Men as Partners	Engage men as supportive partners	Improve healthy communication and joint decision making within couples. Expand men's knowledge of and participation in their partner's contraceptive planning and use (e.g., knowledge of partner's method, fertility, and desired family size). Increase shared responsibility for decisions around contraception and protection against sexually transmitted infections and HIV. Promote men's supportive and enabling role before and during pregnancy and childbirth, and responsibility as parents and caregivers in the family.
Men as Agents of Change	Promote gender equality as a means of improving men's and women's RH as an end in itself	Promote gender equitable fatherhood. Support advocacy against discriminatory SRH laws and policies. Encourage reflection on and challenge attitudes about gender roles to help shift assumptions and values that drive gender inequality.

Source: Adapted from Margaret Greene's *Male Engagement in Family Planning Framework* (2006)

Depending on the intervention or strategy, the inclusion of men in achieving the desired FP outcomes fell within one or more of the three categories. Of the 72 papers in the desk review (some of which were mentioned during the KIIs), the most common approach was engaging men as clients exclusively (n=27), followed by engaging men as partners (n=18) (Figure 1). Few papers reported on programs that engaged men only as agents of change (n=3). One-third of the papers reported overlapping approaches, with 19 papers reporting on engaging men across two categories, and five papers reporting on engaging men across the full spectrum: as clients, partners, and agents of change.

Figure 1. Approaches to engaging men in family planning programming



The degree to which male engagement in FP was mentioned and included as a strategic approach in national FP/RH strategies, policies, and frameworks varied significantly. For example, Ethiopia's *National Guideline for Family Planning Services* (2011) explicitly states that "males shall be addressed in family planning programs and services as users, promoters and decision-makers" (Federal Democratic Republic of Ethiopia, 2011). The document lists several guidelines for how to achieve male inclusion, such as making FP services male-friendly, including men in the design and implementation of FP and RH services, and encouraging men to accompany their partners to FP visits. The Philippines, Zambia, and Mauritius also include several strategies in their FP/RH policies on how to involve men. Other documents, such as Rwanda's *National Family Planning Policy* (2012), mention promoting greater male participation in FP programs as one of the goals, but make no further reference to men and do not include a strategy for how this goal will be achieved (Ministry of Health, Republic of Rwanda, 2012). Four others, including Haiti's *National Strategic Plan for Reproductive Health and Family Planning* (2013), do not contain a goal or strategy to engage men in FP or even mention male engagement (Ministry of Health, Haiti, 2013).

Although we looked for trends by different variables that might affect how countries address male engagement in FP, such as region, predominant religion, USAID FP priority country, and global FP partnerships, among the 23 national FP/RH strategies reviewed, we found no clear trend for including male engagement in FP as a goal and/or programmatic approach among the countries. For example, countries in Africa were no more or less likely to include men in their strategies than were countries in Asia. The same could be said of predominantly Islamic countries. Mali, for example, listed specific activities for engaging men in FP (National Plan of Action for Family Planning in Mali, 2014) whereas Yemen did not include any strategy, activity, nor indicator related to male engagement in FP (Ministry of Health and Population, Yemen, 2011).

Measuring Male Engagement in Family Planning

A challenge identified by one key informant, and confirmed in the literature review, is the ambiguity of some policymakers, program designers, and service providers around deciding whether men should be engaged in FP in the first place. This is because increased involvement of men in SRH may interfere with women's ability to make FP decisions on their own and undermine women's empowerment efforts. Because some countries have not yet made the decision to engage men in FP, there is no need for them to track male engagement in FP services and programs, as users, supportive partners, or agents of change.

Most of the key informants mentioned that the M&E of interventions that engage men in FP have lagged support for these programmatic approaches. As to the measurement of males as clients, this review found that few programs, particularly those that relied on routine national data, reported findings disaggregated by sex and by contraceptive method, making it difficult to determine the effect of programming on male use of methods.

Key informants discussed the difficulty of working within routine systems because the data collection tools that are available at health centers, such as patient registers and files, do not facilitate the tracking of progress in male engagement in FP. This is particularly true in contexts where male engagement in FP is not prioritized in national FP/RH strategies and where it is not tracked by routine health information systems. Key informants mentioned that— except for monitoring condom use and vasectomies—other aspects of male engagement in FP, such as men as partners and men as agents of change, are more difficult to track because of such challenges as expense, time, and locating enough men to survey.

"In general, the information [on male engagement in FP] is hard to get. We use a lot of government forms, but there's no place to capture the information."

– Key informant

Among the country strategies and policies reviewed, although nearly all included indicators, few included indicators for measuring male engagement in FP. Approximately one-half of the strategies we reviewed do not have any indicators specific to male engagement in FP. Among those that do, most of the indicators would be specific to men only if disaggregated by sex: for example, FP counseling provided; percentage of the population with a favorable attitude towards an FP product, practice, or service; and percentage of eligible couples who access birth spacing services. A limited number of strategies include indicators specifically focused on men: for example, number of men attending SRH services; male sterilization coverage rate; and number of male participants reached by FP sensitization workshops. (These indicators are listed in Appendix E, and are marked with an asterisk.).

"We need to come up with more cost-effective and easier ways to collect indicators. Otherwise, people aren't going to collect information on them. The gap really shows in male engagement."

– Key informant

Because of the lack of routine data on men in FP collected through larger health information systems, our key informants discussed the need to rely on program-specific M&E or the DHS. Program-specific M&E is generally tailored to the needs of the implementing organization and is therefore not consistent across projects and interventions. Programs implemented as randomized control trials, for example, have highly monitored implementation, collect large amounts of data, and are difficult to reproduce and sustain beyond the initial implementation. Programs may collect monitoring data through monthly reports, supervisory forms, or internal audits, however, these mechanisms are not routine and cannot be built into a systematic health information system.

Even in situations where the preferred health management information system (e.g., DHIS 2) is used to collect and aggregate data at the global, country, and local levels across several countries, the data may be limited to organizational or program use. For example, one key informant stated that they used DHIS 2 to track the number of FP users from service delivery sites and sales of condoms. Yet the organization's proprietary rights over their data limit the data's usefulness to other program implementers and

researchers working in FP. These limitations often prevent triangulation and comparisons of data across interventions.

Although core FP indicators were developed and standardized more than 20 years ago, few commonly used indicators specifically capture male engagement in FP. Some RH indicators depend on sex and age disaggregation (e.g., service use; counseling); however, the data may not be collected or analyzed by sex/age in practice. Gender-sensitive measures may provide an opportunity to collect more nuanced information on male engagement, such as power relations in the household that may drive FP decision making; men and women's perceptions of FP; and/or cultural norms around fertility. Promundo (http://promundoglobal.org), an international NGO that focuses on engaging men and boys for gender equality, has spent almost two decades developing, testing, and validating its Gender Equitable Men (GEM) scale (Pulerwitz & Barker, 2008), which many projects use to measure gender attitudes among men and women. However, based on our desk review and the KIIs, we found that such measures have not been integrated in any routine data collection tool, and therefore, require organizations to dedicate additional resources to such data collection.

Relying on DHS to assess changes in gender outcomes among both men and women is restrictive. DHS data are collected on gender norms, but assessing FP outcomes is more challenging as questions on whether men have accessed FP services are not included in the main questionnaire. For example, questions on FP decision making are generally only asked of women, therefore, information on male engagement or joint decision making is indirect or partial. There is a male questionnaire in the DHS, however, not all country DHS include it for reasons that include time and cost.

Moreover, even when data are collected on men from other data sources, such as service statistics, they are rarely disaggregated by age, as is the norm for data on women. The key informants stated that, like FP data on women, data must be triangulated to fully understand the status of men's involvement in FP, which in most cases implies data collection from different sources and by various methods.

Qualitative data, gathered from such methods as KIIs, program participant focus groups, observations, and case studies, are often required to complement quantitative measurements, especially because few indicators for male engagement in FP are collected through routine data collection. The desk review and KIIs revealed that qualitative data are essential to understanding the context in which programs are, or are not, successful and are helpful to understand the perceptions and attitudes that may drive male behavior.

DISCUSSION

Through our document review and KIIs, we found consensus on how male engagement in FP is defined. Among the three intersecting areas of male engagement, most FP programs or strategies that make a conscious effort to involve men focus primarily on men as clients. Programmatically, this is considered low hanging fruit, because it is typically easier to design, monitor, and evaluate programs that increase men's use of FP methods than programs that increase men's participation in their partners' contraceptive planning and use, or programs that improve gender equity. Few programs address men across the spectrum. This is partly because of the traditional focus on women in FP programs and activities, with men's involvement being an ancillary strategy to improve women's access to and use of FP, rather than approaching men as pivotal influencers of contraceptive use and fertility trends. In other words, programs that addressed men across the spectrum of male engagement in FP acknowledged men as key players in improving FP and gender equity outcomes.

By supporting *men as clients*, programs provide an opportunity for men to improve their ability to make informed choices about their fertility through male-centered FP education; awareness; and services, such as condoms, vasectomy, and couple-centered services. However, it is important that these programs not

be gender-exploitative,* galvanizing men's dominant position in certain cultural settings, by focusing on their needs and their control of FP rather than on the couple as a unit and the underlying gender relations.

