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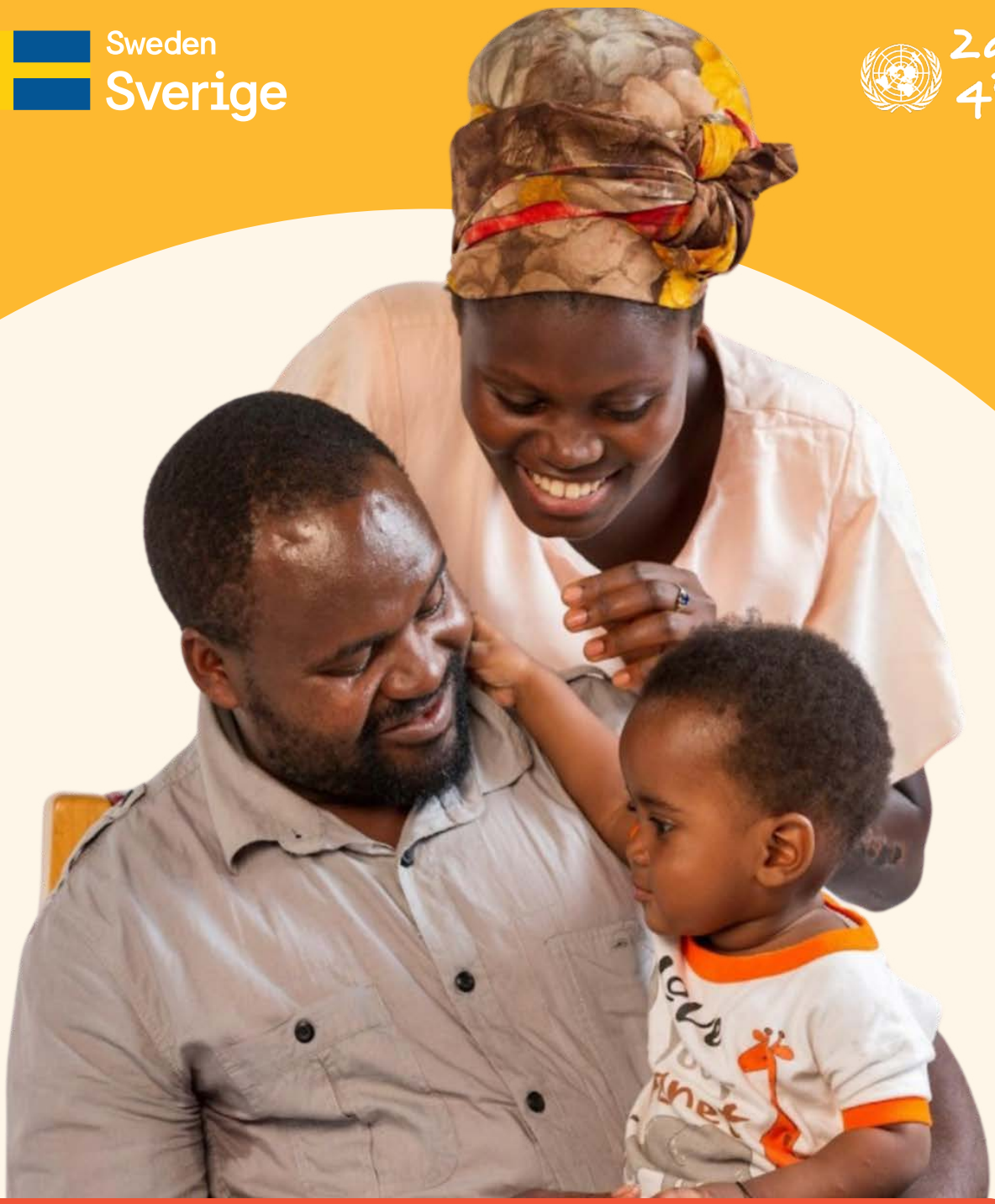
2gether 4SRHR



UNFPA/ESARO

Men and boys and their sexual and reproductive health and rights in five countries in East and Southern Africa

A SITUATIONAL-BASED NEEDS ASSESSMENT STUDY

UNAIDS

UNFPA

unicef
for every child

World Health Organization

SYP
Safeguard Young People
PROGRAMME

THE STUDY HIGHLIGHTS SIGNIFICANT SEXUAL RISK BEHAVIOURS, INEQUITABLE GENDER ATTITUDES AND KNOWLEDGE GAPS ABOUT SEXUAL AND REPRODUCTIVE HEALTH AMONG ADOLESCENT BOYS AND YOUNG MEN

Acknowledgements

This study assesses the structural, social and behavioural factors influencing the uptake of sexual and reproductive health and rights (SRHR) services among adolescent boys and young men aged 18 to 34 years at selected sites in Lesotho, Malawi, Uganda, Zambia and Zimbabwe in 2022 and 2023. It forms part of a larger research project which included a health policy analysis published in a separate report[1] and looked at the extent to which country policies and strategies incorporated the SRHR needs of men and boys.

This research project was conceived under the leadership of the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) under the banner of the 2gether 4 SRHR Programme, the Joint United Nations Regional Programme that aims to improve the SRHR of all people in the region. The needs assessment study was conducted by a team of researchers in each of the five countries, coordinated and implemented by the Health Economics and HIV/AIDS Research Division (HEARD), the University of KwaZulu-Natal in South Africa. The principal investigator of the study was Professor Kaymarlin Govender (Research Director at HEARD). The research team consisted of Mr. Sean Beckett (Research Fellow, HEARD), Dr. Carolien Aantjes (Senior Research Fellow, HEARD), Dr. Charles Banda (Zambia), Mr. Edward Buzigi (Uganda), Dr. Nelson Muparamoto, (Zimbabwe), Dr. Amelia Mashea, (Lesotho) and Mr. Murphy Kajumi (Malawi).

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[1] C.J. Aantjes and K. Govender. Bridging the Gap: An assessment of health policies and strategies with a focus on men and boys' SRH in selected East and Southern African countries. (Durban, South Africa, HEARD & UNFPA ESARO, 2022).

List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
BREC	Biomedical Research Ethics Committee
CAC	Comprehensive abortion care
CSE	Comprehensive sexuality education
DRC	Democratic Republic of the Congo
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
ESARO	East and Southern Africa Regional Office
FGD	Focus group discussion
GBV	Gender-based violence
HDI	Human Development Index
HEARD	Health Economics and HIV/AIDS Research Division
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSSREC	Humanities and Social Sciences Research Ethics Committee
IBM	International Business Machines
IEC	Information, education and communication
IPV	Intimate partner violence
IQR	Interquartile range
KII	Key informant interview
Km2	Square kilometres
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex
MRCZ	Medical Research Council Zimbabwe
NCST	National Commission for Science and Technology
NGO	Non-governmental organization
OPD	Outpatient department
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SGBV	Sexual and gender-based violence
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TASO	The AIDS Support Organization
TB	Tuberculosis
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VMMC	Voluntary medical male circumcision

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UNFPA Mozambique/Mbuto Machili

Executive Summary

The sexual and reproductive health and rights (SRHR) needs of adolescent boys and young men in East and Southern Africa are critically overlooked in policy, programme and service provision, calling for immediate and decisive action. In this region, adolescent boys and young men grapple with a range of SRHR challenges that profoundly affect their overall well-being. Currently, there is a glaring absence of targeted policies that specifically address the SRHR requirements of adolescent boys and young men. While many existing programmes prioritize women's health due to the significant disease burden among adolescent girls and young women, this oversight has detrimental effects not just on adolescent boys and young men, but also on adolescent girls, women of reproductive age and families as a whole. It's essential to recognize that addressing the SRHR needs of adolescent boys and young men is vital for fostering healthier communities and promoting gender equity in health initiatives. In the East and Southern Africa region and worldwide, adolescent boys and young men significantly underutilize SRHR products and services compared to women. However, targeted SRHR programmes for adolescent boys and young men can effectively target male cancers, sexual dysfunction, reduce risk-taking behaviours, lower sexually transmitted infections (STIs) and HIV rates and prevent unintended pregnancies. Adolescent boys and young men also share the responsibility as partners and parents in making decisions about contraception and promoting SRHR within their communities. Despite this, there is a lack of research in East and Southern Africa focused on the social and behavioural factors influencing men's SRHR. Conducting such studies can provide valuable

insights to tailor interventions that meet the unique challenges faced by men. This study employed a mixed method approach to assess the structural, social and behavioural factors influencing the uptake of SRHR services among adolescent boys and young men aged 18 to 34 years at selected sites in Lesotho, Malawi, Uganda, Zambia and Zimbabwe.

The study highlights significant sexual risk behaviours, inequitable gender attitudes and knowledge gaps about sexual and reproductive health (SRH) among adolescent boys and young men. Many participants had not completed secondary education, with high dropout rates and challenging economic conditions. HIV-related stigma persists, with almost a quarter lacking family support upon disclosing their status, alongside feelings of loneliness and hopelessness for the future. While HIV testing and treatment services were said to be accessible at primary level, other SRH services for adolescent boys and young men are limited. Physical examinations are not routinely conducted, and condom provision is the primary contraceptive option offered. STI services often rely on syndromic management or referrals to private clinics, with inadequate partner treatment. Some initiatives like 'male corners' in Lesotho have improved men's health-seeking behaviour but (still) lack integration with broader SRHR services. Barriers such as confidentiality concerns, judgmental attitudes, insufficient staff training, time constraints and affordability issues hinder effective responses to male involvement and attention to gender-based violence (GBV) during pregnancy care. In the policy analysis, we found that key components of the global package for men and boys are absent from national policies, leaving providers at the selected sites in our study uncertain on how to meet client needs. Basic information on infertility and male cancers is often missing in primary health-care settings, further compromising service quality in resource-strained environments. Participants indicated preference for pharmacy visits over clinical services for their SRHR needs. Besides privacy issues, adolescent boys and young men also narrated experiences of having been faced with significant expenses to access SRHR services at government clinics, and denied care if they cannot pay. Non-clinical services primarily focus on providing information, counselling and resources to prevent STIs and unintended pregnancies. However, there is a notable lack of attention to topics like sexual rights, pleasure, well-being in relationships and questions about puberty among adolescent boys and young men; not only in health facilities but also in the school setting. Lastly, the study found limited evidence of encouraging male leadership roles to challenge harmful traditional masculine behaviours. While initiatives like male corners, male action groups, school clubs and sports-based activities show promise in engaging adolescent boys and young men in SRH programmes and services, efforts to shift gender norms are often hampered by inadequate theories of change, low intervention fidelity, short-term funding and scaling challenges.

Recommendations

GLOBAL PACKAGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

1. Improve the incorporation of components from the global package of services for men and boys in countries' policies and strategies. Countries should review their national health policies and strategies to determine the extent to which the national package of essential services and essential medicines list includes the global package of services for men and boys across their life course.

2. Countries should develop national guidelines around the provision of services to address men and boys SRHR needs across their life course. Additionally, training packages based on these guidelines should be created to enhance the capacity of existing health-care workers. In parallel, collaboration with schools of public health, medicine and nursing at tertiary institutions is essential to integrate men's health into their curricula.

3. Implement demand creation interventions to raise awareness and bolster demand for neglected areas of men's health programming including vasectomy, sexual health problems, infertility, reproductive health cancers and encourage male involvement in the birthing process and upbringing of their child.

4. Increase education, information and screening for male infertility, reproductive disorders, sexual dysfunction and sexual health counselling, premature ejaculation and reproductive cancers at lower-level health facilities.

5. Increase initiatives aimed at fostering discussions on comprehensive abortion care (CAC) and, more broadly, on the influence of men in women's abortion trajectories that can possibly lead women away from seeking CAC at institutions or public facilities (for example, in the case of a man's denial of paternity), and induce an abortion privately with an unsafe method and/or without having access to proper information.

6. Promote greater male participation in HIV and STI testing and pregnancy services for their partners, regardless of the nature of the relationship—steady or casual—while ensuring a non-coercive approach that respects their partners' sexual health and reproductive choices.

7. Better provision of male-oriented information, education and communication (IEC) materials on contraceptives, childbirth and rearing, sexual and gender-based violence (SGBV), psychosocial and mental health, high risk sexual behaviours, as well as drug and substance abuse.

SEXUAL AND GENDER-BASED VIOLENCE REDUCTION INTERVENTIONS AND COMPREHENSIVE SEXUALITY EDUCATION PROGRAMMING

1. Improved conceptualization of gender-sensitive approaches within health and educational programmes, focusing on how gender influences perceptions of health and illness, as well as access to social and health services, and the implications for service delivery.

2. Expand initiatives to challenge harmful social norms that uphold traditional masculinity and address health-seeking behaviours, while combating stigma and discrimination against 'the others'—those who do not conform to dominant masculine ideals and may be marginalized, including other heterosexual men, women, children and individuals of diverse gender and sexual identities.

3. Broaden the scope of comprehensive sexuality education (CSE) programmes for both in-school and out-of-school youth, emphasizing the importance of topics such as sexual rights, social justice, sexual pleasure and well-being in a sexual relationship and response to pressing questions of biological and psychosocial changes occurring in puberty.

4. Invest in community-based interventions that utilize participatory approaches, such as sports, dialogues and discussions involving men, boys, girls and women. These initiatives should address topics like sex, sexuality, relationships, alcohol and substance abuse, health and well-being, and social and gender norms to improve SRHR and educational outcomes for these groups.

5. Develop more programmes focused on male leadership, engagement and activism in combatting SGBV and challenging traditional heterosexual masculine behaviours that can lead to harm.

SERVICE DELIVERY QUALITY AND INTEGRATION OF SERVICE PROVISION

1. Improve the integration of HIV services with other SRHR components for male clients, while also incorporating SRHR services into HIV care. This comprehensive approach aims to address male health-care needs more effectively, reducing time, inconvenience and costs associated with clinic visits.

2. Foster increased engagement and collaboration between health service providers and male partners during the delivery of reproductive health care, with an emphasis on identifying and addressing issues of intimate partner violence (IPV) in the context of pregnancy care.

3. Enhance the quality of service delivery by implementing more specific and standardized guidelines for SRHR services that address the unique needs of men.

4. Investigate strategies to improve access to SRHR services by ensuring confidentiality in facilities, training health-care providers to offer respectful care, increasing the number of male health-care workers and considering extended operating hours, including weekends, to better accommodate men and boys.

COORDINATION, TRACKING AND SUSTAINABILITY OF PROGRAMMES

1. Improve alignment between policies and strategies and linked programmes and budgeting, as well as a more effective tracking of health service utilization (for example, number of adolescent boys and young men utilizing SRH services in health facilities and use of GBV services) to inform future policies, strategies and programmes.

2. Improve coordination of SRH services and programmes across different sectoral mandates, particularly between the ministries of health and education, social development and finance.

3. Enhance the efficient pooling of financial and human resources to strengthen the delivery and provision of SRH services.

Introduction

Evidence shows that the SRH needs of adolescent boys and young men are not specifically addressed in East and Southern Africa and that more must be done to meet those needs (Hook et al., 2021). It is during these formative years that identities are moulded and where sexual behaviours take shape. In a study conducted among eight African countries (Uganda, Zambia and Zimbabwe were included in the study) 27.3 per cent of school children reported having sex before the age of 15 years (38.1 per cent for males and 15.8 per cent for females) and access to and use of contraceptives was low (Peltzer, 2010). Furthermore, previous work has shown that the total burden of adult HIV and AIDS is due to sexual risk behaviours that start in early and middle adolescence. In addition, adolescent boys experience a significant increase in HIV incidence as they age, suggesting that the transition into adulthood may be a critical time to engage with SRHR (Govender, 2018).

It has been noted that adolescent boys and young men are not as severely affected by HIV and STIs as their female counterparts. However, it is of concern that UNAIDS data estimate that in the five countries, where this assessment study has been undertaken (Zambia, Zimbabwe, Malawi, Lesotho and Uganda), there were approximately 43,200 new HIV infections in 2021 amongst men aged 15 years or older[2] (Joint United Nations HIV/AIDS Programme, 2022). Additionally, the Global Burden of Disease data estimate that there were approximately 4.5 million new STI infections[3] in the same five countries in 2019 among men aged 15 to 39 years (Institute

[2] Lesotho had 2,500, Malawi had 6,100, Uganda had 16,000, Zambia had 12,000 and Zimbabwe had 6,600 new HIV infections.

[3] The estimates include syphilis, chlamydial infection, gonococcal infection, trichomoniasis, genital herpes and a category for other STIs.

for Health Metrics and Evaluation, 2019). Most of the countries mentioned above fall within the 'infertility belt' where subfertility rates of 30 per cent are found, which is much higher than the 8 to 12 per cent at a global level (King, 2018). A study conducted in South Africa and Nigeria highlighted the increase in the prevalence of asthenozoospermia and teratozoospermia, which are the leading causes of male infertility (Akang et al., 2023). Another important contributor towards male infertility is high prevalence of STIs amongst men in the same region (Bowa et al., 2020).

Adolescent boys and young men in the East and Southern Africa have considerable SRHR needs. Among these is the need for information and services regarding contraception, HIV and other STIs, sexual dysfunction, infertility and male reproductive health cancers. Yet these needs are often unfulfilled due to a combination of factors, including barriers to access health facilities and services that do not cater for the needs of men and boys, social and cultural norms that promote risk taking and inhibit health-seeking behaviours, and a heteronormative bias to SRHR in country policy and practice. There is further a lack of agreed upon standards for delivering clinical and preventative information and services to men and boys, in all their diversity. Due to this, adolescent boys and young men are an underserved population with regards to SRHR, and current research points to the need for a nuanced analysis of the situation for adolescent boys and young men in different contexts. Including adolescent boys and young men in SRHR programmes alongside adolescent girls and young women creates valuable opportunities for joint programming. This approach is particularly beneficial during adolescence – a period when both groups are actively exploring their sexuality and facing significant sexual health risks.

A review of the effectiveness of initiatives to improve adolescent health-care access and utilization in low- and middle-income countries shows that interventions that train health workers, improve friendliness towards adolescents in facilities and interventions that improve demand through multiple channels were effective and should be rolled out at a larger scale (Denno, Hoopes & Chandra-Mouli, 2015). However, programmes that focus on delivering services outside of facilities need to be studied in more depth. Furthermore, a review of HIV interventions targeting sexual risk reduction among adolescent boys and young men in sub-Saharan Africa shows that interventions focused solely on education, information and counselling, while neglecting normative and environmental drivers of health outcomes has limited value (Kanyemba et al., 2023). Combination prevention approaches which have biological, structural and behavioural components to the intervention show much more promise in reducing risk behaviours. Chandra-Mouli, Lane and Wong (2015) argue that youth centres, peer education and one-off public meetings have been ineffective in facilitating access to SRH, changing social norms and behaviours. Approaches such as CSE, creating safe spaces for community dialogues and youth-friendly services have been shown to be effective when well implemented. However, these types of services have struggled to be effective given their considerable implementation requirements.

At present, there is a deficit in the East and Southern Africa region on explicit policy, strategy or operational plans on the involvement of men and boys, although the needs of this population seem, in some contexts, to be partially integrated into national health policies and programmes. Available programmes, for good reasons, have largely focused on women of reproductive age. Often men have been included to support their partners and thereby neglecting the role of men as end-users themselves as well as little acknowledgment of their potential as agents of normative change.

In the East and Southern Africa region and globally, men's use of SRH products and services is significantly less than women's use, yet SRH programmes for men have been shown to reduce men's risk-taking behaviour, reduce incidences of STIs and HIV and preventing unwanted pregnancies, among other things. Further, men have a shared responsibility (as partners and parents) for decisions around contraception, preventing STIs and HIV and promoting SRHR in their communities. However, few studies in East and Southern Africa have been undertaken to delineate social and behavioural drivers of SRH among men. Evidence generated through such context driven studies can assist interventions and programmes to address the specific challenges and needs within the male population.

AIMS AND OBJECTIVES

Using a multimethod and life course approach, the current study undertook a formative assessment of the structural, social and behavioural drivers that facilitate or impede the uptake of SRHR services and the impact of COVID-19 on adolescent boys and young men aged 18 to 34 years in selected sites in Lesotho, Malawi, Uganda, Zambia and Zimbabwe.

The more specific objectives of this assignment were as follows:

- Conduct a survey of the SRH needs and exposure to SRH interventions among adolescent boys and young men, as well as the knowledge, attitudes, norms and behaviours of adolescent boys and young men.
- Conduct focus group discussions (FGDs) with adolescent boys and young men and key informant interviews (KIIs) with providers of adolescent boys and young men SRH services, SRH programme implementers, government officials and policymakers on the extent to which SRHR services are being provided to meet the needs of adolescent boys and young men as clients through facility and community-based services, social and behavioural change programmes, including CSE, and the impact of COVID-19 on the continuation of services amongst adolescent boys and young men.
- Make recommendations to strengthen programming to meet the SRHR needs of adolescent boys and young men as clients, partners, and as advocates and agents of change.

UNFPA Uganda

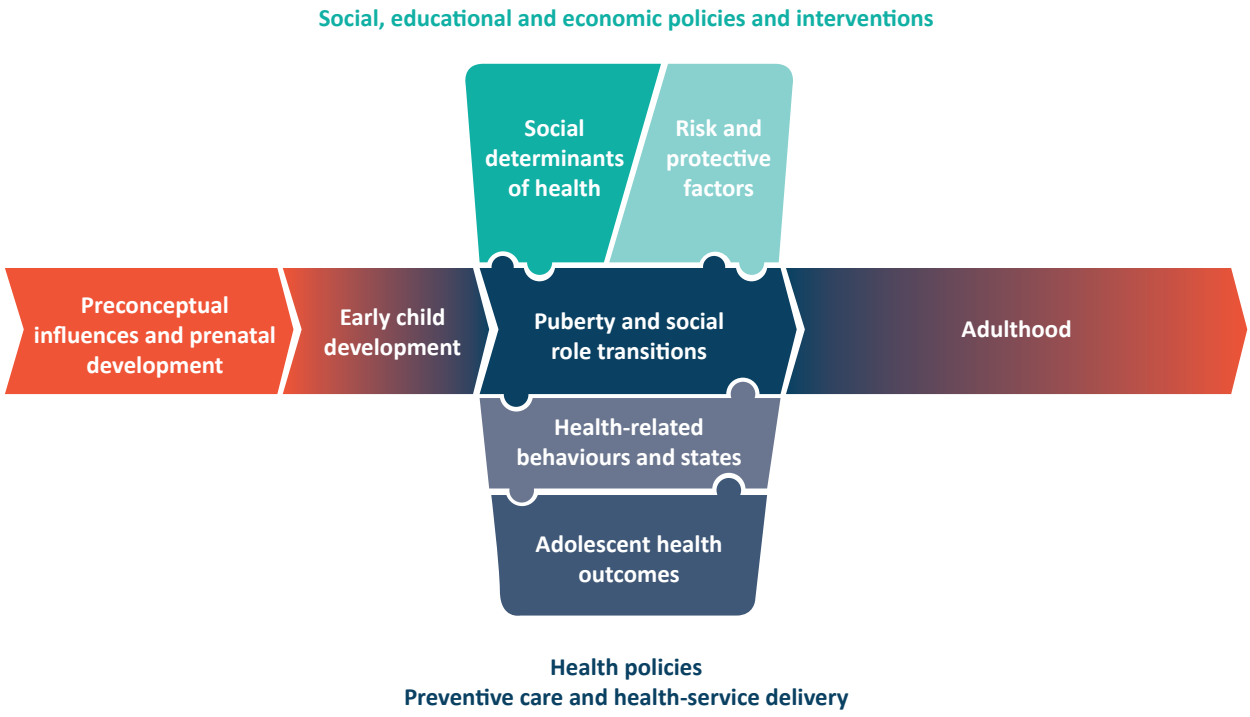
Conceptual Framework

The framework for this formative assessment is guided by the adolescent health Lancet Commission framework (Sawyer et al., 2012). The framework (see Figure 1) emphasizes the importance of using a life-course perspective for studying adolescent health and development. The trajectory of human development is represented by the horizontal path and the influence of social determinants is indicated by the vertical path that eventually leads to health outcomes. The axes cross around the characteristics of adolescence (the complex interactions between puberty, neurocognitive maturity and social-role transitions) to emphasize how these factors affect adolescent health and development. Young adulthood is associated with transitions from school to tertiary education and work, mobility and employment insecurities. Social vulnerabilities are linked to demand and access of sexual and reproductive health. The text outside the boxes refers to settings and scope of policies, preventive interventions and social services that impact adolescent health.

We used the International Planned Parenthood Federation and the UNFPA Global Sexual and Reproductive Health Service Package to understand what services are considered appropriate for adolescent boys and young men. Furthermore, we also used Greene et al.'s (2006) conceptualization of men's involvement in SRH services, which focuses on men as clients, men as partners and men as agents of positive change. Their approach argues that men's roles in SRH must be acknowledged and addressed much more extensively than they have to date, and that doing so will have implications well beyond reproductive health for other aspects of development.

Figure 1:

Conceptual framework for adolescent health



Note: Taken from Sawyer et al., 2012

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Methods

Setting and site selection

The study took place in Lesotho, Malawi, Uganda, Zambia and Zimbabwe. The study areas were selected purposively, Table 1 provides some additional information on the population parameters. Mashonaland East (Zimbabwe) was the largest study area and Livingstone (Zambia) the smallest study area. Wakiso District, selected for the assessment study in Uganda has the highest number of people living in the area and Mokhotlong (Lesotho) has the fewest number of people living in the study area, when compared to other study areas. Harare (Zimbabwe) has the highest population density and Kapiri Mposhi (Zambia) has the lowest population density. Mokhotlong District (Lesotho) has the lowest Human Development Index (HDI)[4] number and Zimbabwe's Harare has the highest figure (United Nations Development Programme, 2023). All the HDI scores for each study area are considered low, except for Harare which is considered to have a medium HDI.

[4] The HDI is a summary measure consisting of three areas namely health, education and standard of living (United Nations Development Programme, 2023). The index uses data from life expectancy at birth, years of schooling for adults aged 25 years and more, expected years of schooling for children of school entering age and gross national income per capita. A low HDI is a score less than 0.550, medium is a score between 0.550 to 0.699 and very high is above 0.800.

Table 1:

Population parameters for study areas

Country and study area	Geographic size (km²)	Population size	Population density (per km²)	HDI	Urban/ rural	National HIV prev. men 15–49 years
Lesotho-Leribe	2,828	337,500	120	0.527	Urban and Rural	15.7%
Lesotho-Mokhotlong	4,075	100,442	25	0.461	Rural	15.7%
Malawi – Mchinji	3,356	602,305	179	0.483	Rural	5.7%
Malawi – Mulanje	2,056	428,322	208	0.480	Rural	5.7%
Malawi – Nkhata-bay	4,071	164,761	41	0.482	Rural	5.7%
Uganda – Kyankwanzi	2,455	257,500	105	0.493	Rural	3.8%
Uganda – Wakiso	1,908	2,915,200	1,500	0.493	Urban	3.8%
Zambia-Kapiri – Mposhi	17,219	294,971	17	0.579	Rural	7.7%
Zambia – Livingstone	695	139,509	200	0.589	Urban	7.7%
Zimbabwe – Harare	872	2,427,209	2,800	0.645	Urban	8.7%
Zimbabwe – Mashonaland east	32,230	1,344,955	42	0.539	Rural	8.7%

Notes: The figures for each country and or district vary as estimates were done at different time periods. The HIV prevalence figures are from UNAIDS and were national prevalence figures as there are no HIV prevalence figures for each district.

UNFPA Mozambique/Mbuto Machili

Study sites and programmes

All five countries have challenging contexts for adolescent boys and young men, and some evidence of elevated HIV prevalence and risk. However, these countries also have targeted HIV and SRHR programmes for adolescent boys and young men that provided researchers with opportunities for participant recruitment and spaces in which to conduct data collection (see Table 2 for programmes). The five countries were selected because these countries are part of the focus countries for the 2gether 4 SRHR Programme where UNAIDS, UNFPA, UNICEF and WHO are working together to implement a Joint United Nations Regional Programme on SRHR, with support from the Government of Sweden. Below is an indication of the research sites per country and the programmes from which participants were selected for the study.

