

Summary Findings From A Rapid Situational Assessment of  
Sexual and Reproductive Health and Rights Needs Among Men and Boys in:

# LESOTHO



## Background:

Men and boys have diverse sexual and reproductive health and rights (SRHR) needs that often remain unfulfilled due to several barriers, such as social and gender norms relating to masculinity, a reluctance to admit ill health, limited access to health facilities, negative stereotypes of male clients among providers, services that do not cater to their needs, and a lack of agreed-upon standards for delivering sexual and reproductive health (SRH) clinical and preventative services.

Key global, continental and regional commitments have called for greater engagement of men and boys on SRHR. Only in recent years has a concerted effort been made in the East and Southern African to consider the needs of men and boys more intentionally.

## Rationale for the rapid situational assessment:

Men have shared responsibility, as partners and parents, for decisions around the health and wellbeing of their families including decision-making about when, whether and how many children they wish to have, to preventing sexually transmitted infections (STIs) and HIV and promoting SRHR in their communities. However, little is known of the extent to which:

- national policies and strategies incorporate male engagement or have dedicated male engagement strategies;
- male social and gender norms and behaviours determine SRH outcomes of men and boys; and
- men and boys are accessing SRHR services.

To respond to these questions, the 2gether 4 SRHR Programme, a Joint United Nations Regional Programme that aims to improve SRHR of all people in East and Southern Africa, commissioned the Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal to undertake a rapid situational assessment<sup>1</sup> of the SRHR needs of men and boys in five countries in the region, including Lesotho.

The purpose of the assessment was to examine the extent to which national laws, policies and strategies integrate issues relating to men and boys and to assess the structural, social and behavioural drivers that facilitate or impede the uptake of SRHR services by adolescent boys and young men aged 18 to 34 years. This was followed by a validation meeting convened with representatives of the countries who reviewed the findings. This brief summarises the key findings of the rapid assessment, the policy review and inputs received during the validation meeting.

<sup>1</sup> Rapid situation assessment (RSA) refers to a methodology that uses a combination of qualitative and quantitative data collection methods. RSA draws on a variety of data sources to arrive at an understanding of certain health problems and of structures and services to address those problems and then formulating responses to deal with them. See United Nations Office for Drug Control, Crime Prevention, and United Nations International Drug Control Programme. Demand Reduction Section. (1999). Drug abuse rapid situation assessments and responses (No. 36-37). United Nations.

## Global, continental and regional commitments on male engagement

promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.

### African Union Initiative on Positive Masculinity

is a commitment by Heads of State and Government; the private sector; religious and additional leaders; academia; civil societies; women and youth to accelerate the prevention and elimination of violence at all levels. It includes a commitment to ensure that the necessary policies measures are put in place by Member States to address any form of impunity.

### The Southern African Development Community (SADC) Regional Strategy for SRHR (2019-2030)

calls for Member States to engage men and boys as partners, and as individuals with their own SRHR needs. It also urges Member States to ensure that services meet the specific SRHR needs of men and boys.

## Methodology:

The 2gether 4 SRHR is a regional programme with applied learning in countries. Lesotho was included in the assessment as it was a focus country in the first phase of the programme.

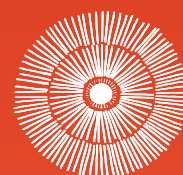
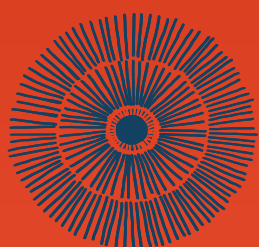
**Study site and Sampling:** The assessment was conducted in Mokhotlong district, a rural area in Lesotho, and Leribe, a mixed urban and rural districts that were purposively selected. The inclusion of rural and urban settings was to ensure that the assessment captured the SRHR realities of adolescent boys and young men in diverse environments. The assessment used a mix methods approach.