Approaches that address *men as partners* reflect the idea that men and women should work as allies in efforts to improve the healthy timing and spacing of pregnancies, contraceptive prevalence rates, and other dimensions of FP. Many of these programs address men within the context of the couple, and encourage men to support and communicate openly with their partners and share in the decision making. However, these programs typically do not evaluate whether they are gender-exploitative or gender-accommodating,* by either intentionally or unintentionally maintaining men as gatekeepers or primary healthcare decision makers in the family, or whether they are pushing men and women as equal allies in sharing FP responsibility and action.

By emphasizing *men as agents of change*, program implementers examine the relationships between women and men in a gender-transformative* approach to support broader social change. These programs address the underlying cultural gender norms and expectations that drive FP attitudes and service use. They do not necessarily focus on specific FP services and to whom they are delivered; they often impact outcomes beyond FP alone, because the approach uses men's social capital and leadership opportunities in the public sphere to advocate for women's rights and access to contraceptive services and products at the policy level. Although these programs address structural norms that drive FP outcomes, their scope lands outside the aim of FP-specific programs. Nevertheless, the changes in gender norms and attitudes should still be monitored and evaluated in the context of male engagement in FP, because of the significant influence they have on fertility intentions, reproductive choice, and contraceptive use.

Gaps in Monitoring and Evaluation of Male Engagement in Family Planning

Because of the lack of attention to male engagement in several country FP/RH strategies, there is a lack of indicators for monitoring and evaluating male engagement. Given the importance of engaging men as FP users, influencers of FP use by their partners, and advocates for improvements in gender equality in society for improved FP outcomes, it is important that national FP/RH policies and strategies acknowledge men's participation and include strategies for how men will be engaged. Including relevant indicators in policy-level documents will help encourage, guide, and track male engagement in FP interventions.

Among the indicators we found through our desk review and KIIs, not only do the sources of these indicators vary tremendously, so does their quality. For example, one of the more poorly worded indicators, which lacks both specificity and clarity, is "Perception of providers to men in FP." Likewise, "Greater resources available for gender equality and male involvement in FP campaigns" would be improved by making the indicator nondirectional and more specific. Thus, although plenty of indicators are being used to track male engagement in FP globally, another M&E gap we discovered was lack of identification of *high-quality* indicators. This was particularly true in the area of men as agents of change.

A set of core indicators for male engagement has not been identified. Additionally, the indicator reference sheets for many commonly used indicators are incomplete (e.g., missing definitions of key terms and guidance on how to accurately capture the information or calculate the indicator or the data sources) or

* From the IGWG "Gender Equality Continuum Tool" (2012): "Exploitative Gender Programs/Policies are programs/policies which intentionally or unintentionally reinforce or take advantage of gender inequalities and stereotypes in pursuit of project outcome, or whose approach exacerbates inequalities. This approach is harmful and can undermine the objectives of the program in the long run. Accommodating Gender Programs/Policies acknowledge but work around gender differences and inequalities to achieve project objectives. Although this approach may result in short term benefits and realization of outcomes, it does not attempt to reduce gender inequality or address the gender systems that contribute to the differences and inequalities. Transformative Gender Programming includes policies and programs that seek to transform gender relations to promote equality and achieve program objectives. This approach seeks long term outcomes by challenging the existing gender inequities and promoting positive changes in gender roles, norms, and power dynamics that drive health outcomes."

nonexistent. For example, none of the indicators related to vasectomies had indicator reference sheets, implying that the data are not being captured consistently or completely.

By examining more than 100 indicators that are being or have been used to measure male engagement in FP, we found evidence of the breadth of male engagement in FP activities being implemented. Although this level of involvement is encouraging, the tracking of these activities tends to be resource-intensive, because most of the indicators (except for condom distribution and vasectomies performed) have not been integrated in any routine data collection tool. This creates a gap: the field of FP advances—in terms of acknowledging and capitalizing on men's roles in contraceptive use and being agents of change in improving the health of families and communities—but it lacks standard M&E resources to track the engagement in a way that is both accurate and cost-effective.

Last, because indicators are typically quantitative, we did not find many qualitative indicators. That is not to say that qualitative measures for male engagement in FP are not collected and reported; they are not collected and reported in a way that allows the information to be reported against an indicator. We included a qualitative indicator in our recommended list of strong indicators to measure health providers' perceptions of men accompanying their wives or partners to an FP visit. This is a common indicator among FP programs working to engage men at the facility level. Though it has not been validated, this indicator is attainable and relevant to the subject of FP and evaluation. It is often used across many types of FP interventions by different projects, regardless of implementing or funding agency. Nonetheless, the use of qualitative measures as indicators is an ongoing discussion in the field of M&E.

Limitations

This review has limitations worth noting. First, our study may not represent all organizations conducting M&E of male engagement. Our initial intention was to interview three more people from partners implementing FP programs, but once we reached data redundancy, we decided not to pursue additional interviews. Secondly, we acknowledge that there are likely more indicators on male engagement in FP than the 103 we compiled in Appendix E. Although our list is not exhaustive, we are confident that it presents the most commonly-used male engagement in FP indicators, and that any others are just slight variations on the ones we have listed.

CONCLUSION AND RECOMMENDATIONS

As programming for male engagement in FP increases, coordinated efforts should be made to improve the systems that collect, analyze, and use data for decision making. This review makes several recommendations to improve the M&E of male engagement in FP programs. The recommendations focus on using a standard definition of male engagement in FP; including male engagement in national FP/RH strategies; identifying and adopting key indicators; and employing existing data collection approaches and methods. The recommendations can form the basis for a guide on M&E of male engagement in FP programs to standardize the way male engagement in FP is conceptualized and measured.

1. Use a Shared Definition of Male Engagement in Family Planning

The design of most national FP programs often excludes men, creating a gap in programming to address men's needs in FP, planning for fatherhood, preventing unwanted pregnancies, and partners' joint decision making in FP choices. This gap exacerbates gender inequality. Program designers, implementers, and evaluators should use a shared definition of male engagement in FP based on the three overlapping spheres of the male engagement framework: addressing men as FP clients, as partners, and as agents of change. By doing so, more effective strategies can be developed to address gaps in FP programming;

therefore, they can improve gender equality both directly and indirectly. A shared definition will also help with the measurement of comparable programs and thus yield more comparable data.

Although many programs focus on one or two of the three approaches to male engagement in FP, understanding and addressing the full spectrum of male engagement will provide longer-term, more sustainable impact.

2. Include Male Engagement in National Family Planning and Reproductive Health Strategies

Male engagement in FP and its measurement are not reflected as priorities in most national FP/RH strategies. This is a missed opportunity for countries, because there is overwhelming evidence of the importance and effectiveness of including men in FP/RH interventions and encouraging their participation. Without the national-level mandate and guidance on how to constructively engage men in FP, and how to effectively include them in FP interventions, monitoring and evaluating their contribution will continue to be challenging.

All the national FP/RH strategies we reviewed were developed with donor support, in consultation with international implementing partners. Donors and implementing partners therefore share the responsibility of advocating for the inclusion of men in national FP strategies and policies, and presenting the evidence for why this will be beneficial. Policymakers in ministries of health should consider evidence-based practices for achieving FP goals and objectives, and formally recognize the importance of male engagement in FP.

3. Use Strong, High-Quality Indicators

Monitoring and evaluating FP programs that engage men is vital to determining the relative success of different strategies, providing data for program improvement, and presenting evidence of the impact of involving men. Evidence of impact entails health outcomes for men and women as well as changes in gender norms and dynamics.

The quality of indicators on male engagement in FP varies significantly, with many not meeting the conventional standards of good indicator design (i.e., the indicator is valid, reliable, precise, measurable, timely, and programmatically important) (Frankel & Gage, 2016). There is also a significant knowledge gap as to which standardized indicators should be used to address all aspects of male engagement in FP—with the goal of increasing men's use of FP, improving men's role as supportive partners in decisions around FP, and encouraging men to be advocates for gender equality and improved FP access and services. Based on the indicators in use for this topic, we identified 18 strong, high-quality indicators for male engagement in FP that could be adopted by designers of male engagement in FP programs and initiatives (Table 3). These indicators cover the full spectrum of male engagement in FP, including both programmatic focus (i.e., men as clients, men as partners, and men as agents of change) and the level of intervention (i.e., individual, community/facility, and structural). Many of the selected indicators pertain to use of condoms and vasectomy services, which are key desired behaviors for male engagement in FP.

The indicators can be used selectively as part of the evaluation of national programs, regional programs, and country projects. For routine monitoring purposes, we recommend that program managers and evaluators select a few relevant indicators that are important to program objectives and easy to collect and interpret. Integration of these indicators in routine health information systems is particularly important in contexts where male engagement in FP is prioritized in national FP and RH strategies. If organizations need more data, they can conduct special studies to evaluate the programs' performance in areas of interest to staff.

We recognize that organizations adapt indicators to their specific circumstances as well as to the socioeconomic and cultural contexts in which their programs operate. This approach not only ensures that the indicators are relevant to the organization or intervention in question, but also promotes

ownership of the M&E process. At the same time, we recommend that countries and organizations consider using some of the indictors listed below, as applicable.