The study employed a mixed method approach, a quantitative survey and a qualitive approach using FGDs and KIIs.

Table 2:

Sites and selected programmes by country.

Country	In-country organization/programmes to work with
Lesotho	Solidamed and Baylor.
Malawi	Family Planning Association of Malawi, Center for Development of People and UNFPA Malawi.
Uganda	Department of Health Services, Nansana Municipality, Wakiso District. Nurture Africa (non-governmental organization – NGO), Department of Health, Kyankwanzi District.
Zimbabwe	Brotha2Brotha (Zimbabwe Community Health Intervention Research Project).
Zambia	Ministry of Health (Livingstone District Health Office, Kapiri Mposhi District Health office); Play it Forward (Livingstone); Planned Parenthood Association of Zambia (Livingstone); Tubombele Pamo (NGO working in SRHR in Kapiri).

Quantitative study approach

SURVEY DESIGN, RECRUITMENT AND SAMPLING

The quantitative survey that was conducted face-to-face using tablets. We used the KoboToolbox software (Kobo, 2023). In each of the five countries, we purposively sampled respondents. We attempted to sample an equal number of adolescent boys and young men attending SRH programmes (such as youth-friendly corners or other interventions) and those not attending SRH programmes or individuals who were from areas where there were no recent SRH interventions. See Table 3 for more information on the recruitment strategy of survey respondents. The sampling strategy is best characterized as purposive. The eligibility criteria for study enrolment were that participants must be aged 18 to 34 years; be able to read or understand or speak English, Nyanga, Bemba, Shona, Ndebele, Chichewa, Tumbuka, Sesotho or Luganda; be willing to be interviewed; and able to provide informed consent to fieldwork staff.

Table 3:

Information on recruitment of respondents for the survey

Country	In-programme recruitment	Out-of-programme recruitment
Lesotho	District administrators and partners (SOLIDAMED and the Elizabeth Glaser Pediatric AIDS Foundation) assisted the team to recruit respondents. In Mokhotlong, respondents were gathered for food aid in three separate places and were recruited while waiting. District Health Management allowed the fieldwork team to recruit respondents from the male friendly corners in clinics.	In Mokhotlong, fieldworkers recruited respondents in the market place, taxi rank and community gatherings with the help of traditional leadership and district administrators. In Leribe, respondents were recruited from taxi ranks, market places, hospitals, taverns and people from the local village. Traditional leadership assisted with identification of villages and arranged community gatherings.
Malawi	In all three districts, adolescent boys and young men were purposively selected from the youth clubs coordinated through the district youth network structure. These were organized through the government district youth offices. The youth clubs were further organized around a youth club area network with participants selected from several youth clubs. Selection of youths from individual clubs was at the discretion of the youth leadership. The adolescent boys and young men were interviewed at a central location, but came from different clubs in the selected area. One aspect to note was that while some youth clubs were organized around health service delivery, others were not connected to health services.	Adolescent and young men were recruited from areas where there had been no recent SRH programmes. Participants via the Kambenje Health Centre. A call for adolescent boys and young men to participate in the study was sent out through the network of youth clubs within the catchment areas of these particular health units. Adolescent boys and young men were interviewed at a central location. In Nkhata Bay, non-programme adolescent boys and young men participants were drawn from the Biya area. The adolescent boys and young men in Biya were not linked to a health unit and were recruited through the youth clubs around Biya School in the northern part of the district. In Mchinji, messages were sent via the District Youth Office to Kapondo area, which is a non-programme area, a call was sent out for adolescent boys and young men to meet at a central location for interviews.
Uganda	Health workers for the district local government and implementing partners assisted the research team to recruit participants. Study participants were recruited from the clinics during clinic days until the required sample size was attained. In the Wakiso District participants were recruited from Nabweru Health Centre III (government-aided) and Nurture Africa clinic (implementing partner). In Kyankwanzi District participants were recruited from the Ntwetwe Health Centre IV clinic and Butemba Health Centre III clinic. These two clinics are government aided. Their implementing partner is Mildmay Uganda.	In Kyakwanzi and Wakiso Districts, research assistants recruited the community participants from football playgrounds, ludo (board game) gatherings, Boda-boda (motorbike) taxi stages, marketplaces, bar surroundings and discotech surroundings. In Kyankwanzi the District Health Inspector and youth leaders helped in the mobilization of study participants. In Wakiso District, the local youth leaders supported the research assistants to mobilize the study participants.
Zambia	Respondents screened and if eligible for the survey, were asked to come to the Play it Forward or Planned Parenthood Association of Zambia offices for an interview.	Tubombele Pamo (community support organization) introduced a study team to respondents in two communities in Livingstone and two communities in Kapiri Mposhi and assisted them with recruitment in these communities.
Zimbabwe	In Mashonaland East, the National AIDS Council is responsible for implementing the Brotha2Brotha club. Participants were recruited through the existing National AIDS Council structures in the wards. Participants were conveniently selected during the Brotha2Brotha intervention to participate. If there was no planned session on the day, mentors helped mobilize their mentees to meet with the researchers. In Hopley (Harare suburb), Zimbabwe Community Health Intervention Research Project is responsible for implementing the Brotha2Brotha programme. Initial connection with study participants was established through community mobilizers for SRH programmes. The mobilizers helped to connect the research team with participants who were asked to participate	The out-of-programme adolescent boys and young men eligible participants often came in numbers to sites where data was being collected. This could also be associated with the incentive that they had heard from their colleagues who would have completed the survey. In Mashonaland East, the research team had to innovatively recruit at some of the centres where adolescent boys and young men met (i.e. at pool/snooker table). The team was also assisted by community members to recruit more respondents in Hopley.

In each country we selected one rural and one urban district to ensure living realities are captured with regards to SRHR for adolescent boys and young men in these settings. Districts were chosen purposively. In each district, we attempted to sample 100 adolescent boys and young men and therefore 200 in each country. This amounted to approximately 1,000 adolescent boys and young men in all five countries. While recruiting adolescent boys and young men within each district, we tried to ensure an even split of in programme and out of programme adolescent boys and young men. We selected SRH programmes that dealt with different types of adolescent boys and young men. An attempt was made to have an equal number of boys and young men aged 18 to 26 years and an equal number of those aged 26 to 34 years in the overall sample. Furthermore, UNFPA decided which districts to sample from in Malawi and in Zimbabwe. In Malawi this meant we did not include urban districts.

MEASURES

The purpose of the survey was to collect standard demographic information (age, employment, education status, housing/living status, relationship status, self-reported HIV status, HIV testing, presence of STIs, experience with HIV and SRHR programmes, employment, financial stability and food security), items on experiences of physical or sexual violence or abuse, self-assessed mental health status screener (using Centre for Epidemiological Studies Depression Scale) (Radloff, 1991); masculinity norms (Gender Equitable Men Scale) (Pulerwitz & Barker, 2008), HIV-related stigma (external and internal), experience of IPV; most recent sexual experiences and experiences with accessing and using contraceptives, social and structural factors impeding access to SRHR and HIV treatment up-take, knowledge regarding SRH, support of partners to access SRHR services and engagement in community organizations. Survey measures were finalized in consultation with UNFPA. The tools were translated into the following languages: Nyanga, Bemba, Shona, Ndebele, Chichewa, Tumbuka, Sesotho and Luganda.

Prior to data collection, all country teams received training on quantitative survey methods. Questionnaires were translated by the in-country teams and piloted in a site that had not been selected for the study. Research assistants were supervised and guided by the country's lead researchers, who accompanied them during field visits. Data collection in the districts took place between August and October 2022.

QUANTITATIVE DATA ANALYSIS

The quantitative data from the survey questionnaire with adolescent boys and young men was analysed using descriptive statistics and bivariate analysis. The bivariate analysis had four main disaggregation variables which included, age of the respondent, whether respondent was part of an SRH programme or not, locality of respondents' residence (urban or rural) and nationality of the respondents. All data were disaggregated by these variables in the study and then specific interesting results were presented given the vast number of variables disaggregated. Data analysis was conducted in IBM Statistical Package for the Social Sciences (SPSS) version 27.

Qualitative study approach

STUDY RECRUITMENT AND SAMPLING

In each of the 10 selected districts, adolescent boys and young men were recruited to participate in an FGD. Participants were not the same adolescent boys and young men who completed the survey. The eligibility criteria for participation in the FDGs were: age 18 to 34 years; ability to read/understand/speak English, Nyanja, Tonga, Bemba, Shona, Chichewa, Luganda or Tumbuka; willingness to participate in a group discussion; and ability to provide informed consent. The FGDs followed an interview guide and were facilitated by two researchers. Questions focused on social norms and expectations of men and boys, young people's experiences with sexuality education, SRH services and programmes and contextual challenges (including the impact of COVID-19) that support or hinder young men to meet their own needs and the needs of their partner in SRH and to be a change

agent on SRH issues in their community. In each country, five or more FGDs were conducted (n=26 FGDs in total). FGDs had a group size of between five to 10 individuals. Participants were recruited at various places in the community, for example, at taxi and bus ranks, in business centres, market places or at clinics. Researchers were supported by local administrators, chiefs, civil society programme managers and health service providers during the recruitment process. During participant selection, there was an attempt to balance the FGDs between younger groups (younger than 26 years) and older groups of men (27 to 34 years).

In the same sites, providers of (adolescent) SRH services and SRH programme implementers were identified through snowball sampling (Babbie, 2020). Semi-structured interviews were conducted with a total of 25 individuals, and guided by an interview guide which focused on the provision of clinical and non-clinical services in accordance to the global package 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 services and programmes on SRH. The number of officials interviewed in each country was the following: Lesotho four informants; Uganda four informants; Zambia five informants; Malawi seven informants; and Zimbabwe six informants.

At national level, 26 government officials and policymakers were identified via snowball sampling and interviewed to understand the current SRHR policy context, the use of data to inform policy, budgeting implications, innovations and challenges around scaling up approaches for men and boys in each country. In all countries, the ministries of health and education were represented in the sample, as well as large civil society organizations working on SRHR and operating at a national scale. In a number of countries, the sample of key informants also included officials from the ministry of gender and/or youth and sports. The number of providers interviewed in each country was the following: Lesotho six providers; Uganda six providers; Zambia five providers; Malawi five providers; and Zimbabwe three programme implementers.

Prior to data collection, all country teams received training on qualitative methods, with an emphasis on the facilitation of FGDs. Research assistants were supervised and guided by the country's lead researchers, who accompanied them during field visits. Data collection in the districts took place between August and October 2022. KIIs continued into the first quarter of 2023.

Interview and focus group guides were translated by the in-country teams and piloted in a site that had not been selected for the study. All interviews and focus groups were audio recorded, translated (if they were not in English) and transcribed.

DATA ANALYSIS

All interviews and FGDs were uploaded into the latest NVivo software and coded, using a generic coding framework to enable cross-country analysis. The study took a thematic approach to data analysis, as laid out by Braun and Clarke (2008). Based on a combination of study specific objectives and interview questions, the first of broad codes were created, after which a number of interview and FGD transcripts were provisionally coded to pilot and assess the stability of the coding framework. The next step was to adjust existing codes, where necessary, and create new codes, either as main codes or as sub-codes, based on emerging themes in the data. After coding, further analysis was conducted to deepen understanding of the data, and identify and query any diverting patterns between the different data sources.

Ethical Approval

The study was granted ethical clearance by the University of KwaZulu-Natal (BREC/00003894/2022), the University of Zambia (HSSREC-2022-APR-024), the National Commission for Science and Technology in Malawi (NCST/RTT/2/6), the Ministry of Health in Lesotho (ID 51-2022), the Medical Research Council in Zimbabwe (MRCZ/A/2906) and from The AIDS support Organization Uganda (TASO-2022-138). Written informed consent was sought from all study participants.

UNFPA Uganda

Results

Socio-demographic characteristics

Table 4 highlights the socio-demographic characteristics of the sample. The median age for the sample was 25 years (interquartile range: 21 to 29 years). The majority of the sample were aged between 18 and 26 years (59.1 per cent). Just over a third (33.6 per cent) of respondents had completed secondary education. Only a minority (15.1 per cent) of respondents have completed tertiary education. A very small minority (5.1 per cent) of people indicated they have a disability, while 15.6 per cent of men indicated they were too sick to participate in daily activities in the previous two weeks. Just less than one fifth (18.8 per cent) of the sample were currently attending school. Just under half (44.9 per cent) of all respondents indicated they had dropped out of school. Approximately half of the respondents did paid work in the past seven days and 31.2 per cent of all respondents had part time work. Nearly a third of all respondents have been away from home for more than one month in the previous 12 months during the past year. With regards to relationship status less than half (43.1 per cent) of all men were unmarried, but in a relationship and cohabiting with their partner and one fifth (20.8 per cent) of respondents were single. More than half of all respondents were recruited from the general community (55.3 per cent) in this study while the rest were recruited via an NGO. Nearly two thirds (65.3 per cent) of the sample were living in a rural district.

Table 4:

Socio-demographic variables for men from five countries, 2022

		Count	%
Median age (IQR)		1,021	25 (21–29)
Age categorized	18–26 years	603	59.1%
	27–35 years	418	40.9%
Highest qualification achieved	No schooling	17	1.7%
	Primary	178	17.5%
	Incomplete secondary	328	32.2%
	Secondary complete	343	33.6%
	Tertiary	154	15.1%
Does the person have a disability	Don't know	8	0.8%
	No	961	94.1%
	Yes	52	5.1%
In the last two weeks, been too sick to participate in daily activities	No	860	84.4%
	Yes	159	15.6%
Currently attending school	Missing	1	0.1%
	No	828	81.1%
	Yes	192	18.8%
Did respondent drop out of school	Still in school	193	18.9%
	No	370	36.2%
	Yes	458	44.9%
Is respondent currently undertaking a degree or diploma	No	941	92.2%
	Yes	80	7.8%
Did respondent do paid work in the last 7 days	No	516	50.5%
	Yes	505	49.5%
Is respondent part time or full time employed	Unemployed	516	50.5%
	Full time	186	18.2%
	Part time	319	31.2%
Length stayed in the community	1–5 years	225	22.0%
	Always	741	72.6%
	< 1 year	55	5.4%
In the past year been away from home for me than one month in the previous year	No	689	67.5%
	Refused	2	0.2%
	Yes	330	32.3%
Respondents current relationship status	Legally married and cohabiting	97	9.5%
	Separated/divorced/widowed	32	3.1%
	Unmarried, in relationship and cohabiting	86	8.4%
	Unmarried, in relationship and not cohabiting	440	43.1%
	Single	212	20.8%
	Traditionally married and cohabiting	153	15.0%
	Widowed	1	0.1%
Respondent recruited from the general community/NGO	Recruited from general community	555	55.3%
	Recruited from NGO	448	44.7%
Locality type	Urban	354	34.7%
	Rural	667	65.3%

Note: Percentages may not add up to 100 per cent due to rounding of decimals.

Social norms, psychosocial characteristics and behaviours

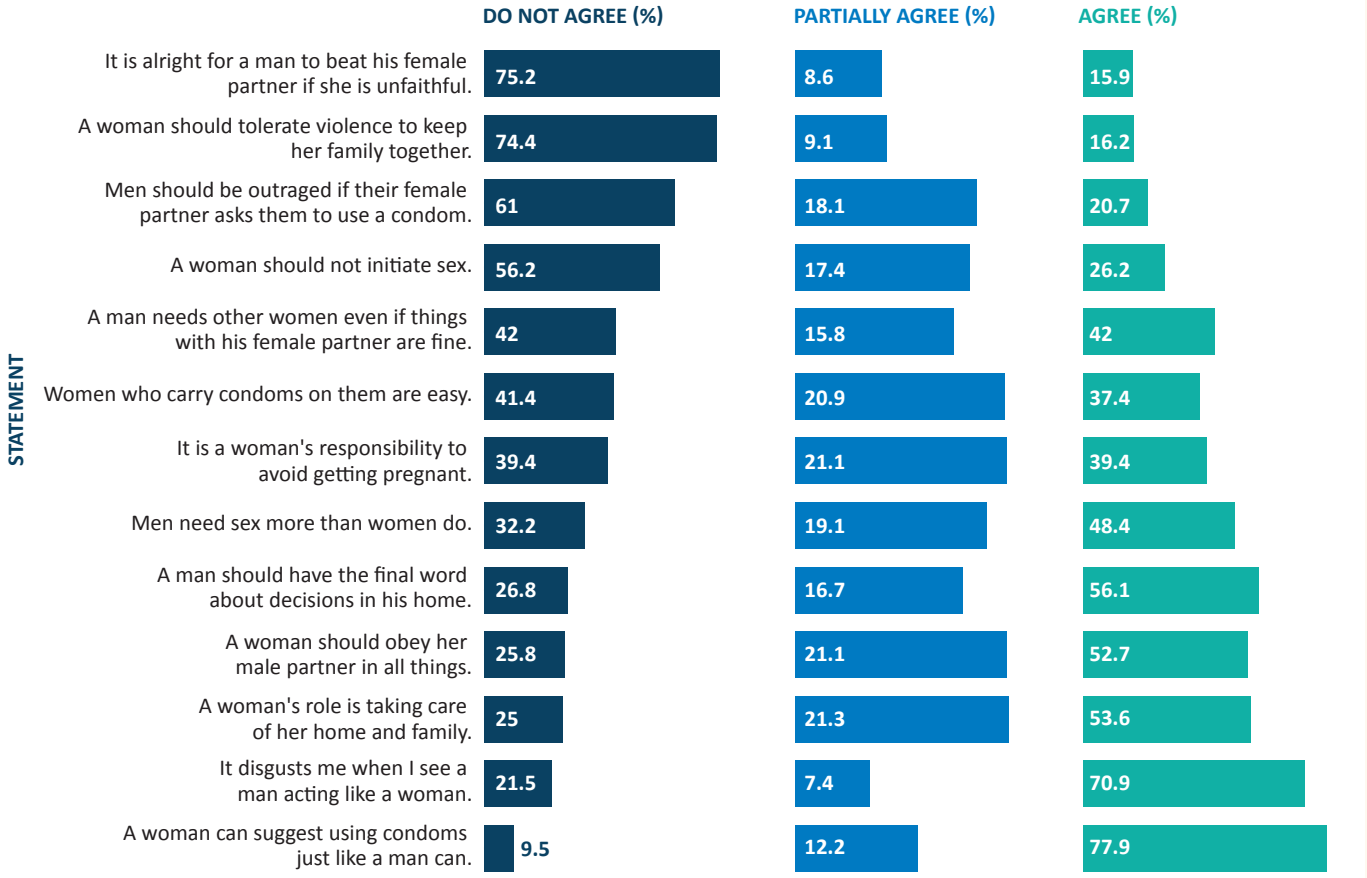
During the survey we asked respondents about their gender related attitudes using the gender equitable men's scale. Encouraging results were evident in the following trends. More than three quarters (75.2 per cent) of men do not agree that it is okay for men to beat their female partners if they are unfaithful (see Figure 2). Just less than three quarters (74.4 per cent) do not agree that women should tolerate violence to keep her family together. More than three quarters (77.9 per cent) respondents agree that women may suggest using condoms. It was of concern that the vast majority (70.9 per cent) of men agree that they are disgusted when they see a man acting like a woman. More than half (53.6 per cent) of respondents said a woman's role is taking care of her home and family, and almost 40 per cent indicated that it is a women's responsibility to avoid getting pregnant. The average score when all the items are summed together is 33 (range: 17–45)[5] and the median score was also 33. Those respondents who were recruited from an NGO during this study held more gender equitable attitudes (Mean=33.4 vs. 32.4) than those recruited from the general community. Rural respondents had more equitable gender attitudes (Mean= 33.1 vs. 32.4) although this may just be a function of the skewness in sampling. Zambia had the highest gender equitable attitudes score (Mean=35.6).

In a multi-country study (Brazil, Chile, Mexico, India, Bosnia and Herzegovina, Croatia, Democratic Republic of Congo, and Rwanda), the Democratic Republic of the Congo (DRC) found that 75.1 per cent of respondents agreed or partially agreed with the statement that men should have the final word about decisions in the home (Levtov et al., 2014). This is slightly higher than in this study which found 72.8 per cent of respondents agreed or partially agreed with the same statement. Rwanda found that 65.9 per cent agreed with the same statement, which is slightly lower than our statement (Levtov et al., 2014). These proportions are all much higher than the percentage of men that agreed or partially agreed (20.2 per cent) to the statement in Croatia (Levtov et al., 2014). In Rwanda and DRC, 53.6 per cent and 65.0 per cent, respectively agree or partially agree that a woman should tolerate violence to keep her family together (Levtov et al., 2014). This is much higher than the 25.3 per cent in our study, although the same question in Croatia only saw 5.5 per cent of men agreeing or partially agreeing with the statement (Levtov et al., 2014). Finally, 49.4 per cent and 61.0 per cent of men in Rwanda and DRC respectively, agree or partially agree that it is a women's responsibility to avoid getting pregnant (Levtov et al., 2014). In our study 60.5 per cent of adolescent boys and young men agreed or partially agreed with this statement. In Croatia only 15.3 per cent of men agreed or partially agreed with this statement (Levtov et al., 2014). Our study results fair a bit better than some findings in other African countries, however gender equitable norms seem to be more prevalent in Croatia as compared to other countries cited above.

[5] A higher score means more equitable attitudes.

Figure 2:

Gender attitudes of men in all five countries, 2022



Notes: Percentages do not add up to 100 per cent as there was missing data for all indicators the highest number for each indicator was five missing responses. The number of responses for each indicator vary from 1,016 to 1,021. All figures refer to a percentage.

During FGDs with adolescent boys and young men we asked them about sexual and gender scripts in their communities.

> "The expectation is that you should behave and not play around with girls, so you hide yourself when you want to have sex. What will people say if they catch you? Adults may kill you if they catch you doing it!"
>
> Lesotho, FGD2, participant 1

Discussions with participants gave insights into the, often contradictory, scripts around male sexual behaviour and masculinity. For example, boys and young men were the recipients of abstinence-only messages from key figures in the community, such as teachers, religious and community leaders, while at the same time being encouraged not to waste any time when dating girls for sex from some of the older men in the community, as two Zambian participants aptly described:

> "Older people experienced a lot in life, even when someone is telling a story which is abusive like when we were young "tenzo pwanya Nini" (we used to have a lot of sex us) not like you young boys "musobelesa" (you young boys play or waste these opportunities) and when I hear that it is like motivation to me that that's how to live."
>
> Zambia FGD2, participant 4

> "I would say from my own experience, it was kind of a mixed environment. Firstly, we had people that preached morality and secondly, we had people that preached the notion that a man should be a man. These believed that a man can do anything in terms of having sex and can have multiple sexual partners (..). In the local language they say "Ubuchende Bwa Mwaume, tabu toba Ing'anda" (the promiscuity or cheating of a man does not destroy a home). I also had that kind of learning environment such that I knew that whichever girl I would see or date, I imagined I cannot be restrained in society as a man. This is because of gender imbalances that exist or are there in our society. In terms of sexuality, a man was given more control over the sexuality of a woman than a woman had control over her own sexuality. That's the kind of environment I grew up in."
>
> Zambia, FGD3, participant 3

The pressure on 'performance' did not only come from male peers (same age and older), but according to the participants, girls also expected them to move beyond flirtations and initiate sex.

> "You know with some of them, the moment you fail to get into her pants, she gets the chance to dump you first. She will have doubts and will think long and hard about whether it is worth dating you."
>
> Zimbabwe, FGD2, participant 2

Whilst participants said they were expected to show they were 'man enough', they were also told to exhibit a degree of self-control and male intelligibility, at least until a certain age, to not get a girl pregnant. In this, the scripted dominance of men in sexual/relational matters assigned both power and responsibility to the study participants, whereby the male condom was of central importance. They said they were expected to acquire, carry, initiate and use such protection at all times. However, a combination of individual and social drivers (for example, preference for condomless sex; difficulties to persuade the girl; condom use within steady relationships/marriage not being the norm; pressure to prove manhood and linked fertility) made it possible to divert from this script and – in the words of the participants – 'get into trouble'. If trouble included a pregnancy, male responsibility was not necessarily a given. Some participants said one could still evade his responsibility by denying involvement with the girl or suggesting there is likely to be more than one potential father.

> "There is a lot of gonorrhoea in this community. The only way to survive it is to use condoms while having sex. The good thing, government health facilities and Mildmay (an NGO) provide free condoms. But reality should be said, men here don't want to use condoms."
>
> Uganda, FGD5, participant 5

Single-sided control over the timing of sex, and the possibility of using coercion, was not perceived as acceptable male behaviour.

Boys or men in the community who did not conform to the 'heterosexual script', either by having a same-sex sexual relationship or through a trans or gender fluid identity, solicited contemptuous reactions in FGDs.

> "This has always been unacceptable, there are so many women out there, but you still see someone being homosexual. We will never tolerate that, no matter what."
>
> Zimbabwe, FGD3, unspecified participant

> "On the issue of homosexuality, the church priests are totally against it. It is satanic and we should never engage in homosexual behaviours."
>
> Uganda, FGD4, participant 5

In Lesotho, participants' responses also included threats of physical violence if they would meet these people in the street. Different participants from across the five countries indicated the topic of sexual diversity had not been part of the school-based or community-based sex education they had attended, and often referred to religious discourse to explain their own and/or the communal stance.

During the survey we asked respondents about the sexual risk behaviours they engage in with their partners. Similar to the FGDs, high levels of sexual risk were evident. Table 5 highlights that more than three quarters (77.7 per cent) of respondents have engaged in sexual activity. The median age at sexual debut was 17 years. A study that collated data for Southern Africa indicated that the median age at sexual debut in the region is over 18 years

(Nguyen & Eaton, 2022). The median number of sexual partners over the participants lifetime was five partners. In a study in South Africa, the median number was three for men aged 15 to 49 years, which is a lower median than in our study (Kharsany et al., 2018). Only 30.4 per cent of sexually active respondents used condoms consistently in the previous 12 months. A different study showed that in Zambia, 40.5 per cent used condoms consistently and consistent condom use was higher in Namibia (69.9 per cent), Tanzania (49.5 per cent) and Eswatini (54.9 per cent) than among this sample of adolescent boys and young men (Reynolds, Luseno, & Speizer, 2013). A small minority (14.9 per cent) of respondents felt using a condom would be an insult to their partner and less than half (43.4 per cent) of all respondents agreed that they do not enjoy sex with a condom. Of concern, approximately one fifth (19.9 per cent) of respondents indicated they have had a sore or ulcer or warts in their genital area previously. Approximately one in ten (9.9 per cent) respondents who have tested for HIV indicated they are HIV positive. This is slightly higher than in most of the countries bar Lesotho (see HIV prevalence in Table 1). The majority (61.4 per cent) of men were circumcised in this study. Just over a quarter (26.4 per cent) of respondents knew the HIV status of all their sexual partners.

Table 5:

Sexual risk for all men in five countries, 2022

		%
Have you ever had sex that is vaginal, oral or anal?	No	**21.2%**
	Refused	**1.2%**
	Yes	**77.7%**
Median age at sexual debut (IQR)		**17 (16–19)**
Median number of sex partners (IQR)		**5 (3–11)**
How often used condoms in previous 12 months with sex partners.	Always	**30.4%**
	Sometimes	**57.1%**
	Never	**12.5%**
Using a condom seems like an insult to my partner.	Agree	**14.9%**
	Not sure	**14.3%**
	Disagree	**70.8%**
I don't enjoy sex with a condom.	Agree	**43.4%**
	Disagree	**45.6%**
	Not sure	**11.0%**
Ever had any sores/ulcers/warts in the genital area.	Don't know	**1.0%**
	No	**78.8%**
	Refused	**0.3%**
	Yes	**19.9%**
HIV status (self-reported).	HIV negative	**89.3%**
	HIV positive	**9.9%**
	Indeterminate	**0.3%**
	Refused	**0.4%**
Are you circumcised.	Don't know	**0.1%**
	No	**38.5%**
	Yes	**61.4%**
Did you know the HIV status of all your sex partner?	Don't know	**4.4%**
	No	**69.2%**
	Yes	**26.4%**

Notes: Percentages may not add up to 100 per cent due to rounding of decimals.