Samples were drawn from adolescent boys and young men who had been involved in SRHR programmes and those who had not.

### Recruitment

In-programme recruitment was undertaken with district administrators, partners (SOLIDAMED and the Elizabeth Glaser Pediatric AIDS Foundation) assisted the team to recruit respondents. In Mokhotlong, participants were gathered for food aid and were recruited while waiting. Participants were recruited from the male-friendly corners in clinics. For out-of-programme recruitment in Mokhotlong, fieldworkers recruited participants in the marketplace, taxi rank, and community gatherings.

In Leribe, participants were recruited from taxi ranks, marketplaces, hospitals, taverns and people from the local village. Focus group discussion participants were recruited from taxi and bus ranks, business centres, marketplaces or clinics. Providers of (adolescent) SRH services and SRH programme implementers, national-level government officials and policymakers were identified through snowball sampling.



## Data Collection:



The assessment used various data collection methods including:

### A quantitative face-to-face survey:

administered to 200 adolescent boys and young men to identify their SRH need, knowledge, attitudes, norms and behaviours and their exposure to SRH interventions. Participants completed the survey questionnaire using digital tablets. Fifty participants were recruited in each district who were participants in male engagement programmes and 50 who were not involved in any programmes.

### Focus group discussions:

Five focus group discussions comprising of 5–10 participants, who were different from those that completed the survey, were undertaken in the two selected districts. Efforts were made to balance the focus groups between adolescent boys and young men younger than 26 and those between the ages of 27 to 34 years. The purpose of the focus group discussions was to assess the thoughts and feelings of the participants about SRHR services offered in their community.

### Key informant interviews:

were conducted using a semi-structured questionnaire with six SRH service providers and SRH programme implementers, identified through snowball sampling<sup>2</sup>. The purpose was to gain insights on the provision of clinical and non-clinical services in accordance with the global International Planned Parenthood Federation (IPPF)-United Nations Population Fund (UNFPA) package of SRHR services for men and boys, challenges and successes of serving adolescent boys and young men, the use of evidence-based approaches, guidelines and innovations to inform programme interventions and approaches, and the impact of COVID-19 on SRH services and programmes.

### Four government officials and policymakers:

policy context, the use of data to inform policy, budgeting implications, innovations and challenges around scaling up approaches for adolescent boys and young men. The Ministries of Health and Education were represented in the sample, as well as large civil society organizations working on SRHR and operating on a national scale.

Ethical clearance was obtained from the University of KwaZulu-Natal (BREC/00003894/2022) and the Ministry of Health in Lesotho (ID 51-2022).



### Sample characteristics:

The median age for the sample adolescent boys and young men was 26 years of age. Just over half had completed secondary education (50.5 per cent). Approximately three quarters of adolescent boys and young men were rural based (75.2 per cent). Just over two thirds (66.3 per cent) of households had sufficient food in the previous 12 months.

### Men as clients:

**Most adolescent boys and young men had access to HIV testing and counselling (89.1 per cent), male circumcision (73.8 per cent) and STI testing (76.7 per cent)** in their community (see Table 1). Two-thirds of adolescent boys and young men (65.8 per cent), indicated they had access to information and counselling on sexual dysfunction, 61.4 per cent had access to information, counselling and treatment for male reproductive cancers and 59,8 per cent of participants had access to information that challenges sexual myths and addresses cultural barriers. Vasectomy services were least likely available with one third (38.6 per cent) indicating they have access.

### Men as partners:

The majority (88.6 per cent) of adolescent boys and young men indicated they would support their partner to access HIV services, and approximately two thirds (66.3 per cent) would support their partner to access pregnancy services. Just over half (54.5 per cent) indicated they would support their partner to access a medically safe abortion.

Approximately one third (32.8 per cent) of adolescent boys and young men indicated they had perpetrated at least one form of intimate partner violence. The median gender equitable scale score is 32 (range: 17 to 45), where a higher score means more equitable scores.