Table 3. Recommended strong indicators for Monitoring and Evaluation of male engagement in Family Planning

	Men as Clients	Men as Partners	Men as Agents of Change
Individual	• Percent distribution of all men, of currently married men, and of sexually active unmarried men by contraceptive method currently used, according to age (outcome) • Percent of men who have ever used any male FP method or FP method that requires male cooperation (outcome) • Men's condom use at last sex (outcome)	• Couple-years of protection (CYP) (impact) • Percent of men who support the use of modern contraception for themselves or their partners (outcome) • Percent of men who share in the decision making of RH issues with their spouse or sexual partner (outcome) • Percent of men who disagree that contraception is a woman's business and a man should not have to worry about it (outcome)	• Attitudes towards gender norms (GEM Scale) (impact)
Community or Facility	• Number of male condoms distributed (output) • Number/percent of vasectomy referrals (output) • Number/percent of facilities that offer vasectomy services (output) • Number of FP providers trained on male-specific FP (output) • Number of vasectomies performed (outcome)	• Perceptions of providers of men accompanying wives/partners to an FP/RH visit (outcome)	• Number of providers trained on gender equity and sensitivity (output)
Structural	• Inclusion of vasectomy in FP guidelines/ strategies, regulations, or policies (outcome)	• Evidence of engagement of men in FP incorporated in national health standards or policies (outcome)	• Number of national level programs/ policies/advocacy campaigns that address gender equity (outcome)

Brief indicator reference sheets for these 18 indicators may be found in Appendix F. We aimed to include as much information as possible from existing indicator reference sheets, but, where necessary, we revised, added, or deleted language for accuracy and clarity. We developed new reference sheets for indicators that did not have them.

While these indicators have been identified by our research team as high-quality indicators, we are not presenting them as "core" indicators. The intention is for them to be reviewed and validated by the Male Engagement in RH Task Force, organizations working in male engagement in FP, and/or male engagement in FP programs.

4. Use Existing Data Collection Approaches and Methods

At the national level, the men's survey in the DHS contains a wealth of information about men and FP. This includes: contraceptive knowledge; fertility and fertility preference; attitudes toward contraception; gender attitudes; and contraceptive use (MacQuarrie, et al., 2015). However, not all country DHS include the male questionnaire. Countries with a strategic focus on and projects supporting male engagement should be encouraged to include the male questionnaire in their DHS. These data are helpful for evaluating broad trends on a longitudinal basis and for establishing program baselines. However, the data are not useful for routine monitoring, for evaluating the immediate outcomes of a specific FP project or intervention, or for gathering information from a group of men. Examples of indicators that are tracked in the DHS are:

- Percent distribution of men by contraceptive method currently used
- Percent of men who disagree that contraception is a woman's business and a man should not have to worry about it

Only two male-controlled modern FP methods are available: the male condom and vasectomy. Indicators related to the use of these methods, such as the ones given below, may be captured from routine health information records:

- Number/percent of vasectomies performed
- Number of male condoms distributed

Other quantitative facility-level indicators can be collected from facility records or service provision assessments, such as the following:

- Number/percent of vasectomy referrals
- Number/percent of facilities that offer vasectomy services

Data collection forms specific to a program or intervention should be used for quantitative indicators not covered in routine health information systems. This could pertain to facility and community-level data on service delivery, training, and outreach as well as on knowledge, attitudes and practices. Examples of such indictors are:

- Number/percent of facilities that offer vasectomy services
- Number of providers trained on gender equity and sensitivity

Structured or in-depth interviews are a useful method for obtaining more qualitative information on knowledge, attitudes, and practices. A helpful approach is the GEM Scale, which includes 24 items to measure attitudes toward gender-equitable norms. The scale is useful for M&E of male engagement in FP, because it is designed to provide information about the prevailing gender norms in a community, in addition to the effectiveness of programs that seek to influence them. Other information that can be gathered from interviews is:

- Perceptions of providers of men accompanying wives/partners to an FP/RH visit
- Percent of men who share in the decision making of RH issues with their spouse or sexual partner

Last, reviews of laws, guidelines, strategies, and so forth will provide evidence at the structural or policy level. Examples of indicators obtained through such document reviews are:

- Evidence of engagement of men in FP incorporated in national health standards or policies
- Inclusion of vasectomy in FP guidelines/strategies, regulations, or policies

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APPENDIX A. PEER-REVIEWED AND GRAY LITERATURE INCLUDED

Title	First Author	Pub Year	Country	How are men addressed?
Involving Men in Family Planning: The Zimbabwe Male Motivation and Family Planning Method Expansion Project, 1993–1994	Kim, Y. M.	1996	Zimbabwe	Men as clients, Men as partners
Male Involvement in Family Planning: A Case Study Spanning Five Generations of a South Indian Family	Karra, M. V.	1997	India	Men as clients, Men as partners, Men as agents of change
Effects of the Vasectomy Promotion Project on knowledge, attitudes, and behaviour among men in Dar es Salaam, Tanzania.	Muhondwa, E. & Rutenberg, N.	1997	Tanzania	Men as clients
Getting from awareness to use: Lessons learned from SOMARC III about marketing vasectomy services in Jamaica	Futures Group	1998	Jamaica	Men as clients
Getting Men Involved in Family Planning Experiences from an Innovative Program	USAID/NIPORT/ Population Council	1998	Bangladesh	Men as clients, Men as partners
100% condom use programme in entertainment establishments.	World Health Organization	2000	Thailand, Cambodia	Men as clients
Enhancing NGO-LGU Collaboration in Family Planning: Using Community Workers to Reach Men in an Agrarian Setting	Palabrica-Costello, M.	2001	Philippines	Men as clients, Men as partners
Factors affecting ever-married men's contraceptive knowledge and use in Nigeria	Oyediran, K.A., et al.	2002	Nigeria	Men as clients
Reproductive Choices for Asian Adolescents: A Focus on Contraceptive Behavior	Pachauri, S., et al.	2002	Bangladesh, India, Nepal, Pakistan, Sri Lanka, Indonesia, Philippines, Thailand, Vietnam	Men as clients
Impact of a Male Motivation Campaign on Family Planning Ideation and Practice in Guinea	Blake, M.	2002	Guinea	Men as clients, Men as partners
Using men as community-based distributors of condoms.	Green, C.	2002	Cameroon, Kenya, Ghana, Mali	Men as clients
Determinants of Condom Use among Monogamous Men in Ondo State, Nigeria	Oyediran, K. A.	2003	Nigeria	Men as clients, Men as partners
El Salvador: Introducing the Standard Days Method through water and sanitation programs in rural communities	Georgetown University Institute for Reproductive Health	2003	El Salvador	Men as partners
Men in Jordan Get Involved in "Together for a Happy Family"	Yassa, A.	2003	Jordan	Men as partners

Title	First Author	Pub Year	Country	How are men addressed?
Involving men in maternity care	Kunene, B.	2004	South Africa	Men as partners
Involving men in maternity care in India	Varkey, L. C.	2004	India	Men as partners, Men as agents of change
Mobilizing men in Nepal to support safer motherhood and reproductive health: Mid-term evaluation	Engender-Health	2004	Nepal	Men as clients, Men as partners
Integration of Reproductive Health Services for Men in Health and Family Welfare Centers in Bangladesh	Population Council	2004	Bangladesh	Men as clients
Qualitative assessment of the incorporation of the Standard Days Method in a community-based program in Sitapur: A focus on male involvement	CARE India	2004	India	Men as partners
Young Men at Risk: An intervention to improve reproductive health knowledge, attitudes and behaviours of young men using a peer-to-peer approach. Final report	Weir, B.	2004	Jamaica	Men as clients
Prevalence of sexual activity and family-planning use among undergraduates in Southwest Nigeria	Orji, E. O.	2005	Nigeria	Men as clients
Introduction of the Standard Days Method in CARE-India's community-based reproductive health programs	Johri, L.	2005	India	Men as partners
Expanding access to vasectomy services in the Ministry of Health of Guatemala	Rodriguez, B.	2005	Guatemala	Men as clients
Get a permanent smile: Increasing awareness of, access to, and utilization of vasectomy services in Ghana	EngenderHealth ACQUIRE Project	2005	Ghana	Men as clients
Awareness and determinants of family planning practice in Jimma, Ethiopia	Beekle, A. T.	2006	Ethiopia	Men as partners
Strengthening Services and Increasing Access to the Standard Days Method in the Guatemala Highlands	Suchi, T.	2006	Guatemala	Men as partners
Baseline survey results for the 'Young Men as Equal Partners' Project. 10- to 24-year-olds from Nyando, Bondo, and Homa Bay districts in Nyanza Province, Kenya	Thomsen, S.	2007	Kenya	Men as clients, Men as partners, Men as agents of change
Dual protection among South African women and men: perspectives from HIV care, family planning and sexually transmitted infection services	Morroni, C.	2007	South Africa	Men as clients
Evaluation of the African Youth Alliance Program in Ghana, Tanzania and Uganda: Impact on Sexual and Reproductive Health Behavior among Young People	Williams, T.	2007	Ghana, Tanzania, Uganda	Men as clients
Pakistan (2007): Family planning TRaC Study evaluating contraceptive use among married men and women in rural and urban Pakistan. First round.	Population Services International	2007	Pakistan	Men as clients, Men as partners, Men