We disaggregated the data for the above variables by whether they were recruited from an NGO or the community, age of respondent (18 to 26 years vs. 27 to 35 years), urban or rural locality and by country (results shown in appendix, table 7 - 10). Below are some of the significant results from the disaggregation. Not surprisingly older respondents (aged 27 to 35 years) were more likely to have ever had sex (82.8 per cent vs. 74.1 per cent); were older at sexual debut (Median=18 years vs. 17 years); had on average a greater number of sex partners in their lifetime (Median=13 vs. 7); and were less likely to use condoms consistently (always used condom: 17.2 per cent vs. 27.9 per cent). Rural respondents have fewer sexual partners (Median=8 vs. 12) and were less likely to never use condoms (10.1 per cent vs. 17.4 per cent). Zambia had the highest consistent condom use rates (31.2 per cent). Uganda has the highest level of sexual activity (94.6 per cent); lowest level of consistent condom use (11.8 per cent) and highest HIV prevalence (30.6 per cent). Lesotho respondents on average were the youngest at sexual debut (Median=16 years); on average had the highest number of sex partners (Mean=18 years); and lowest consistent condom use (13.4 per cent).

STIGMA, DEPRESSION AND IPV

We asked respondents about their experience of stigma, depression and IPV. More than three quarters (75.9 per cent) of respondents indicated that they think most people are supported by their families when they disclose their HIV status Table 6. Nearly a third (29.2 per cent) felt lonely sometimes during the past week and nearly a third (31.4 per cent) felt sad sometimes during the past week. Only 17.1 per cent of respondents indicated they felt hopeful about the future rarely in the previous week. The vast majority of respondents indicated they never physically forced their partner to have sex with them (82.8 per cent) or used threats or intimidation to get their partner to have sex (88.2 per cent) or forced their partners to do something sexual they did not want to do (85.5 per cent). In a South African study, 30.7 per cent of men said they had been physically violent towards their intimate partner more than once (Jewkes et al., 2011). Those respondents who were recruited from an NGO were more likely to present with depressive symptoms (Mean=2.3 vs. 2.5) than those from the general community. Rural respondents have fewer depressive symptoms than urban respondents (Mean=2.1 vs. 2.8). Zimbabwe had the highest level of depressive symptoms (Mean=2.9).

Table 6:

Stigma, depression and intimate partner violence for all men in five countries, 2022

			%
HIV stigma	Do you think most people with HIV/AIDS are supported by their families when they disclose their HIV status?	No	**24.1%**
		Yes	**75.9%**
Depressive symptoms	I felt sad (Please indicate how often you have felt this way during the past week).	Rarely < 1 day	**54.3%**
		Some of the time (1-2 days)	**31.4%**
		Occasionally (3-4 days)	**10.9%**
		All of the time (5-7 days)	**3.4%**
	I felt lonely (Please indicate how often you have felt this way during the past week).	Rarely < 1 day	**55.4%**
		Some of the time (1-2 days)	**29.2%**
		Occasionally (3-4 days)	**12.7%**
		All of the time (5-7 days)	**2.7%**
	I felt hopeful about the future (Please indicate how often you have felt this way during the past week).	Rarely < 1 day	**17.1%**
		Some of the time (1-2 days)	**15.1%**
		Occasionally (3-4 days)	**24.4%**
		All of the time (5-7 days)	**42.0%**
Intimate partner violence	In the last 12 months, how many times did you physically force your current or previous partner to have sex with you when they did not want to?	Never	**82.8%**
		Once	**6.7%**
		Few	**9.2%**
		Many	**1.4%**
	In the last 12 months, how many times did you use threats or intimidation to get your current or previous partner to have sex when they did not want to?	Never	**88.2%**
		Once	**5.3%**
		Few	**5.6%**
		Many	**0.9%**
	In the last 12 months, how many times did you force your current or previous partner to do something sexual that they did not want to do?	Never	**85.5%**
		Once	**5.3%**
		Few	**8.3%**
		Many	**0.9%**

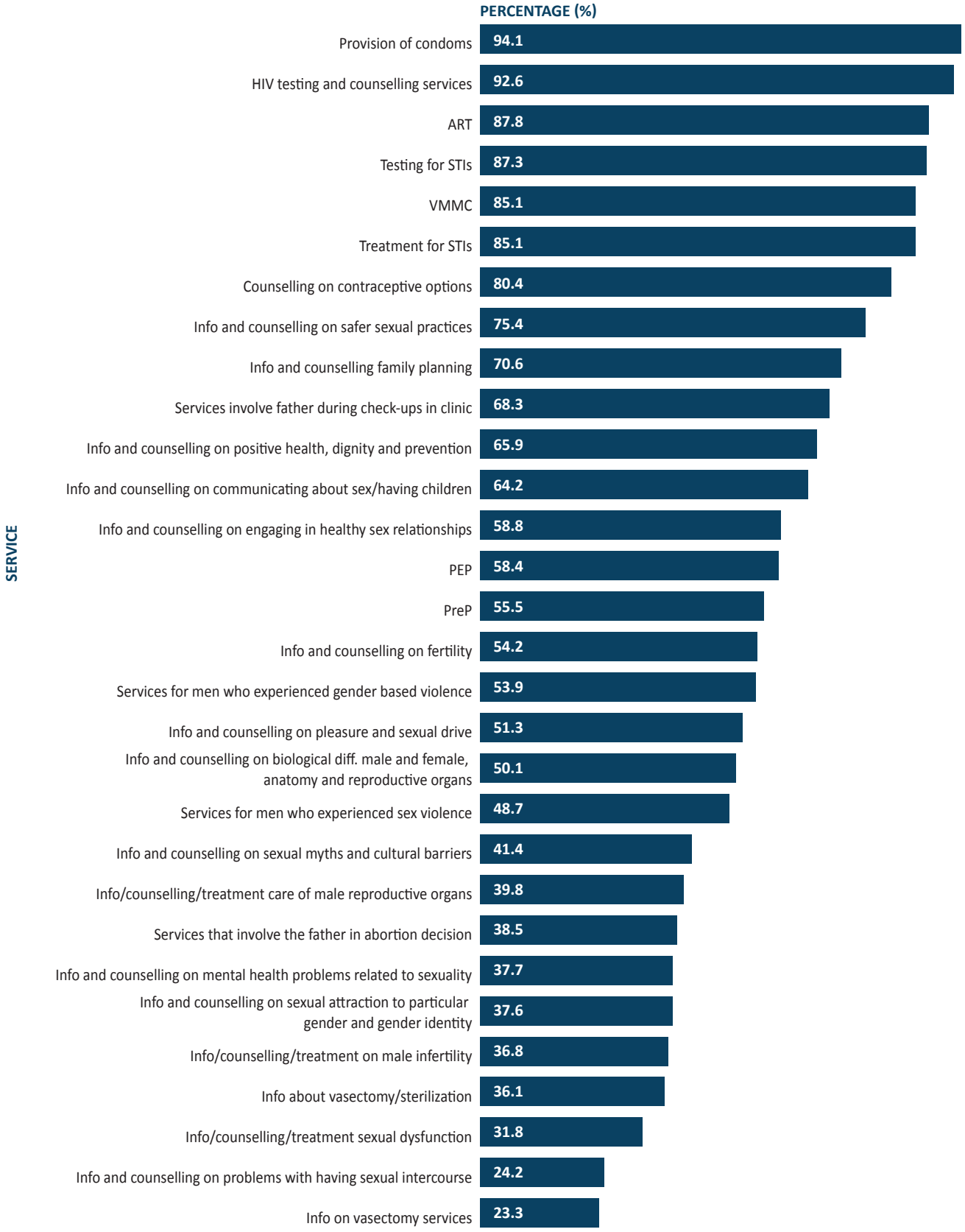
Sexual and reproductive health service needs and utilization

This section of the results will discuss SRH service needs, utilization and some of the barriers regarding service use. The first part presents the survey results, followed by an analysis of findings from FGDs and KIIs.

We asked respondents what SRHR services they believe are currently available in their community. The vast majority indicated that condoms (94.1 per cent) and HIV testing and counselling (92.6 per cent) were available in their community (Figure 3). Just over a third (37.7 per cent) of adolescent boys and young men indicated that access to information and counselling on mental health problems related to sexuality was available in their community. Just under half (48.7 per cent) of the adolescent boys and young men indicated that services relating to sexual violence are available in their community. Less than a quarter of respondents indicated that information and counselling regarding vasectomy services (23.2 per cent) and information and counselling on problems with sexual intercourse (24.2 per cent) were available in their community.

Figure 3:

Information, counselling, treatment and services that respondents indicated are available in their community for all five countries, 2022



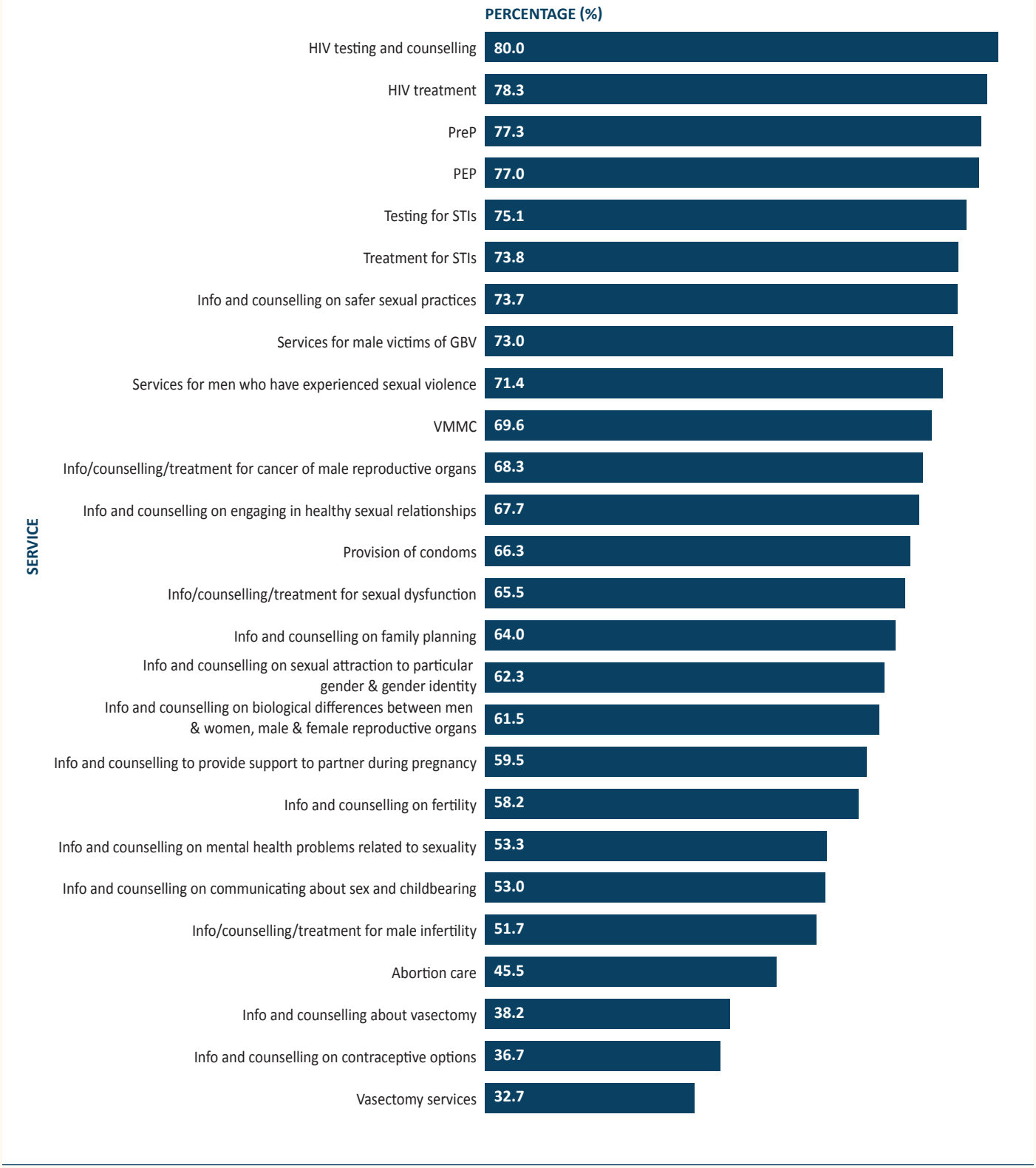
Those respondents who were recruited from an NGO during this study were more likely to indicate that antiretrovirals (ARVs) are available in their community (92.0 per cent vs. 84.0 per cent). All disaggregated data results shown in the appendix, tables 7 - 10. Respondents aged 27 to 35 years were more likely to indicate HIV testing services were available in their community (95.2 per cent vs. 90.7 per cent); were more likely to indicate ARV services are available in their community (92.8 per cent vs. 84.2 per cent); were more likely to indicate voluntary medical male circumcision (VMMC) services were available in their community (90.7 per cent vs. 81.3 per cent); and were more likely to say testing for STIs were available in their community (91.6 per cent vs. 84.2 per cent) than those aged 18 to 26 years.

Rural respondents were less likely to say HIV testing and counselling are available in their community (91.2 per cent vs. 95.2 per cent); were less likely to say antiretroviral therapy (ART) is available in their community (85.6 per cent vs. 91.8 per cent); were less likely to say VMMC is available in their community (81.1 per cent vs. 92.7 per cent); were less likely to say testing for STIs are available in their community (84.7 per cent vs. 92.1 per cent) than urban respondents in the study. Lesotho respondents had the lowest level of VMMC availability in their community (73.8 per cent) and lowest rates of testing for STIs available in their community (76.7 per cent). Ugandan respondents had very high levels of access to HIV testing and counselling services (99.5 per cent).

Figure 4 highlights the services respondents want available in one place in their community. The vast majority wanted HIV testing and counselling (80.0 per cent) and HIV treatment (78.3 per cent). Just under three quarters of men want services for men who have experienced GBV and sexual violence (73 per cent and 71.4 per cent). Less than half (45.5 per cent) want access to abortion care. Less than a third (32.7 per cent) want vasectomy services to be available in their community and just over a third (36.7 per cent) wanted information and counselling on contraceptive methods in their community.

Figure 4:

Services that men want available in one place in their communities for all five countries, 2022

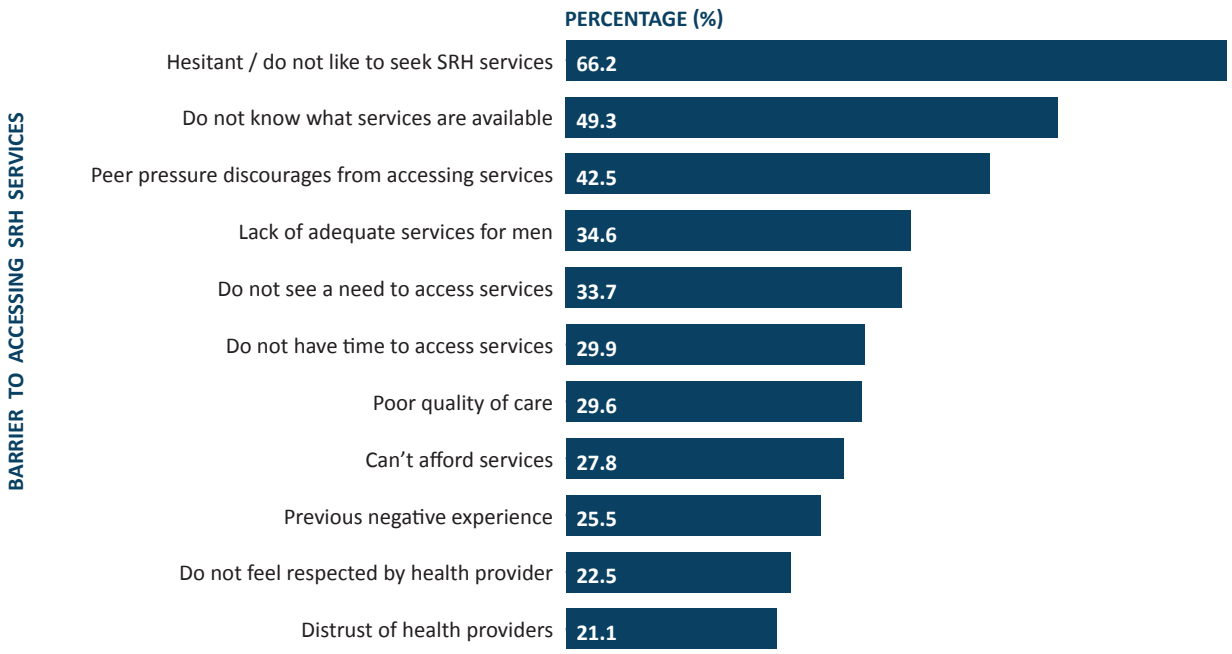


Those respondents who were recruited from an NGO during this study were more likely to want HIV testing available in the community (85.5 per cent vs. 75.1 per cent). These results are shown in appendix, table 7. Respondents aged 27 to 35 years were more likely to want HIV testing to be available in one place (84.7 per cent vs. 76.8 per cent); were more likely to want HIV treatment available in one place in their community (85.2 per cent vs. 73.5 per cent); were more likely to want pre-exposure prophylaxis (PrEP) in their community (81.6 per cent vs. 74.3 per cent); were more likely to want post-exposure prophylaxis (PEP) available in their community (81.8 per cent vs. 73.6 per cent); and were more likely to want testing for STIs to be available to them (79.9 per cent vs. 71.8 per cent). Uganda had a very high proportion that wanted PrEP available (97.0 per cent) in their community. Malawi had the lowest proportion that wanted HIV testing and counselling available (50.0 per cent), the lowest proportion that wanted HIV treatment available (56.1 per cent) and the lowest proportion that wanted testing for STIs available in their community (50.9 per cent) when compared to other countries (see Table 9 in Appendices).

We asked respondents about the biggest barriers to accessing SRH services. Two-thirds (66.2 per cent) indicated they are hesitant to seek SRH services (Figure 5). Nearly half (49.3 per cent) indicated that they do not know what services are available and 42.5 per cent indicated that peer pressure discourages them from accessing services. Just under a third of respondents indicate they do not have time (29.9 per cent) and cannot afford (27.8 per cent) health-care services. Just over one fifth (21.1 per cent) of respondents indicated they distrust health-care providers.

Figure 5:

Biggest barriers to accessing sexual and reproductive health

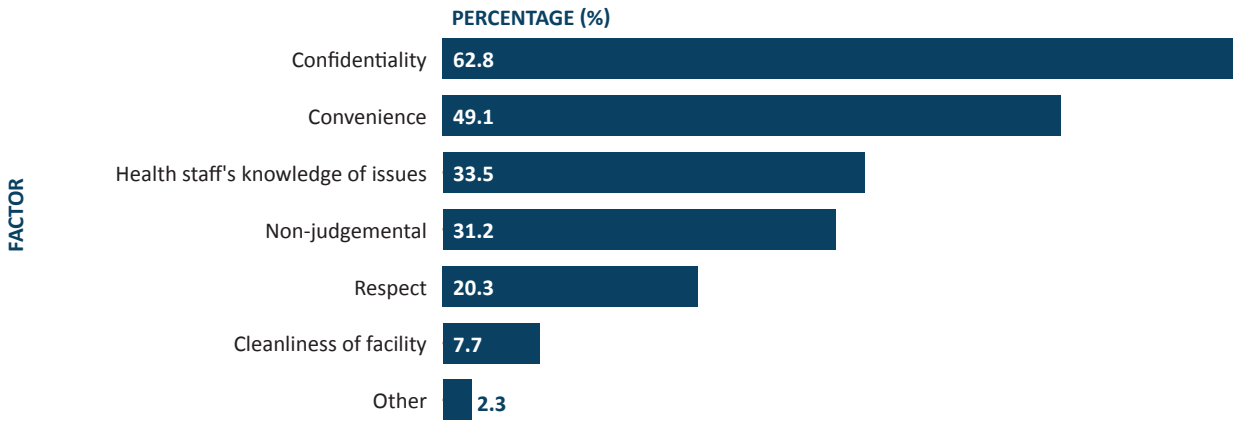


We disaggregated the biggest barriers for respondents to accessing SRH by the location they reside in (results shown in the appendix, table 9). Urban respondents were more likely to indicate that they could not afford SRH services (43.2 per cent vs. 19.6 per cent) and that poor quality of care was a barrier to them accessing services than rural respondents (33.6 per cent vs. 27.4 per cent). Rural respondents are more likely to indicate that peer pressure discourages them from accessing care (46.5 per cent vs. 35.0 per cent). Respondents recruited from an NGO during this study were more likely to indicate that there is a lack of adequate services for men and boys in their community (38.2 per cent vs. 32.1 per cent) and the quality of care is poor (34.2 per cent vs. 26.1 per cent) than respondents recruited from the general community. Respondents aged 27 to 35 years were more likely to indicate that they did not know which services were available (54.8 per cent vs. 45.4 per cent); did not have time to access services (34 per cent vs. 27.0 per cent); a lack of adequate services for men and boys in their community (38.8 per cent vs. 31.7 per cent); and poor quality of care (34.9 per cent vs. 25.9 per cent) as barriers to accessing SRH services than those aged 18 to 26 years in our study.

We asked respondents what were the two most important aspects of SRH services. Nearly two thirds (62.8 per cent) of respondents indicated that confidentiality was very important to them (Figure 6). Nearly half (49.1 per cent) of respondents indicated that convenience was the most important aspect of SRH services for them. Just over one third (33.5 per cent) of respondents indicated that health staff's knowledge of issues is an important aspect of SRH services.

Figure 6:

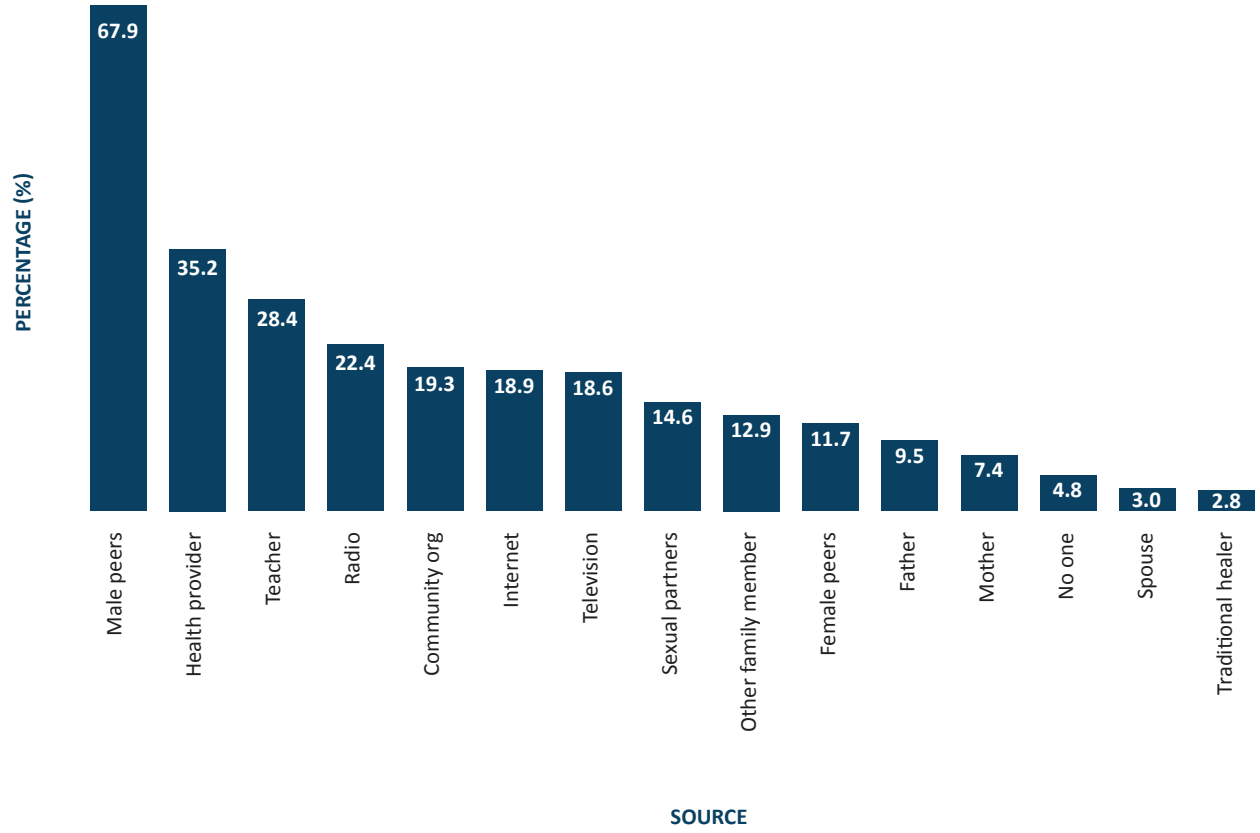
Two most important aspects of sexual and reproductive health services



We asked respondents about where they primarily get SRH knowledge from. The overwhelming majority (67.9 per cent) indicated they get SRH knowledge from their male peers (Figure 7). The second most common source of information (35.2 per cent) was from health providers. Just over a quarter (28.4 per cent) indicated they receive SRH knowledge from teachers.

Figure 7:

Where have primarily got information on sexual and reproductive health



Just less than half (49.6 per cent) of adolescent boys and young men have heard of prostate cancer and only 29.2 per cent have heard of human papillomavirus (HPV) (see Figure 8).

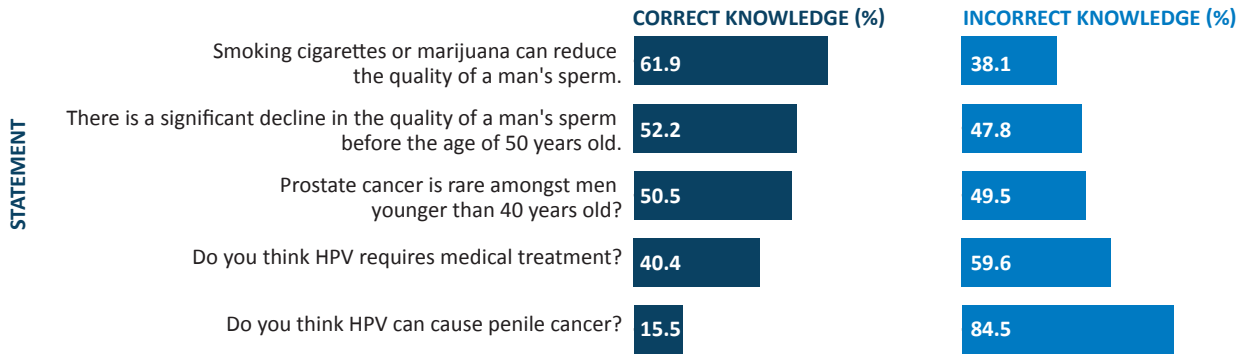
Figure 8:

Whether respondent has ever heard of the following sexual and reproductive health illnesses

Nearly two thirds of men correctly indicated that smoking cigarettes could reduce the quality of a man's sperm (see Figure 9). The vast majority (84.5 per cent) of adolescent boys and young men did not know that HPV can cause penile cancer. Only 40.4 per cent of adolescent boys and young men thought that HPV requires medical attention.

Figure 9:

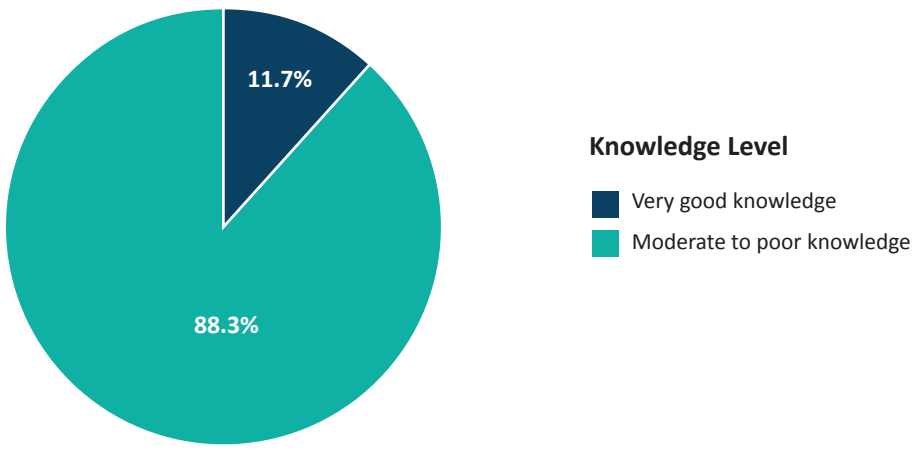
Respondents knowledge on popular sexual and reproductive health problems



The vast majority (88.3 per cent) of respondents had medium to poor knowledge (scored less than 4 out of 5 answers correct) regarding SRH (see Figure 10).