### Men as change agents:

Only 6.3 per cent of adolescent boys and young men were involved in a health-focused non-governmental organization (NGO) in their community.

### Psychosocial characteristics:

Just over three-quarters (77.2 per cent) agreed with the statement that most people with HIV are supported by their families when they disclose their HIV status. Six per cent of adolescent boys and young men indicated they felt sad all of the time (5 to 7 days per week) in the previous month and 5 per cent felt lonely all of the time in the previous month. Eighteen per cent of adolescent boys and young men also indicated they occasionally felt lonely (3 to 4 days per week) in the previous month. Over one-fifth (22.3 per cent) indicated they occasionally (3 to 4 days per week) felt hopeful in the previous month.

**Table 1: Indicators from the quantitative survey for adolescent boys and young men in Lesotho, 2023 (n=200)**

	<b>Median/ %</b>
<b>Men as clients:</b>	
Per cent indicating HIV testing and counselling available in community	89.1
Per cent indicating voluntary medical male circumcision is available in community	73.8
Per cent indicating STI testing is available in community	76.7
Per cent indicating information and counselling on sexual dysfunction available in community	65.8
Per cent indicating information and counselling on sexual myths and cultural barriers available	59.4
Per cent indicating vasectomy services are available	38.6
Per cent indicating information and counselling and treatment for male cancers of the reproductive organs available	61.4
<b>Men as partners:</b>	
Per cent indicating they would support partner to access HIV services	88.6
Per cent indicating they would support partner to access pregnancy services	66.3
Per cent indicating they would support partner to access a medically safe abortion	54.5
<b>Men as change agents:</b>	
Per cent indicating they were involved in health-focused NGO	6.3
<b>Psychosocial characteristics</b>	
Per cent perpetrated intimate partner violence (IPV)	32.8
Median score on Gender Equitable Men Scale (Range)	32 (17-45)
Per cent agree that most people are supported by their families when they disclose their HIV status	77.2
Per cent indicating they felt sad all the time (5–7 days per week) in the previous month.	6.8
Per cent indicating they felt lonely all the time (5–7 days per week) in the previous month	5.2
Per cent indicating they occasionally felt lonely (3–4 days per week) in the previous month	19.3
Per cent indicating they occasionally felt hopeful about the future (3–4 days per week) in the previous month	22.3



## Key findings from the policy review

### Policy gaps relating to male engagement in SRHR:

SRHR policies in Lesotho focus primarily on the prevention and treatment of HIV, which is the leading cause of death among men. Quality SRH services for adolescents, mothers and men are identified as a priority in the National Health Strategic Plan (2017–2022), however, there is no specific guidance in terms of interventions specifically geared towards the male clients.

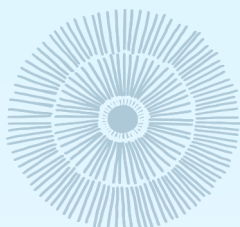
Similarly, the Lesotho School Health and Nutrition Policy (undated) states that “the application of all aspects of this policy will be sensitive and responsive to the different needs of men and women, boys and girls, and interventions will recognize the special social and physiological needs of vulnerable groups based on gender” but does not indicate what specific emphasis and interventions are required for male and female learners in the implementation of this policy.

The (draft) National Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategic Plan (2021–2025) makes minimal reference to the role of men and the need to engage men in pregnancy care and neither does it provide guidance on how male engagement in support of their pregnant partners can be operationalized. Although the National Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategic Plan (2021–2025) signals an increasing trend in HIV prevalence among men, the indicators included to monitor the provision of HIV services only pertain to female clients.