Title	First Author	Pub Year	Country	How are men addressed?
				as agents of change
Men's involvement in family planning in rural Bangladesh	Clark, J.	2008	Bangladesh	Men as clients, Men as partners
Revitalizing underused family planning methods. Using communications and community engagement to stimulate demand for vasectomy in Bangladesh	Taylor, J.	2008	Bangladesh	Men as clients
Promoting Male Responsibility Towards Greater Gender Equality Bangladesh Final Evaluation Report	WBB Trust	2008	Bangladesh	Men as clients, Men as partners
Promoting Male responsibility towards greater gender equality in Vietnam	Van Hung, N.	2008	Vietnam	Men as clients, Men as partners
Accessibility and Use of Family Planning Information (FPI) by Rural People in Kilombero District, Tanzania	Msoffe, G. E. P., et al.	2009	Tanzania	Men as clients
The Male Involvement Programme and Men's Sexual and Reproductive Health in Northern Namibia	Mufune, P.	2009	Namibia	Men as agents of change
Albania family planning: Improving access and use of modern contraception among men and women	Volle, J.	2009	Albania	Men as clients
Cell phone hotline spreads family planning information in DR Congo.	PSI	2009	DRC	Men as clients
Final feasibility evaluation for no-scalpel vasectomy in Rwanda.	Davis, J.	2009	Rwanda	Men as clients
ACQUIRE Azerbaijan Reproductive Health and Family Planning Project: Final Report	Engender-Health	2010	Azerbaijan	Men as clients
Healthy Images of Manhood: a male engagement approach for workplaces and community programs integrating gender, family planning and HIV / AIDS; A case study	Pathfinder International. Extending Service Delivery Project	2010	Tanzania	Men as clients, Men as partners, Men as agents of change
Married women's decision-making power on modern contraceptive use in urban and rural southern Ethiopia	Bogale, B., et al.	2011	Ethiopia	Men as partners
Predictors of Condom-use among Young Never-married Males in Nigeria	Oyediran, K. A.	2011	Nigeria	Men as clients
Religion, culture and male involvement in the use of the Standard Days Method: evidence from Enugu and Katsina states of Nigeria	Ujuju, C., et al.	2011	Nigeria	Men as clients
Male Partner's Roles in Women's Use of Emergency Contraception	L'Engle, K.	2011	Ghana	Men as partners
Targeting Men in Cross-Generational Relationships: Results from the Malawi Male Motivator Study	Kerner, B.	2011	Malawi	Men as partners
Men in maternal care: Evidence from India	Chattopadhyay, A.	2012	India	Men as partners

Title	First Author	Pub Year	Country	How are men addressed?
Childbearing and the use of contraceptive methods among married adolescents in Bangladesh	Mostafa, K. S. M.	2012	Bangladesh	Men as partners
Interactive Workshops to Promote Gender Equity and Family Planning in Rural Communities of Tanzania: Results of a Field Test	Schuler, S.	2012	Tanzania	Men as partners, Men as agents of change
Interactive workshops to Promote Gender Equity and Family Planning in Rural Guatemalan Communities: Results of a field test	Schuler, S.	2012	Guatemala	Men as clients, Men as partners, Men as agents of change
Promising Practices for Scale-Up: A Prospective Case Study of Standard Days Method Integration	Institute for Reproductive Health	2012	Guatemala, India, DRC, Rwanda, Mali	Men as partners
Using an employer-based approach to increase support for and provision of long-acting and permanent methods of contraception: The India experience.	Yahner, M.; Cisek, C. R.	2012	India	Men as clients
Reproductive preferences and contraceptive use: A comparison of monogamous and polygamous couples in northern Malawi	Baschieri, A.	2013	Malawi	Men as partners
Agreement and concordance between married couples regarding family planning utilization and fertility intention in Dukem, Ethiopia	Diro, C. W., et al.	2013	Ethiopia	Men as clients
Male involvement in sexual and reproductive health in the Mendi district, Southern Highlands province of Papua New Guinea: a descriptive study	Kura, S.	2013	Papua, New Guinea	Men as clients, Men as partners
Engaging Men in Family Planning	Christian Connections for International Health	2013	Nepal	Men as partners
Increasing Male Involvement in Family Planning in Jharkhand, India	FHI 360	2013	India	Men as partners, Men as agents of change
Reaching young married couples in Bangladesh: An underserved population for long-acting methods of contraception.	Sultana, Z., et al.	2013	Bangladesh	Men as clients, Men as partners
No-Scalpel Vasectomy: Scale-up Approach in Rwanda Shows Promise	FHI 360	2013	Rwanda	Men as clients
Women's perceptions and reflections of male partners and couple dynamics in family planning adoption in selected urban slums in Nigeria: a qualitative exploration	Aransiola, J. O.	2014	Nigeria	Men as partners
Level of male involvement and associated factors in family planning services utilization among married men in Debremarkos town, Northwest Ethiopia	Kassa, M.	2014	Ethiopia	Men as clients, Men as partners

Title	First Author	Pub Year	Country	How are men addressed?
Male involvement in family planning decision making in sub-Saharan Africa- what the evidence suggests	Vouking, M. Z.	2014	Sub-Saharan Africa	Men as clients, Men as partners
Baseline Household Survey Report Tékponon Jikuagou Project	Jikuagou, T.	2014	Benin	Men as clients, Men as partners
Be a man, Change the rules. Findings and lessons from seven years of CARE International Balkans' Young Men Initiative	Namy, S., et al.	2014	Balkans	Men as agents of change
The Evaluation of EngenderHealth/ CHAMPION's Men as Partners (MAP) Project	Ezekiel, M. J.	2014	Tanzania	Men as partners, Men as agents of change
Male partner involvement in female contraceptive choices in Nigeria	Ajah, L. O.	2015	Nigeria	Men as clients, Men as partners
Costs of integrating demand-based reproductive health commodity model in the Government and NGO service delivery systems in Bangladesh: a supply side perspective	Islam, Z.	2015	Bangladesh	Men as clients
Family Planning Knowledge, Attitudes, and Practices among Married Men and Women in Rural Areas of Pakistan: Findings from a Qualitative Need Assessment Study	Mustafa, G.	2015	Pakistan	Men as clients
Male engagement as a strategy to improve utilization and community-based delivery of maternal, newborn and child health services: evidence from an intervention in Odisha, India	Fotso, J. C.	2015	India	Men as agents of change
Counseling women and couples in family planning: evidence from Jordan. Research insights from Strengthening Health Outcomes through the Private Sector [SHOPS]	Abt Associates	2015	Jordan	Men as partners
Engaging the missing link: evidence from FALAH for Involving men in family planning in Pakistan	Ashfaq, S.	2015	Pakistan	Men as partners
SANAC Men's Sector National Strategic Plan Implementation Audit Report	Mkhize, M. Y.	2015	South Africa	Men as clients

APPENDIX B. NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH STRATEGY DOCUMENTS EXTRACTED

COUNTRY	DOCUMENT	YEAR
	AFRICA	
Democratic Republic of the Congo	Planification Familiale: Plan stratégique national à vision multisectorielle (Family Planning: A multisectoral vision of a national strategic plan)	2014–2020
Ethiopia	National Guideline for Family Planning Services	2011
Ghana	Reproductive Health Strategic Plan	2007–2011
Kenya	National Reproductive Health Strategy	2009–2015
Liberia	National Sexual and Reproductive Health Strategy	2010
Malawi	Costed Implementation Plan for Family Planning	2016–2020
Mali	Plan d'Action National de Planification Familiale du Mali (National Action Plan for Family Planning in Mali)	2014–2018
Mauritius*	National Sexual and Reproductive Health Strategy and Plan of Action	2009–2015
Nigeria	Family Planning Blueprint (Scale-up Plan)	2014
Rwanda	National Family Planning Policy	2012
Somalia*	Reproductive Health National Strategy and Action Plan	2010–2015
South Africa*	National Adolescent Sexual and Reproductive Health and Rights Framework Strategy	2014–2019
South Sudan	Maternal, Neonatal and Reproductive Health Strategy	2008–2011
Uganda	Costed Implementation Plan for Family Planning	2015–2020
Zambia	Family Planning Guidelines and Protocols	2006
	MIDDLE EAST	
Jordan*	National Reproductive Health/Family Planning Strategy	2013–2017
Yemen	National Reproductive Health Strategy	2011–2015
	ASIA	
Afghanistan	National Reproductive Health Policy	2012–2016
Bangladesh	Population Policy	2012
India	Vision Family Planning 2020	2014
Maldives*	National Reproductive Health Strategy	2014–2018
Philippines	National Policy and Strategic Framework on Male Involvement in Reproductive Health	2006
	CARIBBEAN	
Haiti	Plan Stratégique National de Santé de la Reproduction et Planification Familiale (National Strategic Plan for Reproductive Health and Family Planning)	2013–2016

* Not a USAID PRH priority country. The USAID PRH priority countries include: Haiti, Yemen, Philippines, Bangladesh, Afghanistan, Pakistan, Nepal, India, South Sudan, Madagascar, Democratic Republic of the Congo, Mozambique, Ghana, Malawi, Nigeria, Tanzania, Liberia, Senegal, Ethiopia, Zambia, Uganda, Kenya, Rwanda, and Mali.