Figure 10:

Respondents overall score on knowledge items

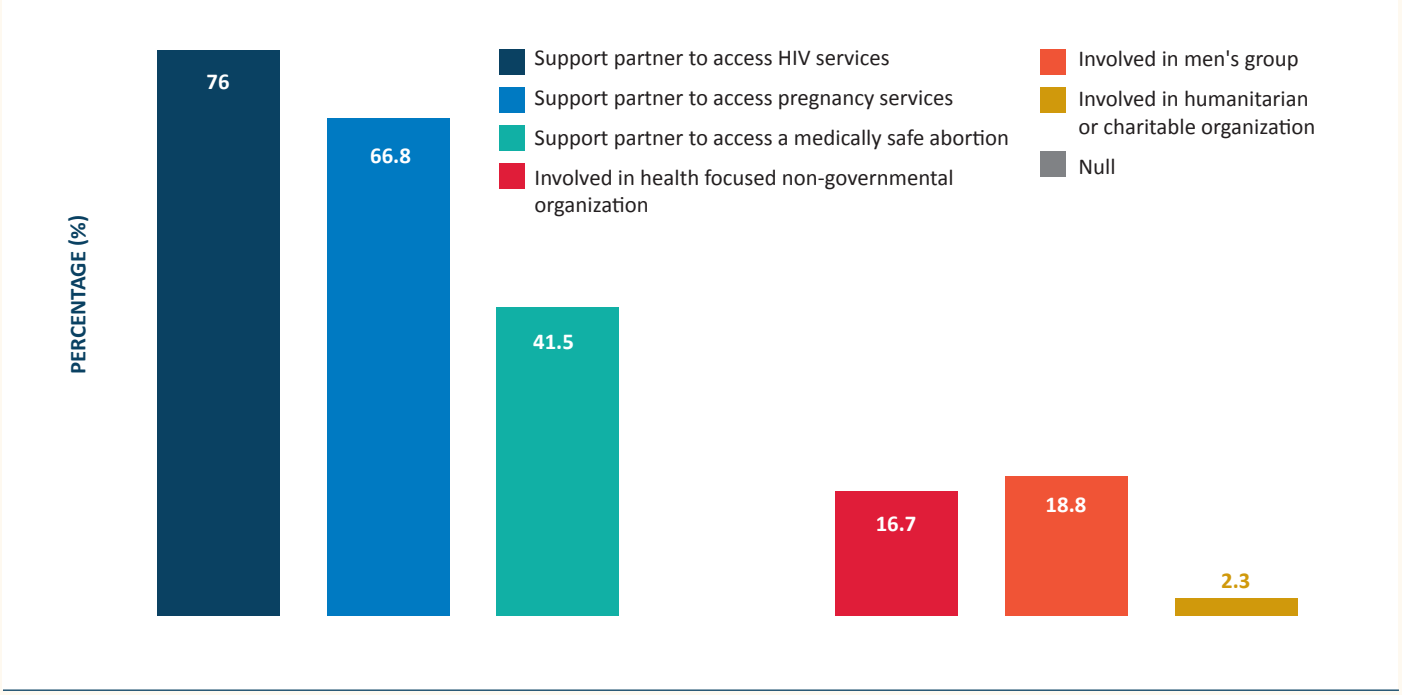


We also asked adolescent boys and young men about their role as a supporter of accessing SRH services of their partner. Approximately, three quarters (76.0 per cent) indicated they support their partner to access HIV services (see Figure 11). Two thirds indicated they will support their partners to access pregnancy services and 41.5 per cent said they would support their partner in accessing a medically safe abortion.

We asked men about their involvement in community organizations to assess their level of activism in their community. Approximately 16.7 per cent were involved in health focused NGOs, 18.8 per cent were involved in men's groups and 2.3 per cent were involved in charitable organizations.

Figure 11:

Men as supporters of their partners and activists



Those respondents who were recruited from an NGO during this study were more likely to support their partner to access HIV services (77.0 per cent vs. 69.9 per cent); were more likely to support their partners to access pregnancy services (67.4 per cent vs. 60.5 per cent); were more likely to support their partner if they want to access a medically safe abortion (47.8 per cent vs. 36.2 per cent); were more likely to be involved in a health-focused NGO (22.6 per cent vs. 11.7 per cent); and were more likely to be involved in a church or religious organization (39.1 per cent vs. 32.6 per cent) than those respondents who were recruited from the general community for this study (see Table 6 in the Appendices). Respondents aged 27 to 35 years were more likely to support their partner to access HIV services (81.3 per cent vs. 67.2 per cent); were more likely to support their partner to access pregnancy services (80.9 per cent vs. 51.7 per cent); and were more likely to support their partners to access a medically safe abortion (80.9 per cent vs. 51.7 per cent) than respondents aged 18 to 26 years (see Table 7 in the Appendices). Rural respondents were less likely to be involved in humanitarian or charitable organizations (1.5 per cent vs. 3.7 per cent) than their urban counterparts (see Table 8 in the Appendices). Zimbabwe had the highest level of involvement in health-related NGO (26.1 per cent) and respondents were very likely to be involved in church organizations (58.3 per cent) than other countries in the study. In Zambia, respondents were very likely to be involved in church organization (54.0 per cent). Ugandan adolescent boys and young men were very likely to assist their partner with a medically safe abortion (66.5 per cent) when compared to other countries.

ACCESS TO QUALITY SRH INFORMATION

A common finding across the five countries was the struggle, particularly, among adolescent boys to gain access to quality and timely information. This was corroborated by the poor levels of SRH knowledge in the survey findings. In several FGDs, participants described an initiation into sexual activities at a young age (approximately 10 years), without or having very scant knowledge of the male and female reproductive system when this occurred. Experimentation with girls or other boys in the veld, or overhearing sex in shared accommodation with parents or older siblings often constituted their first encounter with human sexuality. In the child-parent relationship, sexuality was rarely discussed. The FGDs pointed at the bi-directional nature of silence, in which participants were both fearful and embarrassed to ask their parents questions, and parents would not raise the subject on their own initiative. While the reliance on traditional customs for knowledge transfer, in the form of elders and initiation rites, did emerge from the data, it did not appear to play a central role in the sex education of the boys and young men participating in the study. Peers and school featured most prominently as sources of information. This was the case in the survey data as well. In Malawi, a number of participants indicated the only information they had ever received was through friends, and also in Lesotho, where initiation schools continue to form an important part of social life, friends were mentioned by participants as the prime source of information.

> "We have never been taught. All these things are news to us, in fact aspects to do with how you can have sex with your wife or girlfriend, even to negotiate sex, no one has taught us. They are taboo in the community. Most of us know them from friends."
>
> Malawi, FGD4, unspecified participant

None of the participants mentioned obtaining information from books, television or radio. Instead, the internet was highlighted as the most straightforward and accessible source of information for young people. Participants from several countries said they had learned the actual technicalities through watching porn on their cell phones.

> "I was taught from the things we watched. There were videos we would watch in relation to issues to do with sexual intercourse and that is where I first saw how it's done."
>
> Zimbabwe, FGD3, participant 5

A majority of participants recalled the school setting as the place where they had first received information about sexuality and the reproductive system, either in grade six or seven. In their recollection, lessons had revolved around the biology of conception and signs of sexual maturation in boys and girls, and expanded into the dangers of sexual intercourse in subsequent grades. Message frameworks for in-school youth most commonly included the abstinence before marriage (particularly in Uganda and Zambia) and the condomize for STI/HIV prevention instructions.

> "I first heard about it from school because when we reached Grade 6, we started studying about it. They also got us counsellors (health workers) to tell us so that we should not have sex because it leads to diseases, but also to having children who wouldn't be able to sustain themselves. That's what we were taught when they brought the counsellors."
>
> Uganda, FGD2, participant 4

Experiential learning was an emerging theme in the FGDs, but not from a life skills viewpoint. In fact, the life skills component in school-based sex education seemed to have been very minimal, with just one group of focus group participants from Lesotho and one from Malawi alluding to an exchange on gender roles in the classroom. Early pregnancy, and the linked responsibility for the boy served as a serious warning in adolescence. Participants shared stories of older brothers who had impressed on them to 'wait' and not suffer the same fate as them, and one of the Ugandan participants who had been sentenced to prison for impregnating a minor now advises his male peers.

> "In our youth group, for me when I see my friend who is about to get into sexual problems, such as a possibility of impregnating girls, I always give an advice. This is because me I am a culprit. I impregnated a girl when I was 16 years old. I was taken to prison because of impregnating a girl who was 15 years old, and my education ended there. Currently, I am 19 years, but when I see my friends who are involved in sexual relationships that I think are not right, I advise them accordingly."
>
> Uganda, FGD2, participant 3

As we recruited both enrolled and non-enrolled participants of (male-oriented) SRH programmes, we evidently came across examples of out-of-school teaching in the study sites, but also observed that such interventions were not widely made available. Within these programmes, there seemed to be considerably more attention for the transfer of skills and group processes. In Malawi, a number of enrolled participants noted that, while there was a focus on girls before, this has been changing with the introduction of male champions, and mixed youth clubs where girls and boys come together to discuss SRHR. Non-enrolled participants pointed at the absence, or otherwise irregular frequency, of community talks – often at the initiative of external organizations – on SRH-related topics for the youth, and an overemphasis on girls in community interventions on SRH (such as in the HIV-based DREAMS – Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe – initiative in Zambia).

> "Me, I have never seen any such programmes here in this village, no one talks to us the young men."
>
> Uganda, FGD5, participant 5

> "In our community most services are directed to girls and women because they are more vulnerable, while for boys, they are being told that they don't need any services and hence the result is that men have no services and end up being junkies and drug addicts. This is because of little or no interventions for the boys and young men. There is need for programmes for men too on sexual and reproductive health, unlike women only."
>
> Zambia, FGD 1, participant 4

There was a low-ranking for health workers, pharmacists and community SRH outreach as sources of information. While the expertise of these people was duly acknowledged by the participants, an interaction only seemed to be contemplated if there were underlying health problems. In none of the FGDs, participants reported having paid a visit as clients to a clinic or pharmacy to obtain general information or counselling.

DIFFERENTIAL SRH NEEDS

Participants charted out different SRH needs and behaviours along the male life course. Before the age of 14 years, according to most participants, sexual activity is still mostly confined to fondling and kissing, and there is a general shyness to approach peers or older men for information. Once sexual urges start to increase and the experience with girls transitions into sexual intercourse, the need for SRH services and information rises rapidly, and there is no longer a taboo among peers to discuss sex or ask older men in the community for advice.

> "When I was 14, I knew about sex but never had experience, so you find even as I grew up my needs grew. Because I was working and doing other things you can pick any girl you want at the level I'm at now. Such services of condoms are needed more because I know I can have sex anytime such as condoms, PrEP, PEP. It's actually very possible for me to just make a call then go have sex just now. So, in short our needs are higher now than before."
>
> Zambia, FGD1, participant 4

It also reportedly becomes easier to visit a health facility, in part because parental consent is no longer required, and having a condom in your pocket is no longer viewed as problematic. However, young adults may still not as easily identify and act on an SRH-related problem as older adults do.

> "Also, the young men first become very sick before they seek health care. In contrast, the married older man will be anxious to receive care, because he knows that maybe the wife may get the disease if he doesn't treat himself. So, you even fear your wife to know that you have any infection. Even if it is an STI like gonorrhoea, an older man will go for a check-up and treatment very fast than the young man."
>
> Uganda, FGD5, participant 5

There was a perception that older men have access to sex all the time, as they enjoy it as a marital privilege and have economic autonomy to buy sex elsewhere. With age, fertility needs may arise and sexual satisfaction, more than just the experience of sex, also becomes important, according to participants.

> "For us, our 'side dishes' are not for sure because they need a lot money. Yet the grown-up men have the money, so we youth can't have many girlfriends, because we don't have the money. I can have only one who I can sustain and that's how grown-up men differ from us because they have enough money to get as many girls as they need."
>
> Uganda, FGD2, participant 2

> "There is a difference. At age of 34, I have a vast experience. I have walked a journey and I have experience. In fact, I have slept with different girls from different walks of life. Unlike a boy of 15 years, I know what my needs are."
>
> Lesotho, FGD5, participant 5

After fifty years of age, SRH needs emerge which are not considered a concern for young men.

> "When a man reaches around 50 years old and above, sexual power reduces, yet he still has desire for sex. Such older men may need drugs such as Viagra to boost their sexual arousal. But for us we are still sexually strong, we may not need Viagra. But also, I heard that older men have a higher chance of cancer of sexual organs, but am not sure about which cancer. Therefore, they may need to be screened for such cancers compared to the younger men who have less risk."
>
> Uganda, FGD4, participant 3

UNFPA/ESARO

There was a consensus in the FGDs that age was a critical factor in understanding and acting on one's SRH needs. A considerable number of participants said they had wished to have known earlier what to do and where to go for support. Naivety was also said to lead some 15- to 18-year-olds into the hands of older women, so called sugar mummies (a recurrent topic in FGDs in Uganda), or take considerable risks with sex workers (a recurrent topic in Zimbabwe). The stories below illustrate the different layers of vulnerability that then come into play.

> "As a teenager, I got one challenge. I was sleeping with older women, that age really disturbed me. These women would pretend that they were teaching me how to make love, I realized later that they were using me to satisfy their sexual needs. (..) The only problem I didn't get any information, advising me on what I was doing but when I found out that it was problematic, I was heartbroken and I couldn't confide in anyone about who was breaking my heart because even if I did, it would be like I am dating someone of my mother's age, so I got confused."

> "As young boys and ghetto youths, nowadays there is the use of phones you can just go to the barbershop or anywhere else and ask you to download pornographic content for you. Once it has been loaded for you as young boys you can all just gather around with your peers and watch together. Afterwards if some of you have hustled for a few dollars you can then go by the TouchLine (hot spot) and look for a sex worker and ask them to give you a sample of what you would have watched from the pornographic video. The sex workers will then ask you how much you have, and the moment you tell them you have one dollar or two they will agree and go with you. Judging from your age, they can tell that you are HIV negative, they will then proceed to seduce you in foreplay and get you to have an erect penis. Once you have an erection, the sex worker will ask you to get on with it without using protection and with you being excited you will not even think about putting on a condom, you will end up just indulging in unprotected sex. You may end up getting sick maybe with STIs that show physical symptoms, and for you to tell your mother that you have an STI, it is very difficult. You can confide in a friend from your peers and tell them that you are producing discharge from your penis, and because they know nothing about it, they will laugh at you and even spread the word. In the end you will be troubled without having anyone to talk to, and the condition may even worsen because of fear to speak out. This is what most young people are going through."

Zimbabwe, FGD3, participant 2

ENABLERS AND BARRIERS IN MALE HEALTH-SEEKING BEHAVIOURS

Provider friendliness and expertise on SRH were highly appreciated and made FGD participants return to the same facility. The younger participants especially needed to know they would be welcomed and receive confidential care, as it required considerable courage to discuss their sexual health, as well as undertake the visit without the knowledge of parents or the possibility someone might notify their parents. While there were participants in each of the countries with a positive experience, there was a larger group of participants in each who had previously had one or more negative encounters with health staff on sexual and reproductive, as well as broader health issues at a public health facility. Participants from Zambia, for example, indicated that health staff had threatened to inform their parents or had turned to them with biblical instead of medical advice. There were participants who had prematurely left a facility, as receptionists or health staff had already been rude to them upon entry. Judgemental remarks while approaching the box of free condoms or undergoing treatment was also a common reason for participants to not return to the same facility or to avoid public services all together. Private health facilities and pharmacies, and to a lesser extent traditional medicine, were perceived to be much more responsive to their need for privacy, 'a not-too-many-questions asked' approach, and had shorter waiting times. However, difficulties to afford private service fees would compel most participants to rely on a chemist for over-the-counter treatment or, if available, self-testing kits. Among the Ugandan participants, there were multiple complaints about under the table payments in the public sector. Taking advantage of the client's urgency to obtain medical attention simultaneously fuelled a distrust in the health system, as the following participant narratives below illustrate. Some participants also

drew into question the reliability of test results and the efficacy of drugs provided in the Ugandan public sector. This level of distrust was not exhibited during FGDs in other countries.

> "Government health workers are harsh on us, most especially if you have STIs. They may tell you to pay for lab tests and medications, yet services are supposed to be for free. One day a male health worker, told that my urine needed to be checked for gonorrhoea. However, he added that I had to pay the lab and treatment fees, because I contracted the disease during my sexual enjoyments. This statement was painful. Imagine, I was having painful urination and pus discharge from my penis. I didn't have the money with me, but I had to go back, and my friend lent me some 10,000 shillings (approx. 3 USD). When I gave it to the health worker, he worked on me thoroughly, well including lab testing and medications. I got cured."
>
> Uganda, FGD3, participant 3

> "One day I had sex with an HIV-positive girl, I realized in the morning that the girl was HIV-positive. We went to test for HIV together at the government health facility. Can you imagine the health worker, whom I will not mention the name, asked me to give him 100,000 Ugandan shillings to give me PEP? For sure, I didn't have money with me. But what I did was to go back home and sold off my goat to get the money. When I brought the money, he gave me PEP. You know I had no option I had to look for the money, HIV has no cure. Now my major challenge is, are those PEP drugs for buying or free from government health facilities? If they are for buying as the health worker told me, then the poor people will never access PEP."
>
> Uganda, FGD4, participant 7

The observed large reliance by boys and young men on the 'cash and carry' method in local drug stores across all five study countries does imply that client consultation and assessment are compressed, and important information around transmissibility, partner notification, use of drugs, preventive methods as well as suggestions for additional screening may be missed.

> "Right now, things are available in the community, you just buy in the chemists. If she feels like she is pregnant you buy a self-pregnancy test, she has a headache you buy pain killers and if you want to know your HIV status, there is that one they brought, which is like a toothbrush you just buy and go test at home."
>
> Zambia FGD2, participant 2

> "Drugstores of nowadays are different from those in the past. In the past, some things were not common and it was a taboo to sell a young person condoms and nowadays they are common even if a young person goes to buy condoms, they will just sell to you because it's business."
>
> Zambia FGD5, participant 5

The distance to a facility was mentioned as a barrier to seeking services by participants from Uganda, Lesotho, Malawi and Zimbabwe. In addition, facility stock-outs or measured quantities of free condoms (two per person) affected participants' ability to obtain the SRH commodities they were in need of.

> "As the youth, we receive counselling but what we struggle with in provision of services like contraceptives they aren't available. They are scarcely available and accessible. Others travel as far as Chintheche to get things like condoms."
>
> Malawi, FGD1, participant 1

Participants who were attached to an NGO-led SRH programme or clinic as peer educators felt fortunate with the low threshold services provided in their community.

> "We, from Nurture Africa are lucky that all the services at Nurture are free. You just go the clinic. So, it's easy for us to get your girlfriend and go to any counsellor, without any hardship. (..) even people from outside who need a counsellor, it's easy for them."
>
> Uganda, FGD2, participant 1

In the interviews with informants who provided clinical and non-clinical services, we could distinguish three approaches or practices which were said to attract men to service points. In Lesotho, the establishment of male corners was perceived as successful based on repeated client visits. Providers indicated that men felt comfortable in seeking health care at these corners. In Zambia, providers felt that the priority given to women who were accompanied by their spouse made an important contribution towards enabling men to be involved in antenatal care and making them feel part and parcel of the care trajectory. For Malawi, condom campaigns were viewed as a very successful approach to come into contact with men, and informants shared their experience of drawing large numbers of men to the site during such campaigns.

There was considerable overlap in the understanding of barriers in male health-seeking behaviours from the side of key informants and those voiced by adolescent boys and young men in the FGDs and survey. This included the lack of information about which services are available to them and where, and lack of adequate knowledge on SRH to prompt individual health seeking and advice/take advice from their partner(s). Gender role expectations also formed an important barrier in timely health-seeking among men. Many informants referred to a combination of the male bread winner role, and strong masculine role whereby health-seeking is regarded as too time consuming and 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

> "Men who like going to the health facilities too much, they say these ones are finished."
>
> Service provider A, Zambia

> "Our definition of masculinity is that the man will be pronounced dead once the intestines are out (a Shona proverb: kufa kwemurume kubuda hura), so men sort of push on before they go the facility to access all these services."
>
> Policymaker health, Zimbabwe

Privacy was another major barrier, both in cultural as well as in practical terms. In Lesotho, informants indicated that culturally men are not fond of speaking about their personal problems and have not been socialized to talk about sex with strangers. In Zimbabwe, men fear exposure when turning to the clinic with a request for help and thus resort to traditional medicine, while informants from Zambia and Uganda emphasized the lack of a proper space for men to raise their issues or accept a physical exam (consultation rooms are small, with thin walls and no bed screen or curtain). Health worker attitudes, especially towards adolescent boys, and discomfort with female health workers negatively affected male health-seeking behaviour. In this context, the threshold for picking up free condoms from the clinic and being questioned or laughed at for this action was already said to pose a formidable barrier for some adolescent boys and young men. In the civil society-led Play it Forward Programme in Zambia, programme managers said they had encountered boys who had let their STI advance too far as they did not want to be examined by a female health worker. Also, in Uganda and Lesotho, the probability of being attended by a female health worker emerged as something problematic for male clients. It was one of the reasons to establish 'male corners' with male-only staff, and pioneer this service in selected health facilities in Lesotho.

"Another reason mentioned (by men) was that some of the staff members are not friendly, some are females, very young and that they are embarrassed to tell them their problems. They further mentioned that female health workers do not understand their language, men's language, such as "lithipa li hana ho seha" (impotence). They mentioned that it becomes difficult to explain to a female what that is."

Service provider B, Lesotho

In Malawi and Zambia, informants indicated that men preferred services, which were distinct from women's health programmes or services, but that these are currently not available to them. At the same time, men are also seen to maintain a distance between themselves and the health service, even if it was made more easily available. An example from one of the informants to illustrate this point pertained to door-to-door health campaigns, whereby men tend to push their wives to the door who then get first-hand information. On a more practical level, men were said to shun the health facility for financial reasons. This issue emerged particularly from KIIs in Uganda and Zimbabwe, where clients need to pay for extra checks, and medical supplies, like IV fluids, and where persistent drug shortages in government facilities generally dissuade men to see these facilities as their first port of call. In Malawi and Zambia, the costs of transport to the clinic were said to be a barrier.

Views on male involvement

Across the five countries, there was an understanding among participants of the importance of male involvement in SRH matters. We found no strongly opposing beliefs or sentiments against this concept, and a majority of participants said they had experience with couple counselling and testing for HIV, and (in the older age group) with pregnancy-related services. Three important observations on the decision-making process to be(come) a supportive male partner emerged from the FGDs. First, the status of the sexual relationship played an important role in the contemplation of a joint health facility visit. Second, distrust of the sexual partner seemed to be a key driver in the motivation of participants to actively pursue such a visit. And third, participants were of the opinion that the initiative for male involvement resided with them, not with the female partner.

There was a reluctance, for various reasons, among participants to accompany girlfriends to a health facility. These included the risk of exposing the relationship to health workers or relatives who may find out you are having sex at a young age, or to other sexual partners who may discover you are having multiple, concurrent partners, as well as an unwillingness to inform a casual partner of one's (potential) health condition. In the latter case, a number of participants confided they had gone for STI screening and treatment on their own and had not contemplated a joint visit when symptoms arose.

"As a boyfriend you cannot escort her. It is for her family to do that. It becomes a problem when her family finds out when you haven't even paid lobola."

Zambia, FGD2, participant 2

"I can go with my wife not a girlfriend. A reason is that our relationship may last for a short while. It may happen that if she leaves me, she may talk about me and start revealing my sickness that I am sick, perhaps say: 'he uses ARVs, bladibla'. When she reveals my sickness which was secret, it will be difficult for me to get another girl. It's my wife that I can go with not a girlfriend, at least we would have lived together for a long time, and also having the same status as partners."

Lesotho, FGD 5, participant 1

This made a marital union with the partner, for a considerable group of participants, almost conditional for assuming the male support role, while other typologies of sexual relations, such as first romances, short-term relationships and extramarital affairs, were excluded from popular perception. Several participants expressed that when males take on supportive roles, it demonstrates their genuine love and serious intentions, distinguishing these actions from casual flirtation. These observations will need to be considered when devising male involvement strategies or programmes.

This did not mean participants did not bring or had never brought any of their girlfriends to the clinic. Proof of having a healthy partner was a compelling reason to do so, despite the risks mentioned above, and men were very keen to acquire first-hand information from the health worker on the HIV test, STI test and/or pregnancy test result(s) of their partners. Some had accompanied a partner for the purpose of seeing a health worker administer a family planning method.

> "I think I have done that several times, maybe when the two of you decide that she goes for family planning we just make sure that when the month comes, I have to take her and observe even when she is being given the family planning injection. Because you know some girls would be there telling you they went whilst they did not, and then the next thing you hear is that she is pregnant when you are not ready to be a father."
>
> Zambia, FGD1, participant 1

> "I can go with her whether it's me or her having a problem. I would go with her and make sure I enter inside the room so that I can find out about the disease she has. Some diseases are brought by them. She has to realize that I will know about what she is doing behind my back."
>
> Lesotho, FGD4, participant 3

It was rare to hear participants indicate that they had gone to a health service at the invitation of a girlfriend or wife. The narratives from across the five countries showed that this decision depended on the male partner, either because they felt responsible, wished to know (and were not fearful to know) their own and their partner's health condition or, very practically, were available during the daytime and did not mind queuing.

> "Personally, with the person I dated before she never told me about it. There is not even a single day in which she asked me to accompany her. If she were to ask me to accompany her anywhere, it would be to the shops or to look for firewood, but not to the hospital."
>
> Zimbabwe, FGD2, participant 2

An FGD with boda-boda (motorcycle taxi) drivers in Uganda illustrated they had little patience with the system. Even if health workers encouraged them to come, they did not see the need to escort their wife, once the HIV test had been done, for subsequent antenatal care visits.

> "Me I don't have to go, even if I know it's my responsibility. The main thing is to give her money and go to the hospital (to drop her off). You know us men you have to rush for work, but they will keep you waiting at the government health facility if you happen to escort her."
>
> Uganda, FGD5, participant 6

> "But if she needs to go back for other visits, does it really require me to go back with her? I don't think it requires me to go back with her again."
>
> Uganda, FGD5, participant 6

Participants mentioned a few incentives for male participation, which would make it more appealing to assume the male support role, especially in pregnancy-related care. Incentives included a more conducive environment for men to be in, as well as preferential services.

> "Honestly, what I had within me was shame, because I had heard before that when they get there, they make them sing songs and the shame was coming in when I thought of myself and how I am going to do those things."
>
> Malawi FGD3, participant 2

> "That is a common thing nowadays. The pregnant mother, who is accompanied by the husband, is worked on first than the one who came alone. By the way, even a man who takes the child for immunization, health workers attend to him first than the child who is brought by the woman. I think this is a motivation to encourage male involvement in health services."
>
> Uganda, FGD3, participant 5

Key informants shared that there is a widely held cultural perception in their countries that pregnancy care is a women's business and, as a consequence, maternal health programmes have struggled to bring men on board. In each country, different nuances were brought to light, but a common thread was found in the limited effort to change the status quo. For example, in Lesotho neither the male corners or the herd boys outreach programmes seem to challenge the cultural notion that men are not supposed to be in the proximity of their partners during pregnancy or while they nurse the newborn.