Harmful, traditional masculinity linked to high levels of violence towards girls and women is problematized across a range of policies, and with the recognition that intervention at an early age is critical. A range of national policy documents connect health with education and promote adolescent-friendly SRHR services within schools and facilities. The comprehensive sexuality education curriculum applies a skills-oriented and reflective approach towards discussing SRHR matters with learners that moves well beyond the provision of information and placement of sexuality in a value and/or risk frame, as observed in other countries in the region. Through role-play scenarios and homework projects, boys and girls are introduced to gender-transformative work<sup>3</sup>.

Despite the lack of male engagement in relevant national policies, efforts are being made to increase the engagement of adolescent boys and men in HIV prevention, treatment and care services. The Ministry of Health, the Elizabeth Glaser Paediatric AIDS Foundation and the Lesotho Planned Parenthood Association have established male-only HIV services that have yielded some success according to participants. Specific interventions for key and vulnerable populations, such as herd boys, long-distance truck drivers and addressing the needs of the lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) community are being implemented.

Lesotho should consider how to strengthen male engagement in relevant national sectoral SRHR policies and strategies, to define the national package of services to be delivered to men and boys linked to the IPPF-UNFPA Minimum Package of SRHR services for men and boys, and to develop guidelines and protocols to ensure the delivery of quality men’s health services drawing on global normative guidelines.



## Structural factors impacting uptake of health services

Adolescent boys and young men said they were not keen on being attended by a female health worker for a SRHR need or question. It was one of the reasons for establishing 'male corners' within selected health facilities in the country with services delivered by male staff.

The distance to a facility is another barrier for men in accessing SRH services. This was associated with increased out-of-pocket costs and inconvenience in accessing such services

## The impact of social, gender and cultural norms on male health-seeking behaviours

Multiple barriers impede the uptake of SRHR services by men and boys in Lesotho. Cultural norms and values and the way men are socialized prevent them from discussing personal problems or issues relating to sex with strangers.

As with other countries in the region, gender norms, definitions and expectations of what constitutes a man is an important barrier in men seeking timely health care. Many key informants referred to a strong masculine role with health-seeking behaviours regarded as a sign of weakness.

*It's like you are a woman or a child if you take everything to the clinic. They need to play strong! There is stigma attached to a man who behaves like a woman, always crying for help like a woman*

*-Service provider A. Lesotho*

Perceived transgression of gender boundaries by gay or bisexual men, and men with a non-binary or transgender identity was also regarded as problematic. In the focus groups, most adolescent boys and young men expressed themselves very negatively towards LGBTQI people and threatened physical violence if they would meet them in the street.



## Emerging practices on addressing the SRHR needs of men and boys

Male corners offer male-only health services in a separate section of a health facility or in a temporary unit on the facility's premises, for example, a container. The male corners are staffed by male health workers who offer services to male clients from the age of 15. The package of services is dependent on the size and structure of the health facility. All corners provide HIV- and AIDS-related services, tuberculosis (TB) and STI screening and treatment. Some provide additional services, such as male cancer screening, hypertension, diabetes, asthma and other chronic conditions.

Interviewed providers at several corners indicated that men felt comfortable in seeking health care there, based on anecdotal evidence and repeat client visits. The success of the corners has resulted in providers experiencing difficulty in managing the demand, resulting in additional health workers being allocated from other departments to ensure the continuity of services. This has meant that some corners now also have female health workers, as well as lay health workers who have not been trained to work in the corner. Participants strongly felt that more support is needed to sustain and expand these services.

### Key recommendations

The following recommendations are informed by the country discussion:

- Develop a men and boys' engagement strategy; male engagement programmes are not formally integrated into national policies and strategies. The country has a comprehensive in-school programmes on SRHR that it leverages on. Male engagement programmes work in silos and are not harmonized or coordinated.
- Development of a baseline assessment to identify and measure harmful gender and social norms; the district health information system (DHIS) 2 does have questions relating to modules on gender-based violence and intimate partner violence though these are not comprehensive enough and need to be improved.
- Strengthen Information, education and counselling services that are targeted for adolescent boys and young men to improve their health-seeking behaviour and implement gender transformative interventions.



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