APPENDIX C. KEY INFORMANTS

Organization[2]	Location
Pathfinder International	Watertown, MA, USA
John Snow, Inc.	Arlington, VA, USA
HealthChild	Kampala, Uganda
Promundo-US	Washington, DC, USA
FHI 360	Durham, NC, USA
Institute for Reproductive Health	Washington, DC, USA
IPPF South Asia	Delhi, India
Population Services International	Washington, DC, USA

[2] We had hoped to engage a representative of EngenderHealth's Men as Partners program as a key informant but the organization did not respond to requests to arrange a meeting.

APPENDIX D. KEY INFORMANT INTERVIEW GUIDE

Male Engagement in Family Planning Programs
Telephone Interview Guide

The objective of the activity is to determine how male engagement in FP (MEFP) is defined, monitored, and evaluated. This interview is intended to answer the following questions:

1. *How is MEFP defined by the organization?*
2. *What MEFP programs or interventions have been implemented by the organization?*
3. *What indicators have been used to track MEFP?*
4. *Were there any challenges with monitoring MEFP programs or interventions?*
5. *Has the organization conducted any evaluations of its MEFP programs and if so, were there any challenges, best practices, or lessons learned?*

BACKGROUND INFORMATION

Interview Date: Time:

Name of interviewer:

Name of key informant interviewee and job title:

Name of Organization:

INTRODUCTION & CONSENT

Hello, my name is _____ and I work for the University of North Carolina on the USAID-funded MEASURE Evaluation Project. We are interviewing program and M&E staff who work in male engagement in family planning programs. We are particularly interested in identifying what indicators are used to track male family planning service use and male family planning methods use and how these programs are evaluated. The purpose of this activity is to gain information on the gaps in monitoring and evaluating male family planning service use and male family planning methods.

There are no direct benefits in participating in this interview, other than contributing to a better understanding of M&E of male engagement in family planning programs. The risks involved in participation are very low; these questions should not be stressful or upsetting in nature, as they focus on your daily work and organizational experience.

Your participation is important but completely voluntary; you may stop at any time or skip questions, with no penalty. Your responses will be treated as confidential, and we will ensure that any statements or comments you make cannot be linked to you as an individual.

The interview should take no more than 30 minutes. Please let me know if you would like to be interviewed at this time.

Are you willing to participate? ❑ Yes ❑ No (stop interview)

If NO, provide reason: _____

This information will help inform a report on improving the M&E of male engagement in family planning programs, and we plan to include the names of all of the key informants in an appendix of that report.

May we include your name and organization in the report appendix? ❑ Yes ❑ No

INTERVIEW QUESTIONS

GENERAL INFORMATION ABOUT THE PROGRAM(S)

1) I want to first ask you some questions about your organization and its FP program(s) that include male engagement.

    a. How does your organization define male engagement in FP programs? (If the program does not have a definition, then ask the person how they define it. We care more about the program.)

    b. Does your organization both implement and evaluate male engagement in FP programs or interventions, or does it carry out only one or the other?

MONITORING OF MALE ENGAGEMENT

2) Now I'm going to ask about your experience with monitoring male engagement in FP. Can you list for me the indicators you've used to monitor these programs or interventions?

    a. Were the indicators used for one specific project? If so, please provide the following:
        - Name of the project:
        - Where it was implemented:
        - Donor:
        - Years implemented (can be approximate):
        - Intervention:

    b. If they were used for more than one project, please provide the above information for all the projects. *(Note: Interviewee may provide a list of indicators and a list of their male engagement in FP projects. It's okay if not all the indicators pertain to all the projects.)*

    c. Have reports of these programs been produced? [If "yes"] Are they available on a website, by request, or published?

3) Were there any indicators you ended up not using or not reporting on and why? In other words, what did you find to be problematic with those indicators?

4) Conversely, were there any indicators you now wish you would have included? Why?

5) Is there anything you would change or do differently to monitor your male engagement in FP programs?

    a. PROBE: Is there particular technology that you did not use for monitoring that you would use now, such as GIS?

    b. PROBE: Are there any systems related to data collection, for example, that you would address prior to implementing such a project again?

EVALUATION OF MALE ENGAGEMENT PROGRAMS

6) Lastly, I'm going to ask you about evaluations. Can you share with me your experiences with evaluating male engagement in FP programs? We are interested in learning about challenges, best practices, or lessons learned.

   a. PROBE: Can you describe some approaches you or your colleagues have used that have led to a successful evaluation, or a successful step within an evaluation?

   b. PROBE: If you were mentoring or giving advice to a colleague who had not been involved with such evaluations before, what if anything you would identify as a best practice in evaluating male engagement in FP programs?

   c. PROBE: What do you think are the challenges of evaluating a male engagement in FP program?

   d. PROBE: If you had to do the evaluation over again what, if anything, would you do differently?

   IF INTERVIEWEE TALKS ABOUT MALE ENGAGEMENT IN FP PROGRAMS AS A WHOLE, PROBE ABOUT SPECIFIC EVALUATIONS THEY MIGHT BE REFERRING TO.

   IF INTERVIEWEE IS TALKING ABOUT SPECIFIC EVALUATIONS, PROBE ABOUT GENERAL OBSERVATION.

7) IF INTERVIEWEE HAD PREVIOUSLY NOT SHARED (BY E-MAIL OR PHONE) NAMES OF OTHER POTENTIAL KEY INFORMANTS: Are there other program managers or M&E officers you recommend we interview?

FINAL COMMENTS & THANK YOU

Your feedback and thoughts have been very important, and we appreciate your assistance. Before we end, do you have anything else you would like to add? Anything else you think we should have asked?

SUPPLEMENTARY INFORMATION

MAKE A NOTE OF WHAT INFORMATION THE PARTICIPANT HAS PROMISED TO SEND YOU. THIS WILL HELP IN TRACKING ALL THE INFORMATION WE NEED.

1) [enter]
2) [enter]
3) [enter]

APPENDIX E. INDICATORS TO MEASURE MALE ENGAGEMENT IN FAMILY PLANNING PROGRAMS

	MEN AS CLIENTS	MEN AS PARTNERS	MEN AS AGENTS OF CHANGE
INDIVIDUAL	• Knowledge of FP/RH (output) • Percentage of all men, of currently married men, and of sexually active unmarried men who know any contraceptive method, by specific method (output) • Attitudes towards RH (outcome) • Percent of population with a favorable attitude toward an FP product, practice or service* (outcome) • Belief about FP method effectiveness, acceptability, side effects (outcome) • Percent of men who report currently using FP (outcome) • Percentage of men using contraception at last sex (outcome) • Distribution of men's contraceptive use at last sex by method type (modern vs. traditional) (outcome) • Distribution of men's contraceptive use at last sex by whether the method is a male-controlled/cooperative method or a female-controlled method (outcome) • Percent of men who have ever accessed FP services (output) • Percent of men who have ever used an FP method (output) • Percent of men who are new FP users (outcome) • Percent of men who plan on using FP in the future (output) • Percent of men who do not plan on using FP in the future (output)	• Couple-years of protection (impact) • Men's participation in women's method use (dual use, decision making, supporting partner's use, keeping track of fertile days, purchasing methods) (outcome) • Percent of men (husbands) who are supportive of their partners' RH practices (outcome) • Percent of men who support the use of modern contraception for themselves or their partners (outcome) • Percent of audience who believes that spouse, friends, relatives, and community approve (or disapprove) of the FP practice* (outcome) • Percent of men who help/facilitate their partners' access to FP (outcome) • Proportion of women reporting using contraceptives without partner's knowledge (outcome) • Percent of contraceptive method use requiring male cooperation (output) • Percentage of eligible couples who access birth spacing services* (outcome) • Number of men who know partner's fertility window (output) • Number of men who know their partners FP method (output) • Number of men/women who report joint decision making* (output) • Percentage of men who disagree that	• Extent of change in men's attitudes toward traditional practices such as: female genital cutting, son preference, inheritance, forced marriages, multiplicity of sexual partners, and harmful practices such as trafficking of women and girls (impact) • Percent of men completing education sessions on community gender norms who demonstrate improved attitudes toward women's RH needs (outcome) • Extent of change in attitudes towards gender norms (GEM Scale) (impact) • Belief that men are more "male" if have children (outcome) • Belief if women use FP, they're unfaithful/promiscuous (outcome) • Belief women have last word on FP (outcome) • Experience of intimate partner violence (outcome) • Reproductive autonomy (impact) • Reproductive and sexual coercion (impact)