> "We never talked about it, but culturally it is a woman's business. Even those who are married know that they should not be anywhere near the woman during that time. This is when they stay in the mountains shepherding until say after two years when he comes to wean the child and make another. But I never raised the topic myself."
>
> Service provider C, Lesotho

Iga Figula/UNFPA

In Malawi, interviewed clinical staff admitted that, despite the clear policy guidance on this point in the national SRH policy, male involvement is not very much encouraged at facility level. The set-up for pregnancy care remains in essence for the female client, and women are told to pass the information they receive to their husbands.

> Interviewer: "You said you don't have a family clinic in the hospital?"
>
> Interviewee: "I can say we have it, but it is not programmed. It is not set up in a way that defines it like that. Now it is only accessible to females."
>
> Service provider A, Malawi

In Uganda, clinical staff believed the lack of male involvement primarily stems from ignorance, as men do not know their role in reproductive health matters. National level efforts to roll out the country's male engagement strategy were said to include capacity strengthening of health workers at project-supported health care facilities, health worker supervision to ensure services are male-friendly and non-discriminatory, health education talks at facilities to increase male involvement and improvements in data collection through the use of a register for male involvement. In addition, there is an incentive of a health check for men who escort their spouse to antenatal care (blood pressure, weight, malaria, temperature and diabetes). However, this level of intensified effort towards the male support role was not corroborated by the clinical staff we interviewed in study sites. A critique on the strategy by a Ugandan key informant from one of the non-health ministries was that it does little to shift the role perception for men, as the concept of involvement has been crafted in service of the female client and the un/newborn child.

> Interviewee: "Like I mentioned earlier, focus has always been on women and children. Men have been left out in issues of SRHR. Even when you have the aspect of male involvement, it is for the benefit of the girl child, women and children."
>
> Interviewer: "Could you please elaborate more on the male involvement that benefits the girl child, women and children?"
>
> Interviewee: "For example, we encourage men to escort their spouses during ANC, so that they are both tested for HIV. This is an entry point for accessing services to eliminate mother to child transmission of HIV. Couple counselling is also done to make sure that men support their spouses during ANC for better birth outcomes for both the wife and newborn."
>
> Policymaker gender, Uganda

Informants from Zambia did not report much progress in encouraging the supportive role of men and challenging the perception that pregnancy care is a women's business. Being the head of the household, men have no time to waste at the clinic and subsequently miss information and are not being screened together with their partner. Furthermore, the disconnect between the health service and male partners make it very hard to adequately address GBV when signs are present during the provision of pregnancy care.

> "Culture and society already define what a man should be in a relationship, their needs, their demands and how they enforce those particular demands. See that is where the challenge has been, so it is about countering the negative norms that have been set out already by society, so that tends to be a challenge. You can find people who will tell you 'Okay (name of the informant's organization) I hear what you are saying but me as a particular person, I have been raised up to or behave in a certain way as a man, or to treat a woman like this as a man'. This is where the challenge has been."
>
> Programme implementer A, Zambia

In Zimbabwe, conversations on male involvement focussed on the struggle to shift the perception of men who think women are just there for childbearing, to being open to the challenges of women and viewing these as challenges that also concern them. One national level informant articulated this as follows:

> "Men enforce their own opinions, will not listen and remain in control which sometimes has a detrimental effect on family health."
>
> Policymaker HIV and AIDS, Zimbabwe

UTILIZATION AND AVAILABILITY OF MALE SERVICES

HIV and AIDS, contraception, information and counselling and STI services were the most frequently mentioned services for which participants or other men they knew had previously sought interaction with a health service provider. HIV and AIDS encapsulated different (primarily preventive) services, such as HIV testing and counselling, VMMC and PrEP/PEP. Quite possibly for privacy reasons, participants did not mention services, such as ART, viral load or CD4 count testing. Contraceptive services were synonym to the acquisition of male condoms. None reported having had interactions with a provider on a vasectomy, and only a handful of participants had visited a facility with or for contraceptive methods of a female partner. Participants felt there were very limited options for men to control or space a pregnancy, and thus did not consider themselves a prime client of the contraceptive services offered at health facilities, as the following excerpt from a FGD in one of the Ugandan study sites illustrates:

> Interviewer: "It is good you have talked about contraceptives, which one have you thought of as a man to use?"
>
> Participant: "No, it will be my wife to use, because I don't think those ones available for men are appropriate for me."
>
> Interviewer: "Why are you saying that they are not appropriate for you?"
>
> Participant: "I mean that I only know two types of contraceptives for men, the condom and vasectomy. Tell us, do you know any other? First, I cannot use a condom with my wife, I need to enjoy her to my fullest. Maybe I can use it when I am with my concubines. Secondly, vasectomy is an irreversible permanent method. At this age with only one child, I cannot take on vasectomy. However, there so many options for women, including injections, pills, Norplant, among others."
>
> Uganda, FGD5, participant 4

Difficulties in obtaining STI treatment at health facilities, due to stock-outs or prohibitive service fees, seemed to compel participants and other men and boys in their community to make use of alternative providers, such as traditional healers, private pharmacists or trusted relatives with knowledge of herbal medicine. A few of the older participants also mentioned a great reluctance to undress in front of a female health provider as an additional reason to seek alternative STI services or delay health-seeking.

> Participant 6: "Yes, telling a female young doctor about you STDs. Sometimes you feel shy when she tells you to check your penis. I sometimes go back home if I find a female young doctor in the consultation room." Participant 3: "Talk about that, I also hate a female doctor to examine my reproductive organs for STDs. I better go back home with my STD than to be treated by a young female doctor."
>
> Uganda, FGD1, participants 6 and 1.

Infertility, disorders of the male reproductive system and male cancers were not mentioned as services that had been utilized by participants or by other men they knew in their community. This is in accordance with the data from the survey. In their role as male partners, there were multiple participants who had undergone couples counselling and testing for HIV during the prenatal period, and who viewed this as their responsibility and a routine issue during any pregnancy, as this participant from Zimbabwe:

> "Yes, we went to the hospital just like participant 2. You have to go and if you are someone who is not comfortable with getting tested, the moment your wife gets pregnant you have no other choice."
>
> Zimbabwe, FGD3, participant 3

Only few talked about having been present during ultrasound scans or in the delivery room, and just one participant brought up the moment of discharge and the postnatal information he and his wife had received on family planning. None of the participants said they had been referred to support groups for expectant or new fathers, or had received classes on parenting skills. Time constraints were a commonly heard reason for men to transfer the responsibility of (the majority of) antenatal care (ANC) visits to the female partner. Support in the event of an abortion was a sensitive issue and only came up if a focus group facilitator had raised the subject. Several participants from Malawi, Lesotho and Zimbabwe said they would not support their partner in procuring an abortion, because they

perceived abortions to be a sin. In Zambia, where the abortion law is less restrictive than in the other four study countries, one NGO (Grassroots Soccer) had broached the subject among the youth by explaining they **"should not be using Coca Cola with Panadol to abort but go to the clinic to seek professional medical help."** Zambia, FGD2, participant C

Services for and the role of men and boys in SGBV was on the radar of the participants, due to an exposure to community awareness campaigns, previous teachings on SGBV in- and out-of-school, and attention for it on television and radio.

> **"I have learnt about this, if you hit a girl in the abdomen her reproductive system is injured and she will stop bearing children, women are not that strong and when you beat her you can injure her. We learnt about all this at school."**
>
> Zambia, FGD5, participant 4

During the discussions, participants raised two concerns around the topic of SGBV. First, they said that services for male victims were absent in their community and there was a general silence on the possibility of boys and men being vulnerable and in need of services. Second, there was a fear of easily being condemned and arrested as the sole perpetrator in a domestic dispute. Men felt that women had the law on their side.

> **"We also need organizations to take keen to men, because previously we used to hear issues of gender-based violence where women were the victims, but now things have changed even men are being abused in their houses silently but unfortunately organizations are focused on women, so it would help if they could shift some focus to men because we are all humans."**
>
> Malawi, FGD4, participant 3

Non-clinical services, as described in the global SRHR service package for men and adolescent boys (i.e. SRH communication materials, support groups or advocacy initiatives exclusively offered or led by men and boys) did neither seem accessible nor available. This linked to the observation that was discussed earlier in this report, that participants had a feeling most SRH programmes focussed on girls and young women and subsequently did not feel ownership of these issues, as one participant from Malawi aptly put into words.

> **"No, we don't have any male support groups. I am even surprised, that this car, it is the second time that it has come, and on both occasions, it is looking for boys and young men only. This has made me realize that men are also useful in the SRHR issues. That we can even have organizations that look at the welfare of boys and men. But here, if these support groups exist, then I am definitely not aware of their existence. Maybe they exist in the context of families, but not the whole community."**
>
> Malawi, FGD5, participant 1

IMPACTS OF COVID-19 ON SERVICE UTILIZATION

Reported disruptions to SRH services during COVID-19 lockdowns were similar across study countries and included temporary closure or reduced operating hours of facilities, widespread stock outs of medicines, and prioritization of services (for example, HIV tests were not done if someone had been tested in the previous six months). Participants had feared and delayed a health facility visit, expecting to be subjected to a compulsory COVID-19 test, to the virus itself, or being put into quarantine, and in a later phase of the pandemic, receiving a compulsory COVID-19 vaccination. For participants who had gone to the facility during this time, there were multiple barriers, such as a requirement for a transport letter, purchase of a compulsory face mask or a certificate of a negative COVID-19 test result before entering a facility. In Uganda, some health workers reportedly took advantage of the situation to further increase their under the table payments to patients.

> "We could not move to health facilities during lockdown, or access health care at the facility as they were beating people, and during curfew times it became complicated. You had to get letters from the local authorities before going to the hospital. Imagine someone who was serious sick to first get a letter from the local authorities. Getting a letter would take more than a day. Actually, so many people died of other ailments other than COVID-19."
>
> Uganda, FGD 5, participant 1

A positive turn of events was noted by participants from Zimbabwe, who reported that an NGO had started distributing HIV self-testing kits in the community. The convenience of these kits was very much appreciated, and the existence of such kits had not previously been known to them.

Mobility restrictions in all five countries negatively affected the utilization of SRH services, and constrained provision at health facilities and in the community. Lack of protective personal equipment and COVID-19 infections among health workers were also raised as major constraints at the time. School closures negatively affected the function of educational institutions to disseminate information on SRH and give attention to pupils' health and well-being, with Ugandan pupils having the most school days missed on the continent. Some informants spoke of an exacerbation of SRH-related problems during this time, such as an increase in SGBV cases in their country.

> "They threw away all the books and the only thing that they could do was to have sex."
>
> Policymaker health, Malawi

> "There was a lot of GBV including sexual violence, as reported by many surveys. I think this is because the couples were redundant at home, a situation caused by the COVID-19 lockdown movement restrictions. Besides, men had to meet the family's basic needs such as food, and pay rent in the face of unemployment due to the COVID-19 lockdown restrictions. In our community, men are the breadwinners, so their wives had to ask them for money for food, which was not available. This would end in a quarrel and consequently a fight between spouses. This indicated that men suffered a lot of psychosocial issues during COVID 19."
>
> Policymaker health, Uganda

A prioritization of health services during lockdowns meant that male clients (as reported in Uganda and Malawi) were only assisted in an emergency situation. In all countries, clients on HIV or (tuberculosis) TB treatment seem to only have suffered minor interruptions, as exceptions were made for outreach workers and for the number of drug refills per client. In Zimbabwe, providers successfully advocated for integrating COVID-19 and HIV to ensure uninterrupted service delivery (both for the prevention and treatment of HIV). While most informants indicated to have gone back to normal at the time of the study, a reliance on digital technology has remained across programmes in the communication with young people and with clients living in remote areas. In Zambia, for example, WhatsApp groups have been formed and include a health worker who can respond to questions on SRH. Providers from Zambia also noted how self-testing gained more prominence since COVID-19, and is helping them to mitigate the problem of overcrowding at health facilities. Lastly, the significant economic impact of national measures to contain the pandemic was pointed out in the interviews, with medicine no longer being affordable (Uganda), loss of employment and linked rise of anaemia and malnutrition cases within families (Zambia), and 'desperate situations' for people in Zimbabwe.

EXPOSURE TO GENDER TRANSFORMATIVE PROGRAMMES

As the study sought to also include participants who actively participate in SRHR programmes in their communities, the findings gave some insight into what men appreciate. There was a large preference for mixed-purpose activities, and peer-based models for the dissemination of knowledge and commodities on SRH. Soccer clubs, which combined sports with teachings on SRH seemed very popular, and also drew the attention from participants who had not been exposed to such programmes.

> "The only male groups we have in the area are soccer teams. It sometimes acts as a support group, but the sole purpose is football, seeking counsel just comes as an advantage as many men are gathered in one place."
>
> Malawi, FGD5, participant 3

> "We do not have such programmes here. We only meet with our peers and we discuss relationships as to how we should treat our lovers. I can't say we have a proper programme."
>
> Lesotho, FGD5, participant 5

Across the five countries, there was a commonly felt need for more organized opportunities where participants could meet with peers, older men and with health experts to discuss men's SRH, and which would actively seek to lower the threshold for young people to interact more freely on these issues.
It also became clear that, for most participants, in-school CSE had not sufficiently addressed or deepened the topics that had their interest or were a concern for them. For example, multiple participants indicated during the FGDs they would like to learn more about having a relationship and how to deal with tensions and expectations. More broadly, the inclusion of gender relations and harmful social norms as discussion topics at school only became apparent from some of the exchanges with participants in Lesotho and Malawi. In the other study countries, there seemed to be a reliance on NGOs to initiate these discussions on the ground. In Zimbabwe, participants referred to a number of such initiatives,[6] who had broached this subject in part or in full, and lauded the way in which these efforts had triggered their mindsets and those of other men in the community.

> "They help us a lot by promoting peaceful coexistence between partners, and helps one accept their partner's ideas and sharing ideas. Not having a situation in which only your ideas are considered whilst infringing on the rights of women. They promote zero tolerance towards domestic violence."
>
> Zimbabwe, FGD1, participant 3

> "In terms of reproductive health, like you mentioned before when you asked about where we got education on how to make babies, in school we would just be given a diagram and got told that this is the female organ and this is the male organ, but when these organizations came in the picture, they started explaining better what it means to have sexual intercourse and its implications and other things. Even the educated, it's very rare for someone to just indulge in sexual intercourse without using protection, they will actually be prepared, moving around with condoms."
>
> Zimbabwe, FGD1, participant 5

However, based on the participants' responses across all five countries, we could observe that the offer of gender-transformative interventions for boys and men on the whole was thin, as well as infrequent. A fair share of interventions is offered in the form of a campaign and does not seek to establish a recurrent format for community discussion on gender and sexuality.

Responsiveness to differential SRH needs

In all five countries, key informants raised considerable shortcomings of currently available SRH information and services to adequately respond to age specific needs along the male life course. This was most prominent for the adolescent period in which an array of issues, such as service restrictions due to age of consent or location (i.e. no condoms and contraceptives in schools), social taboos and ill-equipped health workers, were put forward to explain this shortfall.

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[6] Examples from different FGDs included Zimbabwe Community Health Intervention Research Project, Katswe Sistahood and the Brotha2Brotha programmes.

> "In the system, access to services is limited. Where services are available, they are not friendly to the boys and young men so you would find them bundled with the elders and it is difficult for them to talk about their issues."
>
> Policymaker HIV and AIDS, Uganda

According to informants, STIs were one of the most pressing health needs of adolescent boys and young men. Yet there was an understanding that health facilities were largely unable to attract the age band 14 to 19 years to screen and treat their STIs and prevent further transmission. Furthermore, there was little room within the current HIV/STI programmatic focus to meet the needs of boys for information on sexual maturation. A Zambian informant flagged the many questions boys have on the physical and emotional changes during puberty, and the desire to understand what is normal and what is not normal (for example, in relation to penis size), which are not being addressed in the clinical setting. While more detail will be provided in the services section, difficulties were also noted for older men in need of sexual dysfunction or fertility services. In all five countries, such services were regarded as specialist services and were thus not provided at the primary level. Provision of services at district hospitals was also said to be very limited.

Specific situations of vulnerability to poor SRH outcomes in adolescent boys and young men were linked to risk behaviours and influences of socio-economic conditions and peer pressure on alcohol and substance use, and age-disparate and cross-generational relationships. In Malawi and Uganda, informants noted the deliberate behaviour of young men to seek out very young girls for sexual relationships without prior HIV testing and without the protection of a condom. Key informants from Lesotho and Uganda raised the issue of boys with hardly any sexual experience being groomed by older women and locked into a dependency they find difficult to escape from or to ask a third party for help if problems arise. Specific groups of vulnerable adolescent boys and young men were identified by informants from Zimbabwe (gold panners) and Lesotho (boarders, shepherd and herd boys), and whose commonality of living with other adolescent boys and young men and without parental guidance was believed to place them at a disadvantage, as the following informant explains:

> "Schools are clustered in one area and this forces pupils coming from far places to rent places to stay. This means they are far from parents and with no supervision of parents or guardians. This leads to promiscuous behaviour and early sexual debut. This is further influenced by peer pressure."
>
> Service provider A, Lesotho

With the exception of the shepherd and herd boys in Lesotho, who are also acknowledged as a vulnerable group in the national HIV strategic plan, the interviews did not reveal a high level of policy and programme responsiveness towards the specific vulnerabilities of adolescent boys and young men. Our conversations with informants from the ministries of education and health demonstrated that their plans to address alcohol and substance use, and mental health issues like depression or suicidal thoughts among adolescent boys and young men had only recently began to take shape, and there was no indication of initiatives or plans to discuss power-imbalances in sexual relationships or to put additional efforts into sexuality education for boys living alone from the side of the ministry of education. In fact, an overall picture from across the five countries emerged, which indicated that implementation was already strained in delivering the basic package of SRH information and services to adolescent boys and young men.

> "Our policies in education, they're still restrictive when it comes to how much information you can give on sexual and reproductive health."
>
> Programme implementer A, Malawi

PROVISION AND AVAILABILITY OF MALE SERVICES

In each KII, we enquired after the provision of clinical and non-clinical components of the global SRHR service package for men and adolescent boys (International Planned Parenthood Federation & UNFPA, 2017). Innovations or best practices in working directly with adolescent boys and young men were further explored with informants operating at the implementation level in each country. These informants included district health managers overseeing health service delivery at government facilities, service providers in facilities and civil society organizations involved in SRHR programmes on the ground. Out of five countries, Lesotho stood out by offering male-only health services in designated 'male corners'. These corners were located in a separate section of a health facility or in a temporary unit on the facility's premises, for example, a container. The corners are staffed by male health workers who offer services to male clients from the age of 15 years. The package of services is dependent on the size and structure of the health facility. All corners provide HIV and AIDS-related services, and TB and STI screening and treatment. Some corners provide additional services, such as male cancer screening and services to men with hypertension, diabetes, asthma and other chronic conditions. The corners have been established with the support of the Elisabeth Glazer Pediatric AIDS Foundation in response to the low numbers of men tested and treated for HIV and AIDS in Lesotho. The initiative started in 2017 with eight pilot facilities and there are currently 33 corners across the country[7]. Staff interviews revealed that the service provision is not guided by a specific male health guideline or protocol. The only guideline that is currently used are the national ART guidelines. The services seem to have been well received by male clientele.

> "To be honest, we are offering general OPD services. All men come up here, even for other conditions. They do not want to go for services down there."
>
> Service provider A, Lesotho

However, the success of the corners also seems to have started taking its toll. Interviewed health workers from three corners included in this study indicated to have difficulty managing the demand for services. The units are too small to deal with a higher number of clients, and facilities reportedly have had to allocate health workers from other departments in order to provide continuity of services in the male corner. However, this has meant that some corners now also have female health workers on duty, as well as health workers that have not been trained by the Elizabeth Glaser Pediatric AIDS Foundation and the Ministry of Health to work in the corner.

CLINICAL COMPONENTS OF THE PACKAGE

Physical exam and history of male clients: In the majority of service points, there is a routine of history taking to help guide the diagnosis. We noted the use of both structured and unstructured approaches in initiating consultations with male clients. Providers in male corners in Lesotho applied client problem driven questions, and did not follow a particular format as is reportedly done in health facilities in Malawi through a client receipt form. Specific tools were used in the Brotha2Brotha Programme and by Tumbombele to initiate the conversation and assess risk among clients enrolled in their programme (for example, for men who have sex with men).

Physical examinations were not a routine part of service delivery. Across the five countries, a lack of space, bed screens and privacy concerns seemed to be the main reason for not offering male clients an exam. Younger clients visiting an adolescent health corner in Uganda, for example, were said to be re-routed to a general health department because of lack of space. In a number of countries, such as Malawi, there was a clear discrepancy between the affirmative responses from national level informants on routine examinations as part of SRH services, and from providers on the ground.

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[7] https://pedaids.org/our-expertise/integrated-adult-health-service-delivery/male-clinic-model/

Contraception: Condoms seemed the only option on offer as part of contraceptive services for male clients in the majority of facilities and programmes. In Lesotho, Zambia and Zimbabwe, the option of a vasectomy was either not available or not discussed with male clients. According to health workers, men simply do not want to hear about it.

> "Usually that subject raises a hot debate. They say that is man's castration "klaar"! They say it's a man's job to make babies, but we give health talks every morning and we touch on it at times."
>
> Service provider D, Lesotho

Condoms are made available in health facilities. In Zimbabwe, condoms are also provided in public places, and in Zambia, community-based drug distributors provide them to fellow youth in their community. There is much less attention to the male support role and to couple counselling on contraceptive choices within a relationship. Some male corners in Lesotho indicated providing health education to dispel myths around female contraceptive methods while men are waiting to be served. In Uganda, informants reported there is a lot of investment and attention towards family planning, with outreach programmes offering condoms, Norplant, even vasectomy and tubal ligation, with the support of implementing partners. In some health centres where a theatre and a medical doctor are available, vasectomy is included among the services offered. Ugandan informants raised a concern about a noted decrease in the demand for condoms by male clients, which they attribute to the success of the VMMC programme roll-out, and prevailing misconception among male clients that circumcision is 100 per cent protective against transmission of HIV. In none of the countries did we hear informants speaking of condom provision to adolescent boys and young men in schools.

STIs: From the KIIs, it became clear that STI services were in high demand. As previously indicated, physical examinations are not routine due to spatial challenges, but also stock outs of tests force health workers to rely on syndromic management or – in the case of Uganda – to refer men to private laboratories in order to get these tests done.

Drug shortages in public facilities and in NGO programmes seem to be another major challenge in STI service provision in Uganda, and as men are referred to private pharmacies, their ability to pay strongly determines whether they can complete the full course of antibiotics and be cured. Concurrent treatment of sexual partners seemed to be a major gap in STI service provision across the five countries. Informants complained that most male clients come to the clinic without their partner(s), and contact tracing did not appear to be standard policy in all of the facilities or programmes included in the study. At service points where contact tracing was actively pursued, such as in Livingstone, Zambia, the success rate of concurrent treatment relied heavily on the information provided by the client and the human resource and logistical support structures in place at each facility in the district.

> "For treatment to be effective, we normally encourage them to bring the partners of course. Our target is also to have their partners treated and be aware that there are these STIs. If the man is not comfortable coming with the partner, we encourage them to show us the partner, to tell us how we can meet the partner and also try to bring them to the facility. We have all those models that we use to follow up such people, and it may not necessarily be the very partner who goes there and tell them. We have community-based and trained field officers who will go and attend to such."
>
> Service provider A, Zambia

HIV and AIDS: Based on the interviews, the HIV and AIDS component of the global package on SRHR seemed the most well-organized and accessible service in and outside the health facility setting. HIV testing and counselling, including prevention of mother-to-child transmission, ART and VMMC appeared to be standard elements of service provision, and to a lesser extent included provision of PEP and PrEP in the five countries. Add-on services as well as differentiated models of care could be observed, ranging from the inclusion of syphilis screening in Malawi, school-based delivery in support of pupils' ART adherence in Lesotho, treatment support and home visits for people living with HIV through NGO programmes, like Nurture Africa, in support of government HIV

and AIDS services (lost to follow up was marked by the Ugandan Ministry of Health as a challenge and home visits costly for the public system to maintain), provision of PrEP and a safe space for clients from key populations in the NGO programme Tumbombele in Zambia, or the delivery of mobile HIV services in Zimbabwe.

Disorders of the male reproductive system: While informants indicated there was a need for these services, services were generally not available at the primary level, and in some countries also not at secondary level, such as in Zimbabwe, where male clients will be referred to a specialist at the tertiary level. At male corners in Lesotho, health workers provide counselling and education, and may offer supplements like vitamine B complex for clients who come to them with complaints of impotence, premature ejaculation or general concerns about their sexual performance. In Uganda, there are no services for disorders of the male reproductive system at primary level, but health workers at this level indicated that they sometimes change the ART regimen of male clients to help reduce the side effects on their sexual function. Disorders, such as premature ejaculation, are reportedly part of the health workers' training on adolescent health in Zambia, but providers indicate there are no such services available at primary level. Similarly, in Malawi, male clients are referred to a district hospital.

Male cancers: Lesotho seems to be the only country from the study sample to have a national programme on cancer, which includes prostate cancer screening, however, screening services were not (yet) available at every male corner. Other types of cancers are not part of the service package in male corners. District level facilities in Malawi, Uganda, Zambia and Zimbabwe do not have the capacity to perform tests and biopsies, and can only offer a physical exam and information on prostate cancer. Suspected cases are referred to provincial and national referral hospitals.

> "Men would want to test prostate cancer, but there is nowhere in this district to refer them to. Sometimes we can be in a focus group discussion then questions about prostate cancer pop up. We end up referring them to Lusaka where we may also not know exactly where such services are provided. So, these are some of the things that make it very difficult to bring those interventions to men."
>
> Programme implementer B, Zambia

Fertility and infertility: Fertility services for male clients are not a SRH service that is high in demand, in part because men believe infertility is a female problem and consider it taboo for a man to seek such services. It also became clear from the KIIs that this component is a specialist service and even health education on male fertility issues at lower levels in the health system is rarely provided. Furthermore, we noted a lack of knowledge in both government as well as civil society organization informants on where the appropriate referral points or specialists are located within countries. Informants from Uganda indicated that fertility services are sometimes only available in the private sector and at a very high cost. It was also noted in Zambia that fertility and infertility – whether in females or males – do not take up any prominence in sexuality education.

> "There is need to break the silence in the community that either a man or woman can be infertile. Therefore, the issue of infertility should be addressed as a couple, not implicating it to either woman or a man."
>
> Policymaker gender, Uganda

> "You don't pop up as a man, you only go there when your wife has been going there to say I am not conceiving. But as a man you can't go there alone."
>
> Service provider A, Malawi

Supporting prenatal and postnatal care: Efforts were made to bring expectant fathers to the health facility, with a primary focus on the prevention of mother to child transmission. Specific incentives for male clients (mainly the 'first serve' rule; there were no country reports of prenatal care services after work hours) seem to be fairly successful in Uganda and Zambia. From an expectation that maternal and child health clinics assume full responsibility for male involvement in pregnancy care, male corners in Lesotho do not address this component of the package. Pupils in Uganda are reportedly followed and supported during a pregnancy in the community. Teachers are expected to link both the girl and the expectant father to a health worker and community development officer for counselling, and a healthy pregnancy.

Supporting safe abortion care: Across countries, health services and programmes there was a large silence around the support role of men in safe abortion care. In Lesotho and Malawi, legal restrictions were provided as one of the main reasons for this silence, though in less restrictive settings such as Zambia, there was equally no routine in place to inform male partners about safe abortion care and to accommodate their supportive role or address their questions before, during or after the procedure. In Uganda, post abortion care was said to be directed at females alone and one of the civil society organizations in Zimbabwe refrained from including the topic in their SRH programmes for adolescent boys and young men, for reasons as stated below.

> "We don't often support it and we haven't taught about it because they will carelessly indulge in sex knowing that they can abort later."
>
> Programme implementer A, Zimbabwe

SGBV support: There was little evidence of male leadership roles in combatting SGBV in the five countries, and confronting traditionally prescribed masculine behaviours which can produce harm.