	MEN AS CLIENTS	MEN AS PARTNERS	MEN AS AGENTS OF CHANGE
	• Percent of men who plan on using long-acting reversible contraception in future (output) • Men's condom use at last sex (outcome) • Percent of men who discontinue FP (outcome) • Experiences using FP (outcome) • Perceptions of men in FP (outcome) • Barriers in using FP (outcome) • CPR for male sterilization* (impact)	contraception is a woman's business and a man should not have to worry about it (outcome) • Number of men/women who report the ability to negotiate sex/condom use (output) • Number of male participants reporting comfort/self-efficacy with discussing sex and FP with partner (output) • Couple's communication (talk about contraception with partner, frequency, ease, talk about family size preference) (outcome) • Percentage of men who approve of couples using contraception to avoid getting pregnant (outcome) • Number of husbands who accompany wives to seek health services (output) • Belief of spousal approval of FP use (outcome) • Belief avoiding unwanted pregnancies is shared responsibility between men and women (outcome) • Partner's belief of having men involved in services (outcome) • Family size preference/fertility preference (outcome) • Concordance in preference (outcome) • Unmet need (impact) • Unintended pregnancy (impact) • Barriers to partner support (outcome)	
COMMUNITY/ FACILITY	• Number of male-friendly FP services offered/available (output) • Percent of male clients accessing RH services* (outcome) • Number of condoms distributed* (output) • Number of vasectomy referrals (output) • Number/percent of operational facilities that	• Attitudes regarding male participation in family healthcare (outcome) • Perceptions of providers of men accompanying wives/partners (outcome) • Perceived family/social network approval (outcome) • FP talk in social circles/community (output)	• Extent of change in community nonacceptance of violence (impact) • Number of providers trained on gender equity and sensitivity (output) • Number of people trained on male involvement (health officers, community

	MEN AS CLIENTS	MEN AS PARTNERS	MEN AS AGENTS OF CHANGE
	offer vasectomy services* (output) • Number of men told vasectomy an option, permanent (output) • Number of vasectomies performed* (outcome) • Percent of vasectomy cases observed that meet quality standards (outcome) • Percent of complications following male sterilization* (outcome) • Male sterilization coverage rate* (outcome) • Number of FP providers trained on male-specific FP (output) • Number of trainings or workshops held related to men and FP (output) • Percent of primary healthcare facilities providing male-friendly FP services (output) • Number of men reached with FP information/services by community-based worker (output) • Number of male participants reached at FP sensitization workshops or sessions (output) • Percent of men using a modern FP method who obtained their current method from a community-based worker (output) • Perception of providers to men in FP (outcome)	• Changes in clinic hours to make it easier for couples to come in together (output)	leaders, peer educators)* (output) • Changes in providers' knowledge and attitudes about gender norms/equality (impact) • Changes in knowledge, attitudes and skills among male and female peer educators on gender norms/equality (impact) • Number of men's and/or women's groups involved in improving RH* (output) • Number of male role models engaged through husband schools* (output) • Number of male participants reached at SRH sensitization workshops* (output) • Number of men sensitized at the workplace* (output)
STRUCTURAL	• Policies encouraging male-friendly clinics (outcome) • Vasectomy included in FP guidelines/strategies, regulations, or policies (outcome) • Number and percent of men aged 15-49 who use a private sector source to obtain modern FP methods (output) • Availability of accessible, relevant, and accurate information about SRH	• Evidence of engagement of men in FP incorporated in national health standards or policies (outcome) • Policies allowing husband's presence at clinics (outcome) • Media coverage of couples FP (outcome)	• Number of gender equitable laws (outcome) • Number of national level programs/policies/advocacy campaigns that address gender equity (outcome) • Degree of change in the way men and women are portrayed in the media and in schoolbooks (impact)

	MEN AS CLIENTS	MEN AS PARTNERS	MEN AS AGENTS OF CHANGE
	tailored to young men (outcome) • Media coverage of male FP use (outcome) • Inclusion of the topic of male involvement in all behavior change communication/ information, education and communication materials and programs developed and disseminated by the national government* (outcome)		• Greater resources available for gender equality and male involvement campaigns (impact) • Extent of change in national policymakers' attitudes and in public policy statements about gender equality and reproductive rights (impact) • Number of governmental champions demonstrating support for male engagement in RH (output) • Extent of enforcement of anti-domestic violence laws (outcome)

* These indicators are from national FP/RH strategies or policies.

APPENDIX F. INDICATOR REFERENCE SHEETS

Men as Clients

Indicator	Percent distribution of all men, of currently married men, and of sexually active unmarried men by contraceptive method currently used
Definition	Among men ages 15–54 years, the percent distribution of all men, currently married men, and of sexually active men in this age range, by contraceptive method they or their sexual partner are currently using. Contraceptive options include not using, pill, intrauterine device (IUD), injections, condom, female sterilization, male sterilization, implants/Norplant, lactational amenorrhea, periodic abstinence, female condom, and withdrawal. Currently using is defined as men reporting being sexually active in the 12 months prior to the survey. The indicator is calculated as follows: (All men, currently married men, or sexually active unmarried men ages 15–54 currently using any contraceptive method, by method / total number of male respondents) x 100
Disaggregation	Age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location
Data Source/ Requirement	DHS men's questionnaire The men's questionnaire reports contraceptive use among men through the following question, "Are you currently doing something or using any method with any partner to delay or avoid a pregnancy?" Those who respond with a "*yes*" are further asked to state the method they are personally using or their partner(s) are using (within the past 12 months). Data collection may include men ages 15–49, 15–54, or 15–59, depending on the local context.
Purpose	This indicator measures actual contraceptive use at the time of data collection by men by age and marital status. It is a qualitative outcome measure that can be used to track acceptance and use of modern contraception by men over time.
References/ Resources	DHS men's questionnaire

Indicator	Percent of men who have ever used any male family planning method or family planning method that requires male cooperation
Definition	Among men ages 15–54 years, the percent distribution of all men (currently married men and of sexually active unmarried men) who have ever used any male contraceptive method or family planning (FP) method that requires men's cooperation, by specific method and age. FP options include male sterilization (vasectomy), withdrawal, standard days method, and male condom. The indicator is calculated as follows: (Number of men 15–54 ever used a contraceptive method / total number of male respondents) x 100
Disaggregation	Age, marital status (all men, currently married men, or sexually active unmarried men), geographic location, specific method, and modern versus traditional method
Data Source/ Requirement	DHS men's questionnaire Special survey among the male clients at health facilities, program-based sexual and reproductive health sites, or among the men in the general public (population based) Data collection may include men ages 15–49, 15–54, or 15–59, depending on the local context.
Purpose	This indicator measures ever use of a contraceptive method by men by age and marital status. When disaggregated by modern versus traditional method, it is a quantitative outcome measure that can be used to track acceptance and use of modern contraception by men over time.
References/ Resources	DHS mens questionnaire: http://www.dhsprogram.com/data/DHS-Survey-Indicators-Family-Planning.cfm

Indicator	Men's condom use at last sex
Definition	The percentage of male respondents who say they used a male condom the last or more recent time they had sex with a female partner, within the last 12 months This indicator is calculated as follows: (Number of respondents who report using a condom the last time they had sex with a female partner / total number of respondents who report having sex in the past 12 months with female partner) x 100
Disaggregation	Age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location
Data Source/ Requirement	Self-reported data from respondents of special surveys among the male clients at health facilities, program-based sexual and reproductive health sites, or among the men in the general public (population based) DHS men's questionnaire
Purpose	Male condoms are one of the few male contraceptive methods. Tracking this indicator can reveal changes in men taking responsibility for family planning. Because this is also a key HIV/AIDS indicator, it can also signify changes in HIV prevention behavior.
References/ Resources	DHS men's questionnaire: http://dhsprogram.com/What-We-Do/Survey-Types/DHS-Questionnaires.cfm

Indicator	Number of male condoms distributed
Definition	"Condom" refers to male condom. Distributed refers to the condom leaving the source (facility or community-based provider) within a specified time frame. A condom is considered "distributed" if it is delivered or handed out to an individual as well as a drop-off point (e.g., bar, health facility, youth center, or truck stop).
Disaggregation	Source of condoms distributed (e.g., public health facility, private health facility, NGO clinic, community-based worker, etc.), geographic location (district or region)
Data Source/ Requirement	Facility records; program reports; community-based worker logs
Purpose	Condoms are used for dual protection against both sexually transmitted diseases, such as HIV, and unwanted pregnancy. Condoms distributed is a proxy measure for acceptance and use of condoms.
References/ Resources	For reference to this indicator in the context of HIV/AIDS, see the Pacific Aids Network indicator reference sheet found here: https://sparkjoy.org/pacific-aids-network/files/2016/08/Indicator-4.-No-of-condoms-distributed.pdf

Indicator	Number/percent of vasectomy referrals
Definition	The number/percent of men of reproductive age (15–54) who received a referral for vasectomy. A referral occurs if the client is advised where he can go to receive a vasectomy, and the referral is documented at the referral source as proof that a referral was made. This indicator may be a count of the number of men who received a referral for vasectomy. As a percent, this indicator is calculated as: (Number of male clients who received a referral for vasectomy / total number of male clients ages 15–54 served at the site during the reporting period) x 100)
Disaggregation	Age, geographic location, and type of clinic making the referral
Data Source/ Requirement	Data required include the number of male clients of reproductive age served at a given clinic during a given period (e.g., annually) as well as the confirmation of how many were referred for vasectomy. Service delivery statistics
Purpose	The focus of this indicator is to help monitor vasectomy service delivery by tracking the number of referrals given. This indicator may be used in conjunction with number of vasectomies performed, to understand service delivery more comprehensively.
References/ Resources	Adapted from: https://www.measureevaluation.org/prh/rh_indicators/specific/family-planning-and-hiv/number-percent-of-clients-who-received-a-referral-from-an-hiv-service-delivery-point-to-a-family-planning-clinic