> "We look at the drivers of domestic and other forms of violence on how men are prepared to deal with issues of manhood. You know that if you want to get killed insult a man's manhood."
>
> Policymaker education, Zimbabwe

Collaborative programmes between the ministries of health and gender, and community victim support structures are geared towards girls and women who are disproportionately affected by SGBV. At the health facility, survivors are examined, tested and provided with PEP and emergency contraceptives, and if needed, their injuries are treated or a referral to specialist services is made. Providers indicated to rarely, if at all, receive male survivors. Men are reluctant to report rights violations, and police officers in turn, are not sufficiently sensitized to report and attend to men's cases. Interviews further revealed that, while there is an awareness and identification of child abuse cases within the school setting, statistics are not routinely kept.

> "Mainly we receive women as the victims, and males as perpetrators of GBV. You will never get men as victims. To be specific we usually get cases such as defilement, rape and assault."
>
> Service provider A, Uganda

> "At a policy level, they should enact a law/s that states that men can also become victims of GBV. They should also look into the systemic discrimination that men or boys face when they go to the police stations to report their abuse. The police always look down upon the victims, laughing at them. We don't know whether it is there or not. If it is there, then there is need for awareness campaigns so that we become more aware of it."
>
> Programme implementer A, Zimbabwe

NON-CLINICAL COMPONENTS OF THE PACKAGE

Information and counselling: Across the five countries, the primary focus in the dissemination of information and counselling to male clients is on prevention of STIs, including HIV and pregnancy. If physical space in male- or youth-friendly corners allows for it, providers indicate to give health talks on GBV and drug and substance abuse or show educational videos as clients wait to be served. Attention to topics, such as sexual rights, pleasure and well-being in a sexual relationship appears to be very limited across the board, though there is a discernible difference between Lesotho and the other four countries in the way ministry officials articulated their approach to CSE in school settings[8], demonstrating intent to support pupils developing a set of skills in relation to their sexual health.

> "We want them to develop the skill of assertiveness. We are trying to build their self-esteem so that they may cope well in their relationships with other people. They are assisted to manage anger and emotions. This helps them to deal with any form of abuse. They are able to identify a healthy and unhealthy relationship. If a child is aware of his/her weaknesses it is easier to notice when somebody is taking advantage of him or her."
>
> Policymaker education, Lesotho

[8] More observations on the CSE curricula of Uganda, Lesotho and Zambia can be found in the policy analysis report.

However, the interviews also indicated that all ministries, including in Lesotho, are struggling to implement good quality CSE and simultaneously manage the opposing voices in their countries which threaten both the contents and continuity of CSE. In practice, this has led to trade-offs in comprehensiveness of the curricula used in different countries. For example, under the guise of 'age and culturally appropriate CSE', teachings in Lesotho cover prevention of STIs and pregnancy, but exclude information on the use of condoms and/or contraceptives. In Zambia, parents and religious leaders openly protested against providing pupils information about contraceptive methods and this, in combination with considerable media and political attention, created a major backlash against the provision of CSE in the country. Further concerns were raised in light of 'the pick and choose' mentality of teachers and schools, following their own belief systems/discomforts with the subject matter, on the effectiveness of CSE in meeting the needs of adolescents and young people.

> "The teachers responsible for teaching CSE parts, they choose what to cover and what not to cover, so the children may not get the full information. For example, where you need to demonstrate how to place and use a condom, most teachers will skip those parts."
>
> Programme implementer B, Malawi

> "The cultural and religious attitudes and perceptions are a big challenge. When you talk about SRH, people narrow it to sexual intercourse and exclude the provision of services. Most of the schools are religiously founded, which requires a lot of explanation. Moreover, the actual implementation of the sexuality education framework has been partly affected by such reservations around sexuality. When you talk about a comprehensive SRHR for boys or men, a proportion of people will ask how comprehensive is it? Then they conclude that you are talking about homosexuality. Homosexuality is socially rejected in Uganda."
>
> Policymaker education, Uganda

IEC materials for male clients: Key informants alluded to a generic approach in the development of educational materials on SRH, as well as to a general shortage in the availability of IEC materials for dissemination to male clients. Government budgets were said to very rarely accommodate the production of IEC materials, and also implementing partners were not as forthcoming in supporting health facilities with flyers or posters. Out of five countries, only one government institution mentioned having developed a brochure on male involvement in SRH/GBV (Uganda), and only one of the interviewed NGOs indicated to provide boys with SRH information leaflets (Zimbabwe) in their programme. In Zimbabwe, where the government developed a communication strategy on HIV (2019–2025) specifying adolescent boys and young men as one target audience, resource constraints were said to impede the provision of IEC materials at facility and community levels. Informants did note national level campaigns on HIV through billboards, Facebook and short videos, for example, the 'I can' campaign on treatment for people living with HIV in Zimbabwe.

> "This is very important, it is prioritized but it is only a lack of resources that comes in between. The desire to go out and cover every area and all young people is there, but scarcity of resources come in between. But when it comes to awareness raising, giving information and communication we value it very much."
>
> Policymaker youth, Zimbabwe

Skills building and group support: There was a mixed picture on the utilization of skills building and group support for male clients in SRH services and programmes. In Uganda and Malawi, there was the least indication of such initiatives. Despite a male engagement strategy stipulating the establishment of male action groups across Uganda, key informant and provider interviews did not point to active implementation of this concept at the lower level, some of which had received financial support from UNFPA (more information is provided under the section key gaps). In Malawi, one NGO indicated working with male action groups on gender and SRHR issues, but in another study site, informants noted that the work with male champions and groups had ceased to exist when an implementing partner withdrew its funding. In school settings, groups seem to exist for (expectant) mothers, but not for fathers in Malawi. In Zambia and Zimbabwe, boys and young men's clubs were hosted at the initiative of NGOs with a notably strong economic focus in Zimbabwe (for example, stokvels for men

above 19 years of age). In none of the countries, including the male corners in Lesotho, health facilities hosted male groups on SRH. Mentorship clubs, competitions, retreat camps and sports were said to be offered to male pupils as part of CSE in Lesotho.

Engagement in advocacy: There were very few examples whereby existing services and programmes seemed to create a deliberate space for men to advocate for SRHR. Two NGOs in Malawi were said to train men as change agents, and two NGOs in Zimbabwe were said to engage men (more) in their programming; no examples emerged from other countries. More will be discussed under the promising practices section.

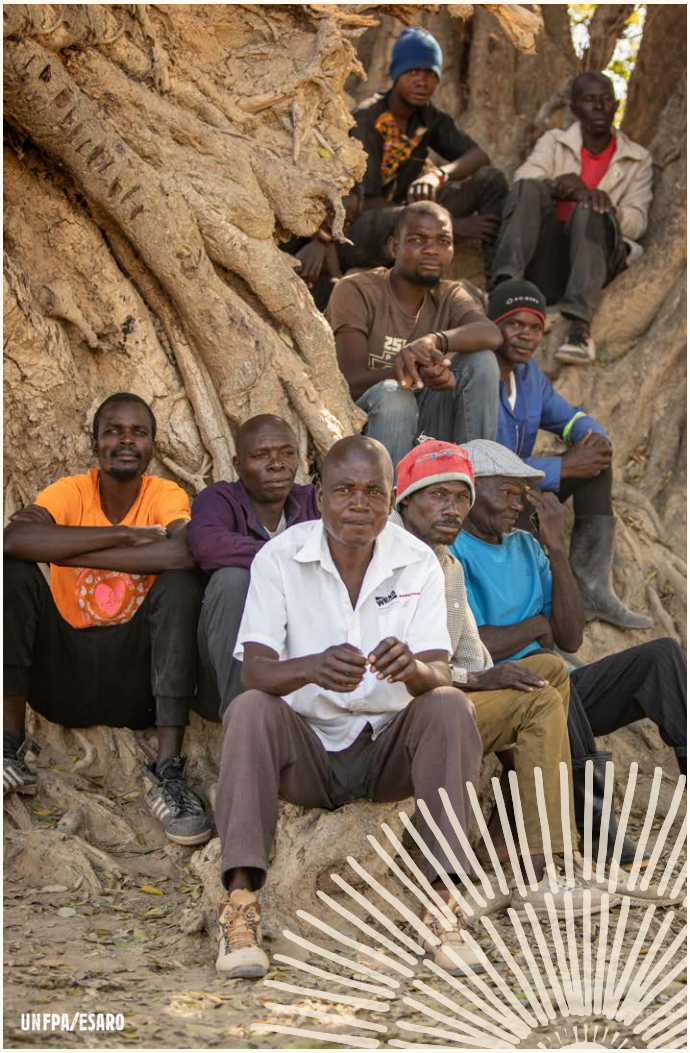
PROMISING APPROACHES AND PRACTICES TO ADDRESS MALE NEEDS AND BEHAVIOURS

Male corners in Lesotho seem to have been successful in bringing men into a clinic setting where this previously proved to be very difficult. The functional set-up was informed by local consultations with men, and an informative visit to male corners in South Africa, whereby extended opening hours, prime locations (for example, close to taxi and bus ranks) and staffing by male health workers became key features of these corners. Other countries, such as Kenya and Tanzania, have since expressed interest in the model and a delegation from Lesotho presented the pilot at the International AIDS Conference in Amsterdam in 2018.

> "The impact was super: HIV testing improved, they were adhering very well to their medications, even the lost to follow-up cases came back and started to take their medications well. Taxi workers were coming in large numbers. Staff members were motivated and were flexible. The corners opened from as early as 5:30 and closed after 7pm or 8pm in some health facilities. The staff members worked in shifts, and used their own phones to allow clients to make special appointments. To our surprise, even high officials like Ministers and their Permanent Secretaries were making appointments. Security Guards were also coming in large numbers because of the flexible opening hours. The intention was to pilot the male corners for three months, but even before the end of the third month the demands were overwhelming."
>
> Service provider B, Lesotho

Apart from operational challenges, already discussed on page 55, interviewed staff of the male corners feel that more promotion needs to be done, as there are men who are not aware that these services are available.

Youth-led programmes in Malawi (spearheaded by a national NGO), Zambia and Zimbabwe had elements of the 'agents for change' concept. Young men and women could give input in programme design (Malawi), participate in needs assessments (travel within the province to speak to young people and identify where the gaps are) and table their observations at a ministerial level (Zambia), develop and share their own videos to speak out against SGBV or were offered with the materials to run their own club meetings (Zimbabwe). Safe spaces are also considered a critical element in the success of the Zambian Insaka's, where adolescent boys and young men can air their views without being judged, or in the Brotha2Brotha Programme in Zimbabwe where adolescent boys and young men may confide in a male mentor.



UNFPA/ESARO

Civil society organizations considered the sports model to be more successful in drawing adolescent boys and young men to SRH-oriented programmes than offering the same information to them in a classroom setting. Equally, there was a more positive experience of interacting with parents of adolescent boys and young men in a focus group session than in a teaching set up. In Zimbabwe, the engagement with adolescent boys and young men cuts across a range of sports: soccer, volleyball, darts and snooker. Health promotion takes place during sports activities, during which clinic visits are encouraged. Health care seeking behaviour is facilitated by the clinic's close proximity to the sport fields and opening hours after sports activities. New adolescent boys and young men are being familiarized with the programme through so called birthday bashes. Current sportsmen are asked to bring in their network of friends who then receive information and education on SRH during these birthday bashes. Also, in Zimbabwe, there is an initiative of 'male mobilisers' by the Ministry of Health and PADARE in 14 districts to encourage men to accompany their wives to the facility. Some NGOs cautioned for an all-male or all-female approach in SRH programming. In their experience, mixed-gender groups worked well in driving gender transformative work in the community.

> **"It is also very important that both men and women, boys and girls are in the same focus group discussions, in the same sensitization programmes, are in the same meeting because the moment you start separating them, we are creating an environment of comparing, and comparing is the one that brings about policies that are superior or inferior to the other gender."**
>
> Programme implementer A, Zambia

Key gaps in policy guidance and programme implementation

Three key gaps in policy guidance to advance men's SRHR could be discerned from the data. Firstly, the limited attention to men's health issues in national guidance documents, and a shortage of deliberate policy action to support male health-seeking behaviours. Secondly, the policy deadlock on some of the most sensitive issues in SRHR. And thirdly, the inability to implement domestic policies, as intended, with the available resource envelop.

The first policy gap was most prominently articulated by the providers of SRH services, whether at government facilities or in civil society programmes. There was an understanding that several components in the global package for men and boys were currently not reflected in any of the country policies and strategies, and providers on the ground had no clarity on how best to respond to client demand in these areas, starting with the provision of basic information, for example, on infertility and male cancers in primary facilities and communities.

> "It's a high time that policies and the strategies should be highly reflective of the issues that address boys and young men, and if possible, that should go alongside with packages that are supposed to be targeted for them."
>
> Policymaker health, Malawi

The importance of policy guidance and derivative instruments, such as facility guidelines and protocols, is underscored by the situation in Lesotho's male corners where providers 'provide as they see fit'. At the same time, corners have become increasingly vulnerable as the 'to-go-to hub for all that concerns the male', with anecdotes emerging out of staff interviews on outpatient departments sending through any male client, regardless of their condition. However, the corners have no medical doctors in their staff establishment, and would not be equipped to manage serious conditions.

> "I think men have been neglected for a very long time. We do not even have a guideline here. We just offer services as we see it necessary. As you can see even the space here is very small. It was a staff house and it is worse when there is rain as the place cannot accommodate these patients."
>
> Service provider A, Lesotho

More deliberate policy actions to overcome some of the well-known barriers for men and boys to seek health care and drive male demand for services were perceived to lag behind the observed shift in policy attention towards men's health in the region. Informants indicated that more needs to be done to complement the policy intent to involve men in maternal and child health, or as one hospital manager from Malawi phrased it aptly: "*we cannot expect women to tell their husbands, as we have done*". In addition to a 'skip the line policy', employment-related incentives (i.e. time off for ANC visits), steps to create a more conducive environment for the spouse at the facility, and intensified community sensitization campaigns on the importance of male involvement were put forward as conditional actions within the different countries. On adolescent health, there was consensus that a first step towards taking more deliberate action would need to be a mindset change. Critical opportunities are currently being missed to help boys navigate through puberty, open up and develop life skills (by some named the 'softer issues'), as all policy and programme attention seems to be placed on the prevention of HIV and risk behaviour. The drivers of risk remain untouched for the most part, according to informants.

> "For us that's a very big gap, where everyone thinks it's health we understand that most of these problems we are talking about that affect young people arise from the environment they live in, easy access to alcohol, neglect from families, sexual abuse. So that supportive environment for us is a big gap. Who is addressing that? Everyone is just sitting on the fence. So again, in our current strategy we want to bring on board parents, we want to bring on board community leaders, religious leaders, traditional leaders, civic leaders. What is your stake in this, what haven't you done which is contributing to this behaviour we are seeing?"
>
> Policymaker health, Zambia

A gap in understanding the magnitude of issues facing men and boys, as noted in the analysis of country policies from Uganda, Lesotho, Malawi, Zambia and Zimbabwe, was corroborated by the KIIs. However, efforts were noted at the country level to more systematically track health service utilization by gender, and to use this data to inform policy action. Within civil society-led programmes, such a routine seemed to already have been established.

> "We have realized as a Ministry sometimes we are failing to really track and appreciate how much of our services are reaching both genders, so yes we now have a strategy and guidelines that will help us ensure that the males are not left behind."
>
> Policymaker health, Zambia

Interviews gave further insight into particular blind spots. For example, ministries of education are keen to know the number of pupils utilizing SRH services in health facilities and at victim units. But this level of specification is not done, thus statistics on the success of referrals (and indirectly the success of inter-ministerial collaboration in SRHR) is a black box.

SRHR policy deadlocks could be observed in all five countries, with CSE provision of adolescent SRH services and sexual diversity as the principal topics for disagreement. For example, Malawi has not renewed its East and Southern Africa commitment on young people's access to SRHR since 2021. It was indicated that particularly commitment 4.4. – access to services within the learning environment – is a point of controversy, which restrains the interventions with young people on the ground.

> "We can't force them (the government), but that has not stopped us. You just ignore the noise up there, but down here you continue with some minimal interventions."
>
> Programme implementer A, Malawi

Equally in Uganda, informants noted that their national SRH policy has been shelved for a while now, and interviewed facility staff feel exposed to all the negative attention around SRH services while executing their tasks.

> "Generally, providing sexuality education for young people mainly those in schools is a very big challenge. The wider community has perceptions that when we provide sexuality education among young people, we are actually teaching them to engage in sexual intercourse, including homosexuality. The sad reality is that as a country we lack a policy guideline for sexuality education for adolescents and young people."
>
> Service provider B, Uganda

Delivery of CSE in Zambia attracted a lot of negative publicity over the past year and a half. The Ministry of Education is currently in the process of revising the curriculum, which includes extensive community consultations in order to 'bring everyone on board'. Sexual and gender diversity will not become part of the new curriculum, due to constitutional issues. In Malawi, a country with a similar restrictive legal framework as Zambia, a ministry official indicated the topic is excluded for cultural reasons.

> "We wouldn't include issues that are not culturally acceptable in the curriculum. Although we understand there are also.., there are people that are in that category, it is not part of the curriculum."
>
> Policymaker education, Malawi

Legal issues were identified as a continued source of policy tension and conflict in the provision of SRHR information and services to men (and women too). Some room for manoeuvre was reportedly provided under the umbrella of HIV and key population targeted policies strategies at the country level.

> "Services are provided freely to the key population just like any other Ugandan. They can access services in an integrated way, taking into consideration the high risks of transmission amongst them. The service delivery model acknowledges the LGBTQI and follow their behaviours and provide services to them among other things."
>
> Policymaker health, Uganda

"The schools do not want to participate in sexuality education, talking about condoms in schools, so that becomes antagonistic at times. Sometimes we would have challenges in the age of consent, for example, legally you find that there will be inconsistencies. We are saying age of consent is 16 years and then somewhere it is 18 years, you get what I'm saying? There are all those inconsistencies sometimes which may be challenges. If you look at HIV, I mentioned that there are key populations and I mentioned sex workers as an example. When you say sex work is something that is criminal. To be soliciting for sex and paying for sex is criminal in Zimbabwe but we are saying sex workers are key populations that we need to attend to, so sometimes there will be those challenges as well where you need to make sure that the policies speak to each other, so that they are aligned."

Policymaker health, Zimbabwe

"I think sometimes we have mixed up things, the sexual rights and health rights. For health rights, we are responsible. Sexual rights, like this is how I want to practice my sexuality, it is not our mandate; that should be the Human Rights Commission, something like that. But health, someone should not complain that we denied them health services because of this, I think that is unethical. It is our mandate, our responsibility to treat everyone who comes to us with a health need. We treat them. So, it is not sexual rights, it is health rights which we need."

Policymaker health, Zambia

In the KIIs, a lot of concerns were raised around the resourcing of policies and strategies. Domestic budgets for SRHR were said to be small, even shrinking (for example, informants from Malawi said the SRH budget line of 10 per cent had been stagnant for a while now, where it previously made up 15 per cent of the health budget) to adequately implement the breadth of country policies and to do so at scale. Subsequently, the reliance on donor agencies for (sexual and reproductive) health has meant country foci end up getting distorted, and are narrowed down to HIV and AIDS service delivery and specific SRH components concerning adolescent girls and young women, according to informants.

Furthermore, the donor's orientation on measurable outcomes has meant that the more onerous tasks to improve people's SRH, for example, shifting social norms and gender transformative work, have not been prominent.

"At the moment men's health services are led by partners. In many instances, the partners have their specific mandate like focusing on HIV. Sadly, HIV has been singled out and eventually has killed other programmes. There is no clear sustainability plan beyond partner funding. The financial contribution of the Ministry of Health is small."

Programme implementer A, Lesotho

As for male-specific interventions, we observed how donor support for – what appeared to be promising practices – in Malawi was short-lived. At the time of the study, none of the following programmes and activities were still in place: the male champions and club activities funded by UNFPA, the community courts for SGBV, and the netball and soccer programmes, which were only funded for three months.

In the case of Uganda, an under-resourced national-level commitment has curtailed the intention for male engagement short at the district health office, who are responsible for policy implementation. In places where implementing partners have stepped in, the approach seems to yield results.

"At the community level, districts and health facilities have to come up with a workplan and budget to implement the male involvement strategy. However, many districts and health facilities lack a budget and workplans. They do not have Male Action Groups in place, those which are in place are not as such functional. Districts, such as Namayingo, Gulu, Amudat and Kampala, where the implementation has registered a success, have been supported by implementing partners."

Policymaker health, Uganda

Various informants from Zimbabwe voiced the concern that even if good policies and strategies are in place and have been costed, it does not imply that there are funds to implement them. To illustrate this, they pointed to this year's 30 per cent resource gap in the Ministry of Health's budget for HIV alone.

In overcoming the complexities of implementing SRH services and programmes across different sectoral mandates, we could discern a number of country practices or models of interest, particularly between the ministries of health and education. In Uganda, gender, education and health now fall under one programme budget called Human Capital Development. Within the scope of this study, we were unable to dive into this model and assess its merits for SRHR practice, but it is worthwhile to do so in the future. In Zambia, adolescents stationed at youth-friendly services serve as the linking pin between schools and the facilities. They have a role in ensuring that pupils in need reach the services and provide information that goes beyond a disease and risk frame (see quote below). Furthermore, teachers and health workers receive training in the same institution. Efforts to streamline the work of the ministries of health and education have not gone unnoticed and civil society informants in Zambia were said to applaud the steps made.

> "Collaboration occurs between Health and Education through training of teachers and health workers under the same roof and then also collaboration occurs through creating demand from the school system to the health facilities where learners can go and access services and were teachers can go and access services."
>
> Policymaker education, Zambia

> "We are working with the Ministry of Education to develop a peer educators counselling booklet to utilize in school and health facilities, covering basic information on major areas of concern, like what is hygiene, what is puberty, what is self-esteem, what is HIV, how does it affect me now, does it affect my education, how does it affect my future, what is mental health, what are the signs and symptoms, how does it affect me now, how does it affect my education and future. That is a document that is almost completed. It is being supported by UNESCO."
>
> Policymaker health, Zambia

In Malawi, the Ministry of Education was invited to the process of developing a new health strategic plan. The ministries, as well as other stakeholders, meet regularly on issues of SRHR as members of a technical working group. Also in Lesotho, the collaboration between the two ministries is said to be close. However, as the following quote also indicates, the success of this collaboration in meeting the SRH needs of young people hinges on the assumption that they will find their way to the facility and be served. In our FGDs with young men, it became clear that the school-to-clinic pathway is challenging due to different reasons.

> "The curriculum was revised to include sexuality education at different levels, starting from Grade 4 to Grade 12. So, the information is age specific according to the level of study. On the other hand, the Ministry of Health provides friendly health services to the youths in their health facilities. It may happen that some of the clients who are adolescents or youths may be referred from the schools to the health facility."
>
> Policymaker education, Lesotho

From the KIIs in Zimbabwe, we understood the Ministry of Health is considering priority service for young people in school uniform, which may make a difference. Sectoral collaboration is, according to the Ministry of Education, stipulated clearly in the Education Act Section 64, and enacted through information provision and psychosocial support to pupils in the education system, and clinical services under the purview of the health ministry.

> "Health facilities are being educated now to be quick and have systems, for example, that help accommodate serving adolescents who come in uniform, so that they can go back to school early."
>
> Policymaker health, Zimbabwe

Despite the many challenges in providing SRH information in school settings, there was consensus among informants in the five countries that this is where it needs to happen, as sexuality is still too much of a taboo in the family setting. Similarly, findings from our FGDs indicated that the places where young men first learn about sex and reproduction were in the classroom or through experimenting with their peers in the community.

Discussion

The study sought to assess the structural, social and behavioural drivers that facilitate or impede the uptake of SRHR services among adolescent boys and young men in five countries in sub-Saharan Africa, using a mixed methods approach, including KIIs, FGDs and surveys. The study assessed the knowledge, attitudes, norms and behaviours of adolescent boys and young men pertaining to SRH, as well as examined the extent to which SRH services that are being provided meet the needs of adolescent boys and young men.

Emerging evidence shows that SRH outcomes along the life course in adolescent boys and young men are partly attributable to differences with regard to age, developmental progression, socio-cultural norms and expectations of adolescence and young adulthood, and the environmental context in which development occurs (Foulkes & Blakemore, 2018). It is also evident that SRH outcomes in adolescent boys and young men are embedded within discourses of traditional masculinity (stoicism, breadwinner, pride, virility, sexual prowess, procreation and invulnerability to illness) and prevailing gender norms (men as breadwinners, women being responsible for caregiving) (Govender, 2011; Odimegwu & Adedini, 2013). A life-course perspective on SRH outcomes acknowledges the developmental change in relation to social and structural determinants of health (Brook et al., 2006; Sawyer et al., 2012), where the development of young people unfolds as a transactional process that is the product of bidirectional and synergistic effects of the individual and their experiences within the social environment (Sameroff, 2009).

In the following sections, we discuss some of the key social determinants which lead to vulnerabilities related to SRH outcomes in adolescent boys and young men in the five countries under study. These include socio-demographic factors, normative beliefs around gender and sexuality, sexual risk behaviour, protective factors and health system factors (health policy, programming and service delivery). The discussion will also look at a number of promising practices emanating from this research, which hold potential for policy and programming on SRHR in East and Southern African region.

Socio-demographic factors, gender norms, sexual risk behaviours, age-related differences and protective factors

The results from this study highlight that there are significant sexual risk behaviours, inequitable gender attitudes, gaps in knowledge of common SRH problems (for example, HPV and penile cancer) and poor socio-economic conditions prevalent amongst our sample group of adolescent boys and young men. Regarding the socio-demographic profile of the sample, the median age for adolescent boys and young men in our sample was 25 years and the majority (65.3 per cent) was rural based. Educational vulnerability included attainment problems with less than half having completed secondary education and/or tertiary education and many respondents (44.6 per cent) indicating they had dropped out of school. Even though many respondents were not currently in school (81.8 per cent) only 7.8 per cent were currently undertaking a degree or diploma. Regarding livelihoods, mobility and living arrangements, approximately half of the men were involved in income-generating activities in the previous seven days; the sample was quite mobile with nearly a third having been away from home for more than one month in the previous 12 months and 72.6 per cent having always lived in the communities where they currently reside. Less than half (43.1 per cent) of the men were unmarried but cohabiting with their partners.

Inequitable gender norms reflect and perpetuate unequal power relations that are often disadvantageous to women (Connell, 2014). This is evidenced in approximately 72 per cent of the sample indicating that the man should have the final word about decisions in his home and it is a woman's responsibility to avoid getting pregnant (approximately 60 per cent) and women should obey their male partners in all things (approximately 73 per cent), all of which are linked to poor SRH outcomes in women (Pulerwitz & Barker, 2008; Verma et al., 2008).

There were also discrepancies between attitudes and behaviours regarding violence against women. While the majority (75.2 per cent) of men believed that it is not okay for men to beat their female partners if they are unfaithful, nearly a quarter (22.3 per cent) of men have committed at least one form of sexual IPV in the previous 12 months. Male perpetrators of IPV engage in riskier sexual behaviours in general which put their partners at risk for HIV and other STIs (Campbell et al., 2008). The lack of condom use coupled with high levels of IPV is a significant concern for adolescent boys and young men and their partners in the study.

Traditional masculinity, which is linked to unequal gender relations, is also associated with perceptions on male invulnerability, where denial of weakness and rejecting help is a key practice of masculinity and help seeking behaviour (Manandhar et al., 2008). Findings from both the quantitative and qualitative data indicate reluctance to seek SRH services, and fear of being seen accessing such services, with service providers often finding it difficult to getting men to clinics or to health interventions.

The study findings also point to masculinity being associated with policing the boundaries of heterosexuality, where male peer culture is perceived as promoting stigma and violence against non-heterosexuals (Bakeera-Kitaka et al., 2008). These findings are corroborated by the vast majority (70.9 per cent) of men agreeing that they were disgusted when they see a man acting like a woman. The FGDs with adolescent boys and young men also revealed contemptuous reactions towards boys or men in the community who do not conform to the 'heterosexual script', either by having a same-sex sexual relationship or through a trans or gender fluid identity. Prejudiced attitudes and acts of discrimination against sexual minority populations is frequently cited as a factor among this group in not seeking SRH services (Wanyenze et al., 2016; Wirtz et al., 2014).