Indicator	Number/percent of facilities that offer vasectomy services
Definition	Among the health facilities in a given area that provide FP services, the number or percent currently offering vasectomy services on-site during a specified time frame (e.g., one year or at the time of data collection) As a percent, this indicator is calculated as follows: (Number of facilities currently offering vasectomy services on-site / total number of surveyed facilities providing FP services) x 100
Disaggregation	Geographic location, type of facility, type of vasectomy (conventional or no-scalpel), or type of service (i.e., routinely offered at a facility or periodically)
Data Source/ Requirement	Facility survey/responses to a facility survey question asking whether a facility offers vasectomy services. Vasectomies can be part of the facility's routinely offered services, or they can be provided periodically on-site by a visiting provider, in which case the service must have been offered during the specified time frame. The question or questionnaire should specify that the service must be provided on-site, rather than as client referrals. Data may also be obtained from a service provision assessment.
Purpose	This indicator determines the extent to which facilities that offer FP are providing a permanent FP method to male clients. It is also a long-term indication of whether a national FP policy that includes permanent methods is being implemented. To measure quality of services, it is recommended to use this with a complimentary indicator, "Percent of facilities offering vasectomy services that meet the minimum standards with regard to essential supplies and equipment."
References/ Resources	Adapted from MEASURE Evaluation FP/RH Indicators Database, Long-acting and Permanent Methods: https://www.measureevaluation.org/prh/rh_indicators/specific/long-acting-permanent-methods/percent-of-facilities-with-appropriate

Indicator	Number of family planning providers trained on male-specific family planning
Definition	An FP provider is any health worker (e.g., physician, nurse, or community health extension worker) who provides FP counselling and methods. Male-specific FP refers to male-controlled contraceptives (condoms and vasectomy) and FP counselling to men. This includes couples' counselling, because men who are counselled on FP are often accompanied by their partners. Training can refer to any type of male-specific FP training event, regardless of its duration or location. It involves a trainee getting a thorough understanding of the essential knowledge required to perform the job and progressing from either lacking skills or having minimal skills to being proficient.
Disaggregation	Sex, type of provider, geographic location, and type of training (pre-service or in-service). If targeting and/or linking to inequity, classify trainees by areas served (poor/not poor) and disaggregate by area served.
Data Source/ Requirement	Training attendance rosters from project records and public and private facility records of in-service trainings (usually kept by the training division), which are used both for administrative purposes during the training (e.g., distributing per diem) and for monitoring trainees at a later date.
Purpose	This indicator serves as a crude measure of activity and provider knowledge of male-specific FP methods. Evaluators can use it for determining whether a program/project meets its target and/or for tracking progress from one year to the next. Because this indicator does not assess improved knowledge and/or skills, it should be used in conjunction with the indicator, Number/Percent of trainees who have mastered relevant knowledge, as appropriate.
References/ Resources	Adapted from MEASURE Evaluation FP/RH Indicators Database, Training indicators: https://www.measureevaluation.org/prh/rh_indicators/crosscutting/training

Indicator	Number of vasectomies performed
Definition	The number of male sterilizations, "vasectomies," that have been performed within a given time frame. Data should be collected continuously at the facility level and should be aggregated periodically (e.g., monthly or quarterly) for use at the local level.
Disaggregation	Type of vasectomy (nonscalpel or conventional), age (of patient), and location of procedure (e.g., private facility, public facility, or community-based event) geographic location
Data Source/ Requirement	Service delivery statistics and program records This indicator assesses the number of vasectomies recorded in health facilities (versus in informal settings, such as a vasectomy camp), which should be performed according to national standards. However, unless the evaluator is observing the procedures to assess compliance with national standards, the standard of care can only be assumed.
Purpose	This output indicator tracks vasectomy service delivery. It can be a reliable measure for effectiveness of provider trainings in vasectomy and interventions to improve quality standards at facilities to provide permanent family planning methods.
References/ Resources	Adapted from: https://www.measureevaluation.org/prh/rh_indicators/mens-health/mc/number-of-male-circumcisions-performed-according

Indicator	Vasectomy included in family planning guidelines/strategies, regulations, or policies
Definition	In countries with formal family planning (FP) or reproductive health guidelines, strategies, regulations or policies, this indicator assesses whether vasectomies are specifically included in these documents, and to what extent. In addition, these documents should be evaluated to make sure they are technically sound, based on scientific evidence, and grounded in informed choice. The assessment should include the extent to which the national FP strategy or policy has a strategic or long-range plan in place to increase access to and use of long-acting/permanent methods, including vasectomy. To measure changes over time, the indicator should consider only those policies developed or modified during a specific reference period, such as the last calendar year.
Disaggregation	Stage (drafted/proposed/adopted)
Data Source/ Requirement	Document review or policy analysis for evidence that vasectomy services are included in a country's FP or health policy documents.
Purpose	The inclusion of vasectomies in formal policy statements reflects a country's recognition of and commitment to effective FP options. It also signifies a recognition of male involvement in FP.
References/ Resources	

Men as Partners

Indicator	Couple-years of protection (CYP)
Definition	The estimated protection provided by family planning (FP) services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed over all methods to obtain a total CYP figure. See the MEASURE Evaluation FP/RH Indicator Database for the CYP conversion factors: https://www.measureevaluation.org/prh/rh_indicators/specific/fp/cyp
Disaggregation	None
Data Source/ Requirement	Service statistics or logistics management information system The data required are quantities of pills, condoms, and spermicides distributed to clients; numbers of IUDs and NORPLANT implants inserted; number of injections administered; number of sterilization operations performed; number of trained, confirmed clients of natural FP; and number of lactational amenorrhea clients during the reference period.
Purpose	CYP measures the volume of program activity. Program managers and donor agencies use it to monitor progress in the delivery of contraceptive services at the program and project levels. This measure is currently one of the most widely used indicators of output in international FP programs.
References/ Resources	MEASURE Evaluation FP/RH Indicator Database, CYP: https://www.measureevaluation.org/prh/rh_indicators/specific/fp/cyp

Indicator	Percent of men who disagree that contraception is a woman's business and a man should not have to worry about it
Definition	The percent of men ages 15–54 years who respond negatively to the statement "contraception is a woman's concern, and a man should not have to worry about it." This indicator is calculated as follows: (Number of men surveyed/interviewed who report they disagree with the above statement / total number of men surveyed/interviewed) x 100
Disaggregation	Age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location
Data Source/ Requirement	DHS men's questionnaire Data collection may include men ages 15–49, 15–54, or 15–59, depending on the local context.
Purpose	This indicator quantitatively measures men's perceptions of shared responsibility in family planning and contraceptive use.
References/ Resources	DHS men's questionnaire: http://dhsprogram.com/What-We-Do/Survey-Types/DHS-Questionnaires.cfm

Indicator	Percent of men who share in the decision making of reproductive health issues with their spouse or sexual partner
Definition	The percent of men who report joint decision-making with their wife or sexual partner about various aspects of their sexual and reproductive health (SRH. This indicator is calculated as follows: (Number of men surveyed/interviewed who report that they share in making SRH decisions / total number of men surveyed/interviewed) x 100
Disaggregation	Age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location
Data Source/ Requirement	Surveys among the male clients at health facilities, program-based SRH sites, or among the men in the general public (population based). Alternative sources are surveys among the spouses and partners of male participants in male-focused programs.
Purpose	Increased sharing in SRH decision-making by male and female partners is generally associated with beneficial outcomes for the health and well-being of women, children, and the entire family (UNFPA, 2003). Male engagement interventions often are designed to increase male awareness of SRH issues and to increase partner communication on these topics. This indicator measures the extent to which husbands and wives or other sexual partners discuss and share decision making for specific SRH topics.
References/ Resources	MEASURE Evaluation FP/RH Indicator Database and Male Engagement in RH: https://www.measureevaluation.org/prh/rh_indicators/specific/me/percent-of-men-and-women-who-share-in-the-decision

Indicator	Percent of men who support the use of modern contraception for themselves or their partners
Definition	The percent of men who support the use of modern FP methods for their own use or for their partners' use. "Supportive" can be operationally defined as attitudes toward use of modern FP method, responses to hypothetical situations, and reported actions/behaviors. Modern methods of contraception include hormonal pills, female and male sterilization, IUD, injectables, male and female condoms, diaphragm, foam/jelly, and emergency contraception. In contrast, traditional or 'nonmodern' methods include periodic abstinence, withdrawal, and folk methods. A proposed question is, "Do you support the use of modern contraception for yourself or your partner?" This indicator is calculated as follows: (Number of men who support their own or partners' use of modern contraception / total number of men surveyed) x 100
Disaggregation	Where the detail is available, the indicator can be disaggregated by the specific types of modern FP methods the men support, as well as by relevant socioeconomic and demographic factors, such as, men's age, education level, income, urban/rural residence.
Data Source/ Requirement	Surveys among the male clientele at health facilities or other men's reproductive health sites (program based) or among the men in the general public (population based). Alternative sources are surveys among the spouses and partners of participants in male-focused programs. Responses to structured or in-depth interviews. Evaluators can assess men's level of support for their own or partners' use of modern FP methods using three types of questions: attitudes, responses to hypothetical situations, and reported actions.
Purpose	Modern methods of contraception are generally recognized as more effective than traditional methods, and men's support of modern method use for themselves or their partners can facilitate planning and spacing pregnancies with accompanying benefits for maternal and infant health. This indicator tracks men's involvement in FP decision-making and method use by supporting the men's partners in their use of modern methods. Although some argue that this type of involvement does not go far enough, in societies where males have withheld support, backing their partners in using modern methods can represent an important step forward. One expects that responses for this indicator will become more favorable as a result of interventions directed toward male involvement in FP.
References/ Resources	MEASURE Evaluation FP/RH Indicator Database: https://www.measureevaluation.org/prh/rh_indicators/specific/me/percent-of-men-who-support-the-use-of-modern

Indicator	Perceptions of providers of men accompanying wives/partners to a family planning/ reproductive health visit
Definition	The assessment of provider attitudes or perceptions of men coming along to their wife or partner's family planning/reproductive health visit. The definition of this is dependent upon context and should be developed iteratively.
Disaggregation	Geographic location, type of provider, and age and sex of provider
Data Source/ Requirement	Qualitative interviews with providers
Purpose	This process indicator helps with understanding why uptake of services may be lower in some areas (e.g. if providers have negative perceptions of men's participation, they may be less likely to promote/encourage that and a program would see lower rates of men accompanying wives/partners to FP services). The indicator can be useful for gauging changes in provider attitudes before and after a family planning training. However, it is worth noting that men accompanying their wives or partners to a health facility may have a negative connotation if the intent of the man is to exercise dominance rather than be an engaged and supportive partner.
References/ Resources	

Indicator	Engagement of men in family planning incorporated in national health standards or policies
Definition	Instances in which there is concrete evidence of engagement of men for existing national/subnational policies or strategic plans that promote family planning (FP) services and information. Policy implementation is the process of carrying out and accomplishing a policy. This may require the creation of an implementation plan, policy guidelines and a budget line item to ensure that the policy is carried out in the manner that was intended by policymakers.
Disaggregation	Stage (drafted/proposed/adopted)
Data Source/ Requirement	Directive, resolution, tool to measure policy implementation, meeting minutes providing evidence of dialogue among national and subnational governments on new guidelines, evidence of activity plans or reports that show the policy is being used, or key informant interviews.
Purpose	The inclusion of men in formal health standards or policy documents reflects a country's recognition of and commitment to male involvement in FP.
References/ Resources	

Men as Agents of Change

Indicator	Attitudes towards gender norms (GEM Scale)
Definition	Attitudes toward gender norms in intimate relationships or differing social expectations for men and women, boys and girls, using the Gender-Equitable Men (GEM) scale. The GEM scale includes 24 items in two subscales. The 17 items in Subscale 1 measure 'inequitable' gender norms (e.g., 'It is the man who decides what type of sex to have') and the 7 items in Subscale 2 measure 'equitable' gender norms (e.g., 'A couple should decide together if they want to have children'). Responses are scaled as: Agree = 1; Partially Agree = 2; and Do Not Agree = 3 for the inequitable subscale. Scores are inverted for the equitable subscale, resulting in a higher score for greater gender equity. Scores of the inequitable norm and the equitable norm subscales are calculated separately and can be combined or used individually. The inequitable subscale has been found to be more reliable than the equitable subscale in some circumstances. The combined or individual subscale scores can be used as a continuous variable or categorized as: Low Equity = 1–23; Moderate Equity = 24–47; and High Equity = 48–72.
Disaggregation	Where the detail is available, disaggregation of the indicator by men's age, number of children, education, income, urban/rural status and other relevant factors may contribute to interpretation of findings.
Data Source/ Requirement	Interviews and survey questionnaires using the GEM scale. Completed GEM questionnaires/interviews.
Purpose	The GEM scale and scoring procedures were developed using formative research by Horizons and Promundo to measure attitudes toward "gender-equitable" norms. The scale is designed to provide information about the prevailing gender norms in a community, in addition to the effectiveness of programs that seek to influence them (Barker, 2000, 2001; Instituto Promundo and Instituto Noos 2003).
References/ Resources	Compendium of Gender Scales: https://www.c-changeprogram.org/content/gender-scales-compendium/pdfs/4.%20GEM%20Scale,%20Gender%20Scales%20Compendium.pdf Validation with youth: http://www.jahonline.org/article/S1054-139X(16)30376-7/abstract

Indicator	Number of providers trained on gender equity and sensitivity
Definition	A "provider" is any health worker (e.g., physician, nurse, community health extension worker). "Training" can refer to any type of gender equity and sensitivity training event, regardless of its duration or location. It involves a trainee getting a thorough understanding of the essential knowledge required to perform the job and progressing from either lacking skills or having minimal skills to being proficient. "Gender equity" is the equally fair treatment of women and men, girls and boys. To ensure fairness, some societies adopt measures to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a "level playing field." Gender-equity strategies eventually attain gender equality. Equity is the means; equality is the result (Interagency Gender Working Group, 2000). "Gender sensitivity" is the way service providers treat male or female clients in service delivery facilities and thus affects client willingness to seek services, continue to use services, and carry out the health behaviors advocated by the services. In the context of FP, gender sensitivity also refers to whether a range of male and female methods are offered.
Disaggregation	Sex, type of provider, location, and type of training (pre-service or in-service); If targeting and/or linking to inequity, classify trainees by areas served (poor/not poor) and disaggregate by area served.
Data Source/ Requirement	Training attendance rosters from project records and public and private facility records of in-service trainings, usually kept by the training division, which are used both for administrative purposes during the training (e.g., distributing per diem) and for monitoring trainees at a later date.
Purpose	This indicator serves as a crude measure of activity and provider knowledge of gender equity and sensitivity. Evaluators can use it for determining whether a program/project meets its target and/or for tracking progress from one year to the next. Because this indicator does not assess improved knowledge and/or skills, it should be used in conjunction with the indicator, "Number/percent of trainees who have mastered relevant knowledge," as appropriate. This indicator focuses on gender issues in the client-provider context as a step toward addressing gender bias and promoting a service delivery environment free of gender bias toward female and male clients with the aim of encouraging men to use services for their own health (e.g., voluntary male circumcision, vasectomy, sexually transmitted infections, and HIV/AIDS).
References/ Resources	MEASURE Evaluation FP/RH Indicator Database: https://www.measureevaluation.org/prh/rh_indicators/crosscutting/service-delivery-ii.h.4

Indicator	Number of programs/policies/advocacy campaigns that address gender equity
Definition	Number of programs/policies/advocacy campaigns that address gender equality or nondiscrimination against women or girls at the national or sub-national level. For the purposes of this indicator, "policy" is meant broadly to include any official document issued by a government (e.g., law, policy, action plan, constitutional amendment, decree, strategy, or regulation) designed to promote or strengthen gender equality or nondiscrimination based on sex at the national or subnational level. To be counted, the program/policy/advocacy campaign should have as its objective or intent one or more of the following: reducing an aspect of social, economic, or political inequality between women and men, girls and boys; ensuring that women and men, girls and boys, have equal opportunities to benefit from and contribute to social, political, economic, and cultural development, to realize their human rights, or to have access to/control over resources necessary to survive and thrive; or preventing gender-related discrimination or compensating for past gender-related discrimination or historical disadvantage. To report against this indicator, provide the number (count) of relevant programs/policies/advocacy campaigns drafted, proposed or adopted during the reporting period. Count only once in each stage (e.g., law drafted, proposed, or adopted); do not report on the same program/policy/advocacy campaign across multiple reporting periods, unless it has advanced to the next stage (e.g., law drafted in one reporting period, law presented for legislative action in the next reporting period, or law passed in the subsequent reporting period). If it is a program (or project or intervention) that is addressing gender equity, it should be counted only one time—the reporting period where program implementation begins.
Disaggregation	By program/policy/campaign, stage (drafted/proposed/adopted), or geographic location (for subnational levels)
Data Source/ Requirement	National and sub-national level policies, programs, and advocacy campaigns. This indicator may come from program results data for interventions that aim to strengthen and support the creation of national and subnational level programs/policies/advocacy campaigns.
Purpose	Information generated by this indicator will be used to monitor and report on achievements linked to broader outcomes of gender equality, female empowerment and/or nondiscrimination and will be used for planning and reporting purposes by agency-level, bureau-level, and in-country program managers. Specifically, this indicator will inform required annual reporting or reviews of the USAID Gender Equality and Female Empowerment Policy and the U.S. National Action Plan on Women, Peace, and Security, as well as the Joint Strategic Plan reporting in the APP/APR and Bureau or Office portfolio reviews. Additionally, the information will inform a wide range of gender-related public reporting and communications products and facilitate responses to gender-related inquiries from internal and external stakeholders, such as Congress, nongovernmental organizations, and international organizations.
References/ Resources	Adapted from indicator GEN-1; USAID ADS 205: https://www.usaid.gov/sites/default/files/documents/1870/205.pdf

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