The study also found that HIV-related stigma is still a problem in communities with nearly a quarter of respondents indicating people are not supported by their families if they disclose their HIV-positive status. There were also signs of alienation, with 15.4 per cent feeling lonely more than three out of seven days in the previous week, and hopelessness, with 17.1 per cent of adolescent boys and young men indicating they rarely felt hopeful about the future. While there is an acknowledgment among ministry officials in health and education that mental health and psychosocial services is a need (key informant data), more action is required in offering such services to men.

Regarding sexual risk, the median age at sexual debut was 17 years and the median number of lifetime partners was five, while only 30.4 per cent used condoms consistently in the previous 12 months. We also noted some age differences in the sample in terms of sexual risk behaviours. Males, usually younger than 20 years, were perceived as having a poor understanding of the physical and emotional changes during puberty, limited knowledge of STIs and conception, and were also prone to negative influences of peer pressure (alcohol and substance misuse, as well as misinformation and myths, having multiple sexual partners, not knowing the sexual history of one's partner and infrequent use of condoms during sex). Younger men had fewer lifetime sexual partners and were more likely to use condoms consistently, albeit, still at a very low level than older men who used condoms very inconsistently. The FGD data highlighted a gap in preventive services and information dissemination on SRH to younger men in communities.

However, younger men were more likely to be attending school than the older group and more likely to be attending a sporting or recreational organization, which is considered protective of poor SRHR outcomes. The risk behaviour trends noted above can be attributed to psychosocial challenges associated with transitioning into young adulthood (Govender et al., 2019). Older men, on the other hand, also had limited knowledge and held myths about issues of sexual dysfunction, infertility and reproductive cancers, such as prostate cancer. Older men were more likely to commit IPV than their younger male counterparts. Adolescent boys and young men would benefit from aged-related and differentiated approaches to creating demand for SRH services (Engel et al., 2019).

We also noted the presence of protective factors supporting positive SRHR outcomes. There was some support for partners accessing SRHR services. The survey indicated that approximately three-quarters indicated they would support their partner to access HIV services and two thirds indicated they would support their partner to access pregnancy services. However, it is also noted that less than half indicated they would support their partners to access a medically safe abortion. The fact that, despite our 21st-century medical knowledge and tools at our disposal, abortion rights remain under threat in so many countries arguably connects to the desire of patriarchal societies to exercise control over women's freedom, and deep-rooted patriarchal insecurities about reproductive processes which men do not have power over (Strong, 2022). More efforts, need to be made in engaging with men and boys about healthy sex and relationships, and their role in the sexual and reproductive well-being of themselves and their partners.

Geographical and Population-level vulnerabilities

The survey results disaggregated by country indicate some concerning trends on sexual behaviours and accessing HIV-SRH services. Lesotho had the youngest average age at sexual debut, high levels of inconsistent condom use and the lowest level of VMMC and STI testing services available in their communities. Uganda also had very low levels of consistent condom use and was least likely to support its partners to access HIV services. Malawi appeared to have the lowest proportion indicating they need SRH services, such as HIV testing counselling, HIV treatment and STI testing. The data for Zimbabwe highlighted the lowest HIV testing rates.

Youth-friendly services were limited in rural areas; where civil society organization services did occur, its reach was limited. Additional risks related to poor SRH outcomes in rural areas included adolescent boys and young men being more likely to drop out of school, more likely to be food insecure and more likely to be away from home for more than one consecutive month in the previous year. However, rural respondents were more likely to receive a cash transfer to mitigate poverty than urban respondents. Cash transfers are known to act as a protective factor for positive SRH outcomes (Hindin et al., 2016).

SRH interventions need to target males in early adolescence for SRH education and information campaign services before sexual risk and related dysfunctional behaviours become entrenched (Cowden, Tucker & Govender, 2020). We however noted that certain groups of young men, working as gold panners or who were registered as school boarders (in Zimbabwe) and shepherd and herd boys (in Lesotho), seemed more prone to poor SRH outcomes. These highly vulnerable groups were perceived as having poor access to SRHR services, and the commonality of living with other adolescent boys and young men and without parental guidance was believed to place them at risk of negative peer influences.

Health policy and service delivery factors related to poor sexual and reproductive health outcomes

In all five countries, we noted considerable shortcomings of currently available SRHR information and services to adequately respond to age and developmental-specific needs along the male life course. This was most prominent for the adolescent period in which an array of issues, such as service restrictions due to age of consent or location (i.e. no condoms and contraceptives in schools), social taboos (i.e. poor parent-child communication on sexuality) and trust issues (21.1 per cent of adolescent boys and young men indicated they don't trust health workers and 22.5 per cent said they don't feel respected by health workers) were put forward to explain this shortfall. We noted gaps in policy and programming guidance in meeting the needs of adolescent boys and young men in a holistic and integrated manner, beyond HIV-related clinical and non-clinical services. Study findings also revealed that while the COVID-19 pandemic significantly hampered access to services and support in health facilities, school settings and the community (Govender et al., 2020), limited attention to adolescent boys and young men health issues in national guidance documents and resource constraints to offer comprehensive SRH information and services at scale were already evident prior to COVID-19.

Unmet need for sexual and reproductive health services

Not surprisingly, the study found that there is much greater coverage of HIV interventions than other SRH (fertility services, sexual dysfunctions and cancers) interventions, with the vast majority of men indicating they have access to HIV testing and treatment services. The survey data highlighted which services respondents indicated are available in their community and which services they would like to be available in their community. There was a significant unmet need for SRHR services amongst

adolescent boys and young men. Just over half (55.5 per cent) indicated they had access to PreP in their communities and more than three quarters (77.3 per cent) indicated they would like to access PreP (21.8 percentage point difference). For PEP there was a similar unmet need with more than half (58.4 per cent) indicating they have access to PEP and just over three quarters (77.0 per cent) indicating they would like access to this service (18.6 percentage points difference). More than two thirds (71.4 per cent) indicated they would like access to services for men who are victims of sexual violence, whereas less than half (48.7 per cent) indicated they had access to these services (22.7 percentage point difference). This links with the qualitative findings that police often looked down on male victims of sexual violence, and provider reports of male lack of willingness to report such rights violations. While there seems to be awareness of the barriers for adolescent boys and young men to report to victim units, the study did not identify visible strategies to address this gap. Interviews further revealed that, while there is an awareness and identification of child abuse cases within the school setting, statistics are not routinely kept. Thus, poor record-keeping at various key institutions severely hampers a proper understanding of the extent of the problem among adolescent boys and young men.

A further unmet need is information, counselling and treatment on male cancers of the reproductive organs, less than half (39.8 per cent) said they have access to these services and more than two thirds (68.3 per cent) indicated they would like access to these services (28.5 percentage points difference). Information and counselling on sexual dysfunction is a significant unmet need as less than a third (31.8 per cent) indicated they had access to this form of counselling, while nearly two thirds (65.5 per cent) indicated they would like access to this service (33.7 percentage points difference)[9]. More generally, we noted an absence of IEC materials, support and advocacy groups for men to create demand for SRH services and improve access to SRH services.

[9] It should be noted that the individuals in the study may not have known that these services were available to them and therefore a proper survey of service providers in the community should be undertaken to assess the extent of these services being available in the respective communities.

Gaps in clinical services

The FGD and key informant data revealed numerous gaps in clinical services that were not HIV-specific. Physical examinations of clients were not a routine part of SRH service provision, and condom provision seemed the only option on offer as part of contraceptive services for male clients, with less attention to the male support role and to couple counselling on contraceptive choices. STI services, which were in high demand, occurred mostly in the form of syndromic management, or referrals to private clinics, with concurrent treatment of sexual partners seen as a major gap in STI service provision across the five countries.

While there is attention in country policies and strategies to the issue of male involvement, the involvement of men in HIV testing, pregnancy services and comprehensive abortion care for their partners was not evident on the ground. However, the issue of male partner support for women to attend SRH services is seemingly more complex. The FGD data clearly showed that men distinguish between partners (regular and non-regular sex partners) where usually a regular partner is supported to attend the clinic. Men fear to bring non-regular partners to the same health clinic because they may be stigmatized by health-care workers or other attendees for having more than one partner. The issue of multi-concurrent partnerships and polygamy is missed in policy and strategy conversations, and none of the existing policies openly discuss this, especially in terms of how to manage service provision.

There were efforts to bring expectant fathers to health facilities to support prenatal and postnatal care mostly to prevent mother-to-child transmission of HIV. Specific incentives like the 'first serve' rule for male clients, in this study, had some success in Uganda and Zambia, but these approaches have also been met with critique as they would side-line single women and women who are unable to bring their partner, as well as reinforce gender inequities (Galle et al., 2021). As indicated previously, there was silence on safe abortions across countries, especially on men's roles in supporting the procedure with legal restrictions being the main reason (Lesotho and Malawi) or ambivalent programming on CAC (Zambia), restricting access for both women and men. The study findings also noted the abortion was seen as a sin and safe abortion services would encourage irresponsibility **"We don't often support it and we haven't taught about it because they will carelessly indulge in sex knowing that they can abort later."** Programme implementer A, Zimbabwe.

Services for male reproductive disorders were largely unavailable at primary health-care facilities and in some countries also at secondary care level (for example, Zimbabwe). Information on sexual dysfunction and counselling on premature ejaculation was only part of health-care workers training in Zambia, with services more likely at district hospitals. Lesotho seemed to be the only country to have a national programme on prostate cancer, however, coverage of screening services was patchy, including in the male corners. Fertility services for male clients were not seen as an SRHR priority by policymakers, providers or male respondents because of a perceived low demand, based on the belief that men considered infertility a women's problem and it was considered taboo for a man to seek such services. Earlier studies have linked the lack of prioritization in health policy to high reluctance among men to undergo fertility evaluation and subsequent underreporting of male infertility in the region (Agarwal et al., 2014; Parrott, 2014).

Given the region's long history in engaging with the HIV epidemic, it was no surprise to see the HIV and AIDS component of the global package on SRHR being the most well-organized and accessible health service. HIV testing and counselling, including prevention of mother-to-child transmission, ART and VMMC appeared to be standard elements of service provision, and to a lesser extent, included the provision of PEP and PrEP. Add-on services, as well as differentiated models of care, could be observed, ranging from the inclusion of syphilis screening in Malawi, the delivery of mobile HIV services in Zimbabwe, or school-based delivery in support of pupils' ART adherence in Lesotho. Treatment support and home visits for people living with HIV were provided through NGO programmes, like Nurture Africa (Uganda) and PrEP and a safe space for clients from key populations to access HIV services through Tumbombele (Zambia).

Various initiatives, such as 'male corners' in Lesotho which had set out with an HIV focus, seemed to have made some inroads in terms of promoting male health-seeking behaviour and retention in care. However, the study findings also revealed limited integration of HIV services for male clients with other components of the SRH package, which is evidently a missed opportunity.

Furthermore, existing barriers to service provision for men (for example, lack of confidentiality, judgemental attitudes, health staff's moderate to poor knowledge on medical issues, time inconvenience, cannot afford services, bad experiences in interacting with staff) makes it more difficult for health workers to address issues of GBV, especially when signs are present during the provision of pregnancy care.

Our analysis noted that a number of components in the global package for men and boys (Shand, 2017) were currently not reflected in any of the country's policies and strategies, and service providers on the ground had no clarity as to how best to respond to client demand in these areas. This included the lack of provision of basic information, for example, on infertility and male cancers in primary health care facilities and communities, during client consultations, as well as in specific IEC materials addressing men's health. In settings, where health systems were strained because of resource limitations, the coverage and quality of services were compromised, as evidenced in previous studies (Matare et al., 2015; Ninsiima et al., 2021; Pillay et al., 2020; Snow, Laski & Mutumba, 2015).

Findings, therefore, point to lots of trust and reliance placed on the internet and (inexperienced or not well-informed) peers to meet informational needs of adolescent boys and young men and a large reliance on the 'cash and carry' pharmacies (easier access, quicker and more private) to address immediate SRH problems, instead of the public system.

However, out-of-pocket costs incurred by patients is a major impediment to seeking health care in low- and middle-income countries (World Health Organization & Bank, 2021). In this sample, 37.2 per cent of those that went to a health facility had to pay to go to the health facility (transport fees and clinics fees). Clients had to also pay for some SRH-HIV services at government clinics, otherwise they were turned away.

Of concern, 16 per cent of adolescent boys and young men believe that women should tolerate violence from men to keep her family together. The above is consistent with the study's finding of little on-the-ground evidence of male leadership roles being actively encouraged in the five countries on resisting, confronting and changing traditional masculine behaviours that are related to harm. This is consistent with previous research in such contexts, reporting on both underachievement as well as great variation between interventions in target groups, change objectives and methods to address the perpetration of violence against women and girls in the region (Dworkin et al., 2014).

A study conducted in South Africa on attendance of young men at an IPV intervention highlighted that young men who had recently worked were less likely to attend these types of interventions (Gibbs et al., 2020). Other studies have shown conflict with intervention attendance and work commitments amongst men (Ringle et al., 2015; Williams et al., 2010). Some studies have sought to provide cash incentives for men to attend these interventions in order to overcome some of the structural barriers for attendance. Additionally, young men who had secondary education or higher were also more likely to be medium attenders of the IPV intervention than those who had lower educational attainment. The reasons for this finding are not clear, but the lower attendance for these men may be due to their increased ability to access employment which may in turn influence attendance. A consistent predictor of attendance for men was the length of time that they had lived in the community. Those who lived in their community longer were more likely to attend the IPV interventions. The study took place in informal settlements with lots of migration in and out of the settlement. Many young men lived in the informal settlement on a temporary basis to look for work and may not have had time to attend an intervention that stretches over two weeks. Some of the recommendations from this study include reducing the time span of interventions and making sure that the mechanisms for delivering the intervention suit the intended participants (Gibbs et al., 2020). The context for these studies is not exactly the same as for our study, but the structural barriers that negatively impact attendance is probably an important factor for men's absence from SGBV interventions.

Narrow scope of non-clinical services

In terms of non-clinical services, the emerging picture from the data was that the dissemination of information, counselling and commodities to male clients was the main focus, especially to prevent STIs, including HIV and unintended pregnancies. The provision of education on GBV and drug and substance abuse, though seen as critical by most key informants, was not supported by an availability of IEC materials with government budgets very rarely accommodating the production of IEC materials. Also implementing partners were not as forthcoming in supporting health facilities with flyers or posters. Sexuality education in schools was found to be an important place for adolescent boys and young men to get information on SRHR. However, the importance of addressing topics, such as sexual rights, pleasure and well-being in a sexual relationship and responses to pressing questions of adolescent boys and young men on puberty changes appears to be very limited across the board. Sessions tended to be a one-way flow of information focusing on sexual risk, with a lack of application to teaching sexuality, gender and life skills. However, there is a discernible difference between Lesotho and the other countries in the way ministry officials articulated their approach to CSE in school settings,[10] demonstrating some intent to support pupils in developing a set of personal and social skills in relation to their sexual health.

The qualitative data highlight that in Malawi and Zambia, sexual and gender diversity will not become part of the CSE curriculum because of religious restrictions. However, Zambia unlike Malawi has signed on to the Eastern and Southern Africa Ministerial Commitment on sexuality education and SRH services for adolescent and young people. In addition, the restricted form of CSE (with a focus on sexual risk and abstinence, and excluding or limiting content on sexual desire, sexual and gender diversity, negotiating safe sex, refusing unwanted sex, condom self-efficacy, fertility awareness) falls short of meeting all of adolescent boys and young men's needs during a transitional stage in their life, marked by physical and psychological developments. These remain taboo topics at home and in the school setting to the detriment of young people who need such information.

Of equal importance is the limited responsiveness by state actors to actively support adolescent boys and young men in preventing ill health now and in future, by promoting interventions on males being 'agents of change' at a young age, for instance, through seeking and opening up opportunities for them to engage in health-enabling, norm-changing interventions by interfacing with public, private and civil society actors (Mantell et al., 2020).

Some promising practices and its related challenges

Gender and SRH work with men has a multi-dimensional logic and is therefore not easily accomplished with minimal effort (Gittings et al., 2021). The SRHR needs of young people hinge on the assumption that under enabling conditions (individual and environmental), that they will find their way to the facility or programme and their SRHR will be realized.

The study found various ongoing initiatives which, to some extent, were able to bring adolescent boys and young men into clinical service settings or programmes related to SRH. Male corners, school clubs, sports-based activities with health promotion interventions, and youth led, male mobilizers, are potentially promising community-based interventions which could attract larger numbers of adolescent boys and young men. While these interventions had potential, programmatic strategies that focused on shifting gender norms were hindered in any ways: inadequate theory of change models; a lack of high-fidelity interventions; short term nature of such interventions; and challenges related to scale-up.

Previous research has suggested that instilling personal and collective agency to resist and challenge patriarchal norms is important to driving gender transformative work (Dworkin et al., 2015; Peacock & Barker, 2014). As part of interventions to reduce SGBV, young men and women are encouraged to develop and share examples of practices to foster joint learning on experiences about how gender intersects with health to produce SRH outcomes. For example, some learning activities, evidenced in the study, included

[10] More observations on the CSE curricula of Uganda, Lesotho and Zambia can be found in the policy analysis report.

participants sharing their own videos to speak out against SGBV or offering educational and skills-based materials to run club workshops, participation in needs assessment exercises and identification of gaps in existing services. Adolescent boys and young men also preferred mixed-purpose activities, mixed gender activities and peer-based models for the dissemination of knowledge and commodities on SRHR.

While the above approaches (such as encouraging youth participation in design and delivery of interventions, creating safe spaces, helping to navigate conversations on sensitive issues, using sports-based activities with health promotion interventions, youth-led interventions, etc.) can be referred to as 'youth-friendly' activities, we are uncertain, based on our analysis of programme strategies that were available, as to whether there is a sufficient focus on gender-sensitive type approaches in programmes (understanding of how gender plays a role in ideologies of health and illness and access to social and health services, and its implication for service delivery). We also note a lack of gender transformative type approaches in many programmes (challenging patriarchal social structures) and activities geared towards building personal and collective agency to change harmful masculine norms – that are linked to poor health outcomes. We also note a lack of gender informed perspectives to support partners of adolescent boys and young men in accessing and adhering to SRH services.

Youth-led programmes in Malawi, Zambia and Zimbabwe do show some promise with incorporating elements of the 'agents for change' concept. For instance, safe spaces for opening up and talking about sensitive SRHR are considered a critical element in the success of interventions such as the Zambian Insaka's, where adolescent boys and young men can air their views without being judged, or in the Brotha2Brotha Programme in Zimbabwe where adolescent boys and young men may confide in a male mentor. However, it is also acknowledged that the challenge in tackling gender norms and promoting SRHR, more generally, also needs to be understood in the context of the wider and prevailing public moral panics, backlashes and policy deadlocks that are underlined by divergent views on sexual practice, gender and sexuality.

As evidenced in this study, we have noted some careful navigation occurring by SRHR programmers on these sensitive issues within a broader national and regional SRH discourses, as supported elsewhere in the literature (Chavula et al., 2022; Moore et al., 2022). Legal prejudices (criminalization of same-sex relationships) were identified as a continued source of policy tension and conflict in the provision of SRHR information and services to men (and women) in many East and Southern Africa countries (Izugbara et al., 2020; Lyons et al., 2023). More specifically, we noted that Malawi has not renewed its East and Southern Africa commitment to young people's access to SRHR since 2021 because commitment 4.4. – access to

services within the learning environment – is a point of controversy. Uganda's national SRHR policy has, to some extent stalled because of the negative attention around SRH services (focusing on topics, such as sexual intercourse and homosexuality). We also note some room for manoeuvre, where the provision of SRH services (mainly contraceptives) to men who have sex with men and transgendered populations occurred under the umbrella of HIV services where the focus is on key populations – mostly as a consequence of external donor strategies, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund.

While CSE programmes can offer opportunities for SRH and sexuality education, these programmes, as noted previously, are offered in a restrictive and instrumental manner. Clearly, more efforts need to be placed on the inclusion of gender sensitive and gender transformative approaches in programme design and delivery (see for instance, Freire's 1970 critical pedagogy approach which is useful for the deeper understanding of gender and power and the possibility of consensual social action, using notions of conscientization and dialogue).

Apart from a limited conceptual approach in SRH programming, the study also identified significant challenges in terms of quality of delivery (no specific and standard guidelines on SRHR service provision, aside from HIV testing and treatment protocols) and limited capacity (technical and financial) in responding to the high demand for such services, once adolescent boys and young men become aware of them and find them relevant to their needs. Further, health services in many countries remain static with a limited outreach on SRH services for young people, especially in rural settings. The above occurs in the context of domestic budgets for SRHR being small and not growing in line with needs, and high out-of-pocket costs for accessing SRH services (Lince-Deroche et al., 2019; Poku et al., 2023). This means that the short-lived nature of programmes gives adolescent boys and young men a sense of not being valued and therefore limits the potential worth of engaging them on deeper social issues (gender, sexuality, social justice and power) that affects them, their partner's health and the health of their families.

Scale-up challenges due to limited donor support have affected many programmes (for example, male champions and club activities, community courts for SGBV in Malawi and Uganda male engagement programmes). In addition, male corners where a donor for instance took the initiative to support the Ministry of Health, who now cannot sustain this initiative, incurs a risk that men will drop out as programme quality falters. As noted above, the reliance on donor agencies for SRH has also meant country foci are narrowed down to mainly HIV and AIDS service delivery and specific SRH components (provision on contraceptives, mainly condoms), and or specific populations (adolescent girls and young women). Furthermore, donor programme strategies focusing on narrow and measurable outcomes (mostly clinical outcomes) has meant that the more onerous task of tackling social norms and 'doing gender transformative work' is neglected.

SRH programme delivery can be strengthened through generating better data to inform the planning of interventions. Where SRH interventions are occurring, there also needs to be better tracking of health service utilization (for example, number of pupils utilizing SRH services in health facilities and use of SGBV services) in relation to prevalent epidemiological disease patterns. Building on the gains of the HIV response, some efforts were noted at the country level (for example, Zambia) to more systematically track SRH health service utilization by gender, and to use this data to inform policy action. More coordination and integration of data collection procedures across disease management platforms is required going forward (Armstrong et al., 2020).

In overcoming the complexities of coordinating implementing SRH services and programmes across different sectoral mandates, we could discern a number of country practices or models of interest, particularly between the ministries of health and education. In Uganda, gender, education and health now fall under one programme budget called Human Capital Development. While the scope of this study did not allow for a deep dive into this model and assess its merits for SRHR practice, it is worthwhile doing so in future. We have also noted inter-ministerial collaborative efforts in Malawi and Lesotho. In Zambia, adolescents stationed at youth-friendly services serve as the link between schools and facilities. They have a role in ensuring that pupils in need reach the services and provide information that goes beyond a disease and risk approach. Furthermore, teachers and health workers receive training in the same institution. In

Zimbabwe, inter-ministerial collaboration – health and education is considering a priority service – psychosocial support and clinical services for young people in school uniform.

Despite the many challenges in clearly articulating pathways for SRH service delivery, there was consensus among informants in the five countries that schools are a pivotal entry point for such services. But then, we note that under half (44.9 per cent) of the sample dropped out of school at some stage, therefore community outreach type interventions are equally important. A few studies examining programmes targeting the components of community-based services for adolescents have demonstrated positive outcomes. For example, evidence from a study conducted in Ethiopia among respondents of reproductive age (including adolescents) show that such initiatives can play a significant role in expanding contraceptive use in low- and middle-income countries (Tilahun et al., 2017). Evidence from Ghana also suggests that adolescent SRHR activities should also target parents (and community members) as a way of breaking socio-cultural barriers (Kyilleh, Tabong & Konlaan, 2018). It is also shown that school programmes have been shown to be more effective in empowering adolescents in relation to their SRHR when linked to the broader community (Chandra-Mouli et al., 2015).

Limitations of the study

The survey sampling technique used for the survey was purposive and therefore cannot be considered representative of adolescent boys and young men in these five countries. The survey items were self-reported and may therefore be subject to social desirability bias. This may have affected the reliability of the responses. It did not prove possible to separate the FGDs in younger and older age bands in all countries, as intended. This may have had an influence on the extent of participation by older and young men in the discussions and the type of views and attitudes shared by them. For some participants, their attention span seemed to be a challenge in the group discussions in view of their other commitments. In rural areas, where participants were not so conversant and comfortable with SRHR issues as their urban peers, there was a need to probe more during the FGDs. This may have introduced a bias in the findings from Malawi, where only rural districts were sampled for the study. On the subject of same-sex sexualities, it proved difficult to have participants' full engagement due to the taboo and legal context attached to same-sex relationships across the five countries. The period for data collection among key informants had to be extended due to the constrained availability of ministry officials for interviews. Persistence by the teams was necessary in order to successfully include key ministries in each country.

Recommendations

Global package of sexual and reproductive health services

1. Improve the incorporation of components from the global package of services for men and boys in country's policies and strategies. Countries should review their national health policies and strategies to determine the extent to which the national package of essential services and essential medicine list includes the global package of services for men and boys across their life course.

2. Countries should develop national guidelines around the provision of services to address men and boys SRHR needs across their life course. Additionally, training packages based on these guidelines should be created to enhance the capacity of existing health-care workers. In parallel, collaboration with schools of public health, medicine and nursing at tertiary institutions is essential to integrate men's health into their curricula.

3. Implement demand creation interventions to raise awareness and bolster demand for neglected areas of men's health programming including vasectomy, sexual health problems, infertility, reproductive health cancers and encourage male involvement in the birthing process and upbringing of their child.

4. Increase education, information and screening for male infertility, reproductive disorders, sexual dysfunction and sexual health counselling, premature ejaculation and reproductive cancers at lower-level health facilities.

5. Increase initiatives to foster open discussions on CAC, with a focus on understanding and addressing the influence of men in women's abortion decisions. Specifically, these discussions should explore how men's denial of paternity can lead women to seek abortions outside of institutional and public facilities, often resorting to unsafe methods or lacking access to proper information.Promote greater male participation in HIV and STI testing, and pregnancy services for their partners, regardless of the nature of the relationship—steady or casual—while ensuring a non-coercive approach that respects their partners' sexual health and reproductive choices.

6. Better provision of male-oriented IEC materials on contraceptives, childbirth and rearing, SGBV, psychosocial and mental health, high risk sexual behaviours and drug and substance abuse.

Sexual and gender-based violence reduction interventions and comprehensive sexuality education programming

Improved conceptualization of gender-sensitive approaches within health and educational programmes, focusing on how gender influences perceptions of health and illness, as well as access to social and health services and the implications for service delivery.

7. Expand initiatives to challenge harmful social norms that uphold traditional masculinity and address health-seeking behaviours, while combating stigma and discrimination against 'the others' – those who do not conform to dominant masculine ideals and may be marginalized, including other heterosexual men, women, children, and individuals of diverse gender and sexual identities.

8. Broaden the scope of CSE programmes for both in-school and out-of-school youth, emphasizing the importance of topics, such as sexual rights, social justice, sexual pleasure and well-being in a sexual relationship and response to pressing questions of biological and psychosocial changes occurring in puberty.

9. Invest in community-based interventions that utilize participatory approaches, such as sports, dialogues and discussions involving men, boys, and girls and women. These initiatives should address topics like sex, sexuality, relationships, alcohol and substance abuse, health and well-being and social and gender norms to improve SRHR and educational outcomes for these groups.

10. Develop more programmes focused on male leadership, engagement and activism in combatting SGBV and challenging traditional heterosexual masculine behaviours that can lead to harm.

Service delivery quality and integration of service provision

1. Improve the integration of HIV services with other SRHR components for male clients, while also incorporating SRHR services into HIV care. This comprehensive approach aims to address male health-care needs more effectively, reducing time, inconvenience and costs associated with clinic visits.

2. Foster increased engagement and collaboration between health service providers and male partners during the delivery of reproductive health care, with an emphasis on identifying and addressing issues of IPV in the context of pregnancy care.

3. Enhance the quality of service delivery by implementing more specific and standardized guidelines for SRHR services that address the unique needs of men.

4. Investigate strategies to improve access to SRHR services by ensuring confidentiality in facilities, training health-care providers to offer respectful care, increasing the number of male health-care workers and considering extended operating hours, including weekends, to better accommodate men and boys.

Coordination, tracking and sustainability of programmes

1. Improve alignment between policies and strategies and linked programmes and budgeting, as well as a more effective tracking of health service utilization (for example, number of adolescent boys and young men utilizing SRH services in health facilities and use of GBV services) to inform future policies, strategies and programmes.

2. Improve coordination of SRH services and programmes across different sectoral mandates, particularly between the ministries of health and education, social development and finance.

3. Enhance the efficient pooling of financial and human resources to strengthen the delivery and provision of SRH services.

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Appendices

Table 7:

Recruitment type by disaggregation variables

Disaggregation variables		Recruited from general community		Recruited from NGO	
		N	%/mean	N	%/mean
Mean gender attitudes (17-45)*		555	32.37$_a$	448	33.42$_b$
Mean depressive symptoms (0-3)		555	2.25$_a$	448	2.48$_b$
Ever had sex that is vaginal, oral or anal.	No	113$_a$	20.4%	100$_a$	22.3%
	Refused	5$_a$	0.9%	7$_a$	1.6%
	Yes	437$_a$	78.7%	341$_a$	76.1%
Mean age at sexual debut		555	17$_a$	448	17$_a$
Mean number of sex partners in lifetime		555	10$_a$	448	9$_a$
Condom use in the previous 12 months.	Always	138$_a$	24.9%	98$_a$	21.9%
	Never	54$_a$	9.7%	43$_a$	9.6%
	Sometimes	243$_a$	43.8%	199$_a$	44.4%
Ever been tested for HIV.	No	76$_a$	13.7%	44$_a$	9.8%
	Yes	479$_a$	86.3%	404$_a$	90.2%
HIV status.	Did not test	78$_a$	14.1%	44$_b$	9.8%
	HIV negative	447$_a$	80.5%	339$_a$	75.7%
	HIV positive	28$_a$	5.0%	60$_b$	13.4%
	Indeterminate	1$_a$	0.2%	2$_a$	0.4%
	Refused	1$_a$	0.2%	3$_a$	0.7%
Whether respondent is taking ARVs.	No	1$_a$	3.6%	1$_a$	1.7%
	Yes	27$_a$	96.4%	59$_b$	98.3%
HIV testing and counselling services currently available.	No	31$_a$	5.6%	20$_a$	4.5%
	Yes	507$_a$	91.4%	420$_a$	93.8%
	Unsure	17$_a$	3.1%	8$_a$	1.8%
HIV medicines (antiretroviral treatment, ARV) currently available.	No	46$_a$	8.3%	24$_a$	5.4%
	Yes	466$_a$	84.0%	412$_b$	92.0%
	Unsure	43$_a$	7.7%	12$_b$	2.7%
Voluntary medical male circumcision currently available.	No	74$_a$	13.3%	27$_b$	6.0%
	Yes	449$_a$	80.9%	405$_b$	90.4%
	Unsure	32$_a$	5.8%	16$_a$	3.6%
Testing for sexually transmitted infections currently available.	No	48$_a$	8.6%	22$_b$	4.9%
	Yes	466$_a$	84.0%	407$_b$	90.8%
	Unsure	41$_a$	7.4%	19$_b$	4.2%
Provision of condoms currently available.	No	23$_a$	4.1%	17$_a$	3.8%
	Yes	519$_a$	93.5%	424$_a$	94.6%
	Unsure	13$_a$	2.3%	7$_a$	1.6%
Want HIV testing and counselling to be available in one location for men/boys your age.	No	138$_a$	24.9%	65$_b$	14.5%
	Yes	417$_a$	75.1%	383$_b$	85.5%

Disaggregation variables		Recruited from general community		Recruited from NGO	
		N	%/mean	N	%/mean
Want HIV treatment to be available in one location for men/boys their age.	No	139$_a$	25.0%	80$_b$	17.9%
	Yes	416$_a$	75.0%	368$_b$	82.1%
Want pre-exposure prophylaxis to be available in one location for men/boys their age.	No	127$_a$	22.9%	100$_a$	22.3%
	Yes	428$_a$	77.1%	348$_a$	77.7%
Want post exposure prophylaxis to be available in one location for men/boys their age.	No	133$_a$	24.0%	97$_a$	21.7%
	Yes	422$_a$	76.0%	351$_a$	78.3%
Want testing for STIs to be available in one location for men/boys their age.	No	156$_a$	28.1%	92$_b$	20.5%
	Yes	399$_a$	71.9%	356$_b$	79.5%
Support partner to access HIV services.	Missing data	26$_a$	4.7%	15$_a$	3.3%
	No	118$_a$	21.3%	75$_a$	16.7%
	Not sure	23$_a$	4.1%	13$_a$	2.9%
	Yes	388$_a$	69.9%	345$_b$	77.0%
Support partner to access pregnancy services.	Missing data	37$_a$	6.7%	11$_b$	2.5%
	No	152$_a$	27.4%	105$_a$	23.4%
	Not sure	30$_a$	5.4%	30$_a$	6.7%
	Yes	336$_a$	60.5%	302$_b$	67.4%
Support their partner if they requested a medically safe abortion.	Missing data	2$_a$	0.4%	3$_a$	0.7%
	No	352$_a$	63.4%	231$_b$	51.6%
	Yes	201$_a$	36.2%	214$_b$	47.8%
Involved in community organizations such as health focused non-governmental organization.	No	485$_a$	88.3%	342$_b$	77.4%
	Yes	64$_a$	11.7%	100$_b$	22.6%
Involved in community organizations such as church/religious organization.	No	370$_a$	67.4%	269$_b$	60.9%
	Yes	179$_a$	32.6%	173$_b$	39.1%
Involved in community organizations such as humanitarian/charitable organization.	No	539$_a$	98.2%	429$_a$	97.1%
	Yes	10a	1.8%	13a	2.9%

Note: * higher score means the respondent holds gender equitable attitudes. Notes: Values in the same row not sharing the same subscript are significantly different at $p < 0.05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances. Tests are adjusted for all pairwise comparisons within a row using the Bonferroni correction.

Table 8:

Age by disaggregated variables

Disaggregation variables		18–26 years		27–35 years	
		N	%/mean	N	%/mean
Mean gender attitudes (17-45)*		603	32.62$_a$	418	33.21$_a$
Mean depressive symptoms (0-3)		603	2.30$_a$	418	2.40$_a$
Have you ever had sex that is vaginal, oral or anal?	no	152$_a$	25.2%	64$_b$	15.3%
	refused	4$_a$	0.7%	8$_a$	1.9%
	yes	447$_a$	74.1%	346$_b$	82.8%
Mean age at sexual debut		603	17$_a$	418	18$_b$
Mean number of sex partners in lifetime		603	7$_a$	418	13$_b$
How often have you used condoms in the previous 12 months with your sex partners?	always	168$_a$	27.9%	72$_b$	17.2%
	never	40$_a$	6.6%	59$_b$	14.1%
	sometimes	237$_a$	39.3%	214$_b$	51.2%
Have you ever been tested to see if you are HIV positive?	no	90$_a$	14.9%	30$_b$	7.2%
	yes	513$_a$	85.1%	388$_b$	92.8%
What was the result of your latest HIV test?	Did not test	91$_a$	15.1%	31$_b$	7.4%
	HIV negative	463$_a$	76.8%	340$_a$	81.3%
	HIV positive	45$_a$	7.5%	44$_a$	10.5%
	Indeterminate	3$_a$	0.5%	0^2	0.0%
	Refused	1$_a$	0.2%	3$_a$	0.7%
Are you taking ARVs.	no	1$_a$	2.2%	1$_a$	2.3%
	yes	44$_a$	87.8%	43$_a$	87.7%
Is HIV testing and counselling services currently available to you?	no	38$_a$	6.3%	13$_b$	3.1%
	Yes	547$_a$	90.7%	398$_b$	95.2%
	Unsure	18$_a$	3.0%	7$_a$	1.7%
Is HIV medicines (antiretroviral treatment, ARV) currently available in your community?	no	53$_a$	8.8%	17$_b$	4.1%
	Yes	508$_a$	84.2%	388$_b$	92.8%
	Unsure	42$_a$	7.0%	13$_b$	3.1%
Is voluntary medical male circumcision currently available in your community?	no	78$_a$	12.9%	25$_b$	6.0%
	Yes	490$_a$	81.3%	379$_b$	90.7%
	Unsure	35$_a$	5.8%	14$_a$	3.3%
Is testing for sexually transmitted infections currently available in your community?	no	49$_a$	8.1%	21$_a$	5.0%
	Yes	508$_a$	84.2%	383$_b$	91.6%
	Unsure	46$_a$	7.6%	14$_b$	3.3%
Are provision of condoms currently available in your community?	no	26$_a$	4.3%	14$_a$	3.3%
	Yes	564$_a$	93.5%	397$_a$	95.0%
	Unsure	13$_a$	2.2%	7$_a$	1.7%
Want HIV testing and counselling to be available in one location for men/boys your age.	No	140$_a$	23.2%	64$_b$	15.3%
	Yes	463$_a$	76.8%	354$_b$	84.7%
Want HIV treatment to be available in one location for men/boys their age.	No	160$_a$	26.5%	62$_b$	14.8%
	Yes	443$_a$	73.5%	356$_b$	85.2%
Want pre-exposure prophylaxis to be available in one location for men/boys their age.	No	155$_a$	25.7%	77$_b$	18.4%
	Yes	448$_a$	74.3%	341$_b$	81.6%
Want post exposure prophylaxis to be available in one location for men/boys their age.	No	159$_a$	26.4%	76$_b$	18.2%
	Yes	444$_a$	73.6%	342$_b$	81.8%

Disaggregation variables		18–26 years		27–35 years	
		N	%/mean	N	%/mean
Want testing for STIs to be available in one location for men/boys their age.	No	170_a	28.2%	84_b	20.1%
	Yes	433_a	71.8%	334_b	79.9%
Support partner to access HIV services.	Missing data	29_a	4.8%	12_a	2.9%
	no	136_a	22.6%	63_b	15.1%
	Not sure	33_a	5.5%	3_b	0.7%
	yes	405_a	67.2%	340_b	81.3%
Support partner to access pregnancy services.	Missing data	42_a	7.0%	6_b	1.4%
	no	197_a	32.7%	65_b	15.6%
	Not sure	52_a	8.6%	9_b	2.2%
	yes	312_a	51.7%	338_b	80.9%
Support their partner if they requested a medically safe abortion.	Missing data	5_a	0.8%	0^2	0.0%
	no	388_a	64.3%	206_b	49.3%
	yes	210_a	34.8%	212_b	50.7%
Involved in community organizations such as health focused NGO.	No	495_a	82.8%	345_a	84.1%
	Yes	103_a	17.2%	65_a	15.9%
Involved in community organizations such as church or religious organization.	No	389_a	65.1%	260_a	63.4%
	Yes	209_a	34.9%	150_a	36.6%
Involved in community organizations such as humanitarian or charitable organization.	No	585_a	97.8%	400_a	97.6%
	Yes	13_a	2.2%	10_a	2.4%

Notes: * higher score means the respondent holds gender equitable attitudes. Values in the same row not sharing the same subscript are significantly different at $p < 0.05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances. Tests are adjusted for all pairwise comparisons within a row using the Bonferroni correction.

Table 9:

Locality by disaggregated variables

Disaggregation variables		Urban		Rural	
		N	%/mean	N	%/mean
Mean gender attitudes (17-45)*		354	32.41$_a$	667	33.11$_b$
Mean depressive symptoms (0-3)		354	2.84$_a$	667	2.09$_b$
Have you ever had sex that is vaginal, oral or anal?	no	83$_a$	23.4%	133$_a$	19.9%
	refused	7$_a$	2.0%	5$_a$	0.7%
	yes	264$_a$	74.6%	529$_a$	79.3%
Mean age at sexual debut		354	17$_a$	667	17$_b$
Mean number of sex partners in lifetime		354	12$_a$	667	8$_b$
How often have you used condoms in the previous 12 months with your sex partners?	always	83$_a$	31.4%	157$_a$	29.8%
	never	46$_a$	17.4%	53$_b$	10.1%
	sometimes	135$_a$	51.1%	316$_b$	60.1%
Have you ever been tested to see if you are HIV positive?	no	43$_a$	12.1%	77$_a$	11.5%
	yes	311$_a$	87.9%	590$_a$	88.5%
What was the result of your latest HIV test?	Did not test	43$_a$	12.1%	79$_a$	11.8%
	HIV negative	271$_a$	76.6%	532$_a$	79.8%
	HIV positive	36$_a$	10.2%	53$_a$	7.9%
	Indeterminate	1$_a$	0.3%	2$_a$	0.3%
	refused	3$_a$	0.8%	1$_a$	0.1%
Are you taking ARVs.	no	0[2]	0.0%	2$_a$	3.7%
	yes	36$_a$	100.0%	51$_a$	96.3%
Is HIV testing and counselling services currently available to you?	no	14$_a$	4.0%	37$_a$	5.5%
	Yes	337$_a$	95.2%	608$_b$	91.2%
	Unsure	3$_a$	0.8%	22$_b$	3.3%
Is antiretroviral treatment currently available in your community?	no	14$_a$	4.0%	56$_b$	8.4%
	Yes	325$_a$	91.8%	571$_b$	85.6%
	Unsure	15$_a$	4.2%	40$_a$	6.0%
Is voluntary medical male circumcision currently available in your community?	no	11$_a$	3.1%	92$_b$	13.8%
	Yes	328$_a$	92.7%	541$_b$	81.1%
	Unsure	15$_a$	4.2%	34$_a$	5.1%
Is testing for sexually transmitted infections currently available in your community?	no	10$_a$	2.8%	60$_b$	9.0%
	Yes	326$_a$	92.1%	565$_b$	84.7%
	Unsure	18$_a$	5.1%	42$_a$	6.3%
Are provision of condoms currently available in your community?	no	16$_a$	4.5%	24$_a$	3.6%
	Yes	334$_a$	94.4%	627$_a$	94.0%
	Unsure	4$_a$	1.1%	16$_a$	2.4%
Want HIV testing and counselling to be available in one location for men/boys your age.	No	52$_a$	14.7%	152$_b$	22.8%
	Yes	302$_a$	85.3%	515$_b$	77.2%
Want HIV treatment to be available in one location for men/boys their age.	No	66$_a$	18.6%	156$_a$	23.4%
	Yes	288$_a$	81.4%	511$_a$	76.6%
Want pre-exposure prophylaxis to be available in one location for men/boys their age.	No	92$_a$	26.0%	140$_a$	21.0%
	Yes	262$_a$	74.0%	527$_a$	79.0%
Want post exposure prophylaxis to be available in one location for men/boys their age.	No	86$_a$	24.3%	149$_a$	22.3%
	Yes	268$_a$	75.7%	518$_a$	77.7%
Want testing for STIs to be available in one location for men/boys their age.	No	81$_a$	22.9%	173$_a$	25.9%
	Yes	273$_a$	77.1%	494$_a$	74.1%

Disaggregation variables		Urban		Rural	
		N	%/mean	N	%/mean
Do you support your partner to access HIV services?	Missing data	8_a	2.3%	33_b	4.9%
	no	71_a	20.1%	128_a	19.2%
	Not sure	7_a	2.0%	29_a	4.3%
	yes	268_a	75.7%	477_a	71.5%
Do you support your partner to access pregnancy services?	Missing data	14_a	4.0%	34_a	5.1%
	no	93_a	26.3%	169_a	25.3%
	Not sure	18_a	5.1%	43_a	6.4%
	yes	229_a	64.7%	421_a	63.1%
Would you support your partner if they requested a medically safe abortion?	Missing data	0^2	0.0%	5_a	0.7%
	no	201_a	56.8%	393_a	58.9%
	yes	153_a	43.2%	269_a	40.3%
Involved in community organizations such as health focused NGO.	No	299_a	85.7%	541_a	82.1%
	Yes	50_a	14.3%	118_a	17.9%
Involved in community organizations such as church or religious organization.	No	213_a	61.0%	436_a	66.2%
	Yes	136_a	39.0%	223_a	33.8%
Involved in community organizations such as humanitarian or charitable organization.	No	336_a	96.3%	649_b	98.5%
	Yes	13_a	3.7%	10_b	1.5%

Notes: * higher score means the respondent holds gender equitable attitudes. Values in the same row not sharing the same subscript are significantly different at $p < 0.05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances. Tests are adjusted for all pairwise comparisons within a row using the Bonferroni correction.

Table 10:

Country by disaggregation variables

Disaggregation variables		Lesotho		Malawi		Uganda		Zambia		Zimbabwe	
		N	%/ mean	N	%/ mean	N	%/ mean	N	%/ mean	N	%/ mean
Mean gender attitudes (17-45)*		202	31.96_{a}	212	33.69_{b}	203	31.79_{a}	202	35.59_{c}	202	31.31_{a}
Mean depressive symptoms (0-3)		202	$2.02_{a,b}$	212	$2.35_{a,b}$	203	$2.51_{a,c}$	202	1.98_{b}	202	2.85_{c}
Have you ever had sex that is vaginal, oral or anal?	no	85_{a}	42.1%	$25_{b,c}$	11.8%	11_{b}	5.4%	29_{c}	14.4%	66_{a}	32.7%
	refused	10_{a}	5.0%	0^{2}	0.0%	0^{2}	0.0%	1_{b}	0.5%	1_{b}	0.5%
	yes	107_{a}	53.0%	$187_{b,c}$	88.2%	192_{b}	94.6%	172_{c}	85.1%	135_{d}	66.8%
Mean age at sexual debut		202	16_{a}	212	18_{b}	203	$17_{b,c}$	202	$17_{a,c}$	202	18_{b}
Mean number of sex partners in lifetime		202	18_{a}	212	6_{b}	203	14_{c}	202	7_{b}	202	6_{b}
How often have you used condoms in the previous 12 months with your sex partners?	always	$27_{a,c,d,e}$	25.2%	$75_{a,b}$	40.5%	24_{c}	12.6%	$63_{b,d}$	36.6%	$51_{b,e}$	37.8%
	never	17_{a}	15.9%	15_{a}	8.1%	17_{a}	8.9%	28_{a}	16.3%	22_{a}	16.3%
	sometimes	63_{a}	58.9%	95_{a}	51.4%	150_{b}	78.5%	81_{a}	47.1%	62_{a}	45.9%
Have you ever been tested to see if you are HIV positive?	no	21_{a}	10.4%	19_{a}	9.0%	21_{a}	10.3%	8_{a}	4.0%	51_{b}	25.2%
	yes	181_{a}	89.6%	193_{a}	91.0%	182_{a}	89.7%	194_{a}	96.0%	151_{b}	74.8%
What was the result of your latest HIV test?	Did not test	22_{a}	10.9%	19_{a}	9.0%	21_{a}	10.3%	8_{a}	4.0%	52_{b}	25.7%
	HIV negative	166_{a}	82.2%	$191_{a,c}$	90.1%	119_{b}	58.6%	186_{c}	92.1%	141_{b}	69.8%
	HIV positive	13_{a}	6.4%	1_{b}	0.5%	62_{c}	30.5%	$6_{a,b}$	3.0%	$7_{a,b}$	3.5%
	Indeterminate	0^{2}	0.0%	1_{a}	0.5%	0^{2}	0.0%	1_{a}	0.5%	1_{a}	0.5%
	Refused	1_{a}	0.5%	0^{2}	0.0%	1_{a}	0.5%	1_{a}	0.5%	1_{a}	0.5%
Are you taking ARVs.	no	1_{a}	8.3%	0^{2}	0.0%	0^{2}	0.0%	1_{a}	16.7%	0^{2}	0.0%
	yes	12_{a}	91.7%	1_{b}	100.0%	62_{c}	100.0%	$5_{a,b}$	83.3%	$7_{a,b}$	100.0%
Is HIV testing and counselling services currently available to you?	no	$20_{a,c}$	9.9%	3_{b}	1.4%	0^{2}	0.0%	$7_{a,b}$	3.5%	21_{c}	10.4%
	Yes	$180_{a,d}$	89.1%	$207_{b,c}$	97.6%	202_{b}	99.5%	$189_{a,c}$	93.6%	167_{d}	82.7%
	Unsure	2_{a}	1.0%	2_{a}	0.9%	1_{a}	0.5%	$6_{a,b}$	3.0%	14_{b}	6.9%
Is HIV medicines (antiretroviral treatment, ARV) currently available in your community?	no	31_{a}	15.3%	11_{b}	5.2%	0^{2}	0.0%	10_{b}	5.0%	$18_{a,b}$	8.9%
	Yes	158_{a}	78.2%	196_{b}	92.5%	203^{2}	100.0%	$173_{a,b}$	85.6%	166_{a}	82.2%
	Unsure	$13_{a,b}$	6.4%	5_{a}	2.4%	0^{2}	0.0%	19_{b}	9.4%	$18_{b,c}$	8.9%
Is voluntary male medical circumcision currently available in your community?	no	51_{a}	25.2%	23_{b}	10.8%	3_{c}	1.5%	$13_{b,c}$	6.4%	$13_{b,c}$	6.4%
	Yes	149_{a}	73.8%	$179_{a,c}$	84.4%	194_{b}	95.6%	$181_{b,c,d}$	89.6%	$166_{a,d}$	82.2%
	Unsure	2_{a}	1.0%	$10_{a,b}$	4.7%	6_{a}	3.0%	$8_{a,b}$	4.0%	23_{b}	11.4%
Is testing for sexually transmitted infections currently available in your community?	no	38_{a}	18.8%	$11_{b,c}$	5.2%	2_{b}	1.0%	$6_{b,c}$	3.0%	13_{c}	6.4%
	Yes	155_{a}	76.7%	194_{b}	91.5%	194_{b}	95.6%	$183_{b,c}$	90.6%	$165_{a,c}$	81.7%
	Unsure	$9_{a,b}$	4.5%	7_{a}	3.3%	7_{a}	3.4%	$13_{a,b}$	6.4%	24_{b}	11.9%
Are provision of condoms currently available in your community?	no	15_{a}	7.4%	2_{b}	0.9%	$9_{a,b}$	4.4%	3_{b}	1.5%	$11_{a,b}$	5.4%
	Yes	185_{a}	91.6%	208_{b}	98.1%	$192_{a,b}$	94.6%	$193_{a,b}$	95.5%	183_{a}	90.6%
	Unsure	2_{a}	1.0%	2_{a}	0.9%	2_{a}	1.0%	6_{a}	3.0%	8_{a}	4.0%
Want HIV testing and counselling to be available in one location for men/ boys your age.	No	$11_{a,c}$	5.4%	106_{b}	50.0%	3_{a}	1.5%	21_{c}	10.4%	63_{d}	31.2%
	Yes	$191_{a,c}$	94.6%	106_{b}	50.0%	200_{a}	98.5%	181_{c}	89.6%	139_{d}	68.8%

Disaggregation variables		Lesotho		Malawi		Uganda		Zambia		Zimbabwe	
		N	%/ mean	N	%/ mean	N	%/ mean	N	%/ mean	N	%/ mean
Want HIV treatment to be available in one location for men/boys their age.	No	$18_{a,c}$	8.9%	93_{b}	43.9%	5_{a}	2.5%	27_{c}	13.4%	79_{b}	39.1%
	Yes	$184_{a,c}$	91.1%	119_{b}	56.1%	198_{a}	97.5%	175_{c}	86.6%	123_{b}	60.9%
Want pre-exposure prophylaxis to be available in one location for men/ boys their age.	No	20_{a}	9.9%	67_{b}	31.6%	20_{a}	9.9%	61_{b}	30.2%	64_{b}	31.7%
	Yes	182_{a}	90.1%	145_{b}	68.4%	183_{a}	90.1%	141_{b}	69.8%	138_{b}	68.3%
Want post exposure prophylaxis to be available in one location for men/ boys their age.	No	26_{a}	12.9%	68_{b}	32.1%	6_{c}	3.0%	62_{b}	30.7%	73_{b}	36.1%
	Yes	176_{a}	87.1%	144_{b}	67.9%	197_{c}	97.0%	140_{b}	69.3%	129_{b}	63.9%
Want testing for STIs to be available in one location for men/boys their age.	No	31_{a}	15.3%	104_{b}	49.1%	11_{c}	5.4%	$45_{a,d}$	22.3%	63_{d}	31.2%
	Yes	171_{a}	84.7%	108_{b}	50.9%	192_{c}	94.6%	$157_{a,d}$	77.7%	139_{d}	68.8%
Support partner to access HIV services.	Missing data	1_{a}	0.5%	3_{a}	1.4%	34_{b}	16.7%	1_{a}	0.5%	2_{a}	1.0%
	no	13_{a}	6.4%	20_{a}	9.4%	88_{b}	43.3%	58_{c}	28.7%	20_{a}	9.9%
	Not sure	$9_{a,b}$	4.5%	$10_{a,b}$	4.7%	1_{a}	0.5%	$3_{a,b}$	1.5%	13_{b}	6.4%
	yes	179_{a}	88.6%	179_{a}	84.4%	80_{b}	39.4%	140_{c}	69.3%	167_{a}	82.7%
Support partner to access pregnancy services.	Missing data	1_{a}	0.5%	$16_{b,c,d}$	7.5%	22_{b}	10.8%	$4_{a,c}$	2.0%	$5_{a,d}$	2.5%
	no	$53_{a,b}$	26.2%	$45_{a,d}$	21.2%	68_{b}	33.5%	$71_{b,c}$	35.1%	25_{d}	12.4%
	Not sure	$14_{a,c,e}$	6.9%	$20_{a,b}$	9.4%	3_{c}	1.5%	$5_{c,d}$	2.5%	$19_{b,e}$	9.4%
	yes	$134_{a,b}$	66.3%	131_{a}	61.8%	110_{a}	54.2%	122_{a}	60.4%	153_{b}	75.7%
Support their partner if they requested a medically safe abortion.	Missing data	1_{a}	0.5%	1_{a}	0.5%	2_{a}	1.0%	0^{2}	0.0%	1_{a}	0.5%
	no	91_{a}	45.0%	156_{b}	73.6%	66_{a}	32.5%	135_{b}	66.8%	146_{b}	72.3%
	yes	110_{a}	54.5%	55_{b}	25.9%	135_{a}	66.5%	67_{b}	33.2%	55_{b}	27.2%
Involved in community organizations such as health focused NGO.	No	180_{a}	93.8%	144_{b}	67.9%	191_{a}	94.1%	178_{a}	88.1%	147_{b}	73.9%
	Yes	12_{a}	6.3%	68_{b}	32.1%	12_{a}	5.9%	24_{a}	11.9%	52_{b}	26.1%
Involved in community organizations such as church or religious organization.	No	130_{a}	67.7%	181_{b}	85.4%	$162_{a,b}$	79.8%	93_{c}	46.0%	83_{c}	41.7%
	Yes	62_{a}	32.3%	31_{b}	14.6%	$41_{a,b}$	20.2%	109_{c}	54.0%	116_{c}	58.3%
Involved in community organizations such as humanitarian or charitable organization.	No	184_{a}	95.8%	210_{a}	99.1%	197_{a}	97.0%	197_{a}	97.5%	197_{a}	99.0%
	Yes	8_{a}	4.2%	2_{a}	0.9%	6_{a}	3.0%	5_{a}	2.5%	2_{a}	1.0%

Notes: * higher score means the respondent holds gender equitable attitudes. Values in the same row not sharing the same subscript are significantly different at $p < 0.05$ in the two-sided test of equality for column proportions. Cells with no subscript are not included in the test. Tests assume equal variances. Tests are adjusted for all pairwise comparisons within a row using the Bonferroni correction.

Sweden
Sverige

2gether 4SRHR

United Nations Population Fund
East and Southern Africa
9 Simba Road / P.O. Box 2980, Sunninghill,
Johannesburg, 2191 / 2157, South Africa.

Tel: +27 11 603 5300

Website: https://esaro.unfpa.org

2gether 4 SRHR Knowledge Hub:
https://www.2gether4srhr.org/

X:@UNFPA_ESARO

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