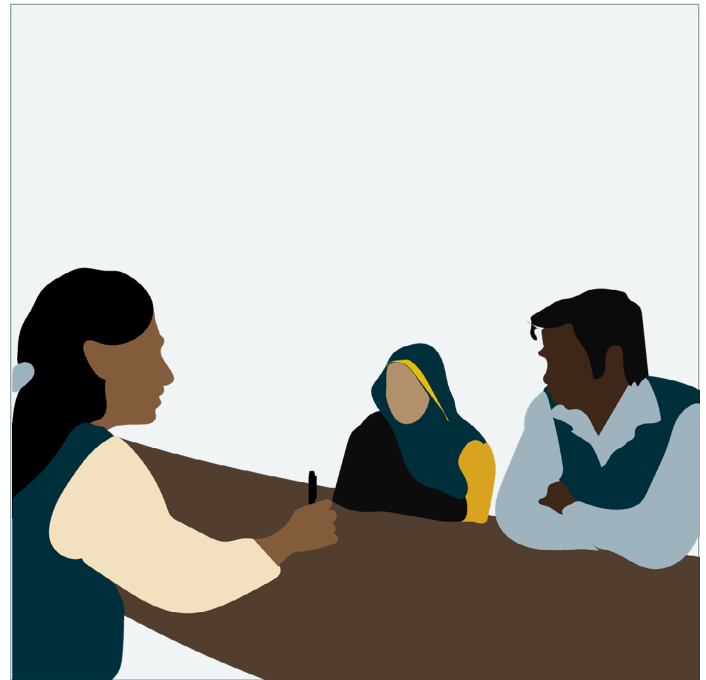
Male Engagement in Family Planning
Indicator Brief



Progress toward the vision of expanded engagement of men in family planning (FP) and reproductive health (RH) has been slow, but steady (Dunn & Gage, 2010). Gender experts agree that men should be engaged as agents of change in families and communities, and men should be encouraged to be supportive partners of women's RH while also meeting their own RH needs (Greene, et al., 2006). Constructive male engagement in FP entails a thoughtful, gender-sensitive approach that places gender equality and women's empowerment on equal footing with other desired outcomes (Gilles, 2015). When men are engaged in FP, gender equity improves, leading to better health outcomes for men, women, and children.

Constructive male engagement can be achieved through interventions that address the following roles:

- Men as clients and beneficiaries who receive FP services and use male FP methods
- Men as supportive partners who actively engage as full partners in FP issues and communicate and negotiate fertility desires and FP use with their partners
- Men as agents of change who act as leaders in shifting social norms, attitudes, and behaviors toward women and girls, and their place in families, communities, and societies at large

Rigorous monitoring and evaluation (M&E) is essential to the success of FP programs, and establishing consistent and effective indicators is part of the work of MEASURE Evaluation, which is funded by the United States Agency for International Development, to improve health information systems globally. This brief outlines 15 key indicators that ministries of health and organizations can use to inform the M&E of programs that encourage male engagement in FP.

No program or project should ever attempt to use all indicators presented here. For routine monitoring, program managers and evaluators should select a few relevant indicators that both are important to program objectives and easy to collect and interpret. The indicators may be supplemented or tailored to reflect a program's unique context and objectives.

Each indicator featured here contains its definition, suggested disaggregations, and, if applicable, calculation. Full indicator reference sheets for all indicators in this brief may be accessed online at the MEASURE Evaluation Family Planning and Reproductive Health Indicators Database, here: https://www.measureevaluation.org/prh/rh_indicators

1. Percent distribution of contraceptive methods currently used by men or their sexual partners

Definition: Among men ages 15–54 years, the percentage distribution of all men, currently married men, and sexually active men, by contraceptive method the man or his sexual partner is currently using. Contraceptive options include the following: not using, pill, intrauterine device, injectable, male and female condoms, female sterilization, male sterilization, implant, lactational amenorrhea, periodic abstinence, and withdrawal. Men are considered to be currently using a contraceptive method only if they report being sexually active in the 12 months prior to the survey. This indicator can be disaggregated by age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location.

Calculation: (All men, currently married men, or sexually active unmarried men ages 15–54 currently using any contraceptive method, by method/Total number of male respondents) x 100

2. Percent of men who have ever used any male family planning method or family planning method that requires male cooperation

Definition: Among men ages 15–54 years, the percentage distribution of all men (currently married men and sexually active unmarried men) who have ever used any male contraceptive method or FP method that requires men's cooperation, by specific method and age. FP options are male sterilization (vasectomy), withdrawal, standard days method, and male condom. This indicator can be disaggregated by age, marital status (all men, currently married men, or sexually active unmarried men), geographic location, specific method, and modern versus traditional method.

Calculation: (Number of men 15–54 ever used a contraceptive method/Total number of male respondents) x 100

3. Men's condom use at last sex

Definition: The percentage of male respondents who say they used a male condom the last or more recent time they had sex with a female partner, within the last 12 months. This indicator can be disaggregated by age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location.

Calculation: (Number of respondents who report using a condom the last time they had sex with a female partner/Total number of respondents who report having sex in the past 12 months with a female partner) x 100

4. Number of family planning providers trained on male-specific family planning

Definition: An "FP provider" is any health worker (e.g., physician, nurse, or community health extension worker) who provides FP counseling and methods. "Male-specific FP" refers to male-controlled contraceptives (condoms and vasectomy) and FP counseling to men. This includes couples' counseling. "Training" can refer to any type of male-specific FP training event, regardless of its duration or location. It involves a trainee getting a thorough understanding of the essential knowledge required to perform the job and progressing from either lacking skills or having minimal skills to being proficient. This indicator can be disaggregated by geographic location. If targeting and/or linking to inequity, classify trainees by areas served (poor/not poor) and disaggregate by area served.

5. Number or percent of vasectomy referrals

Definition: The number or percentage of men of reproductive age (15–54) who received a referral for vasectomy. A referral occurs if the client is advised where he can go to receive a vasectomy, and the referral is documented at the referral source as proof that a referral was made. This indicator can be disaggregated by age, geographic location, and type of clinic making the referral.

Calculation: As a percentage, this indicator is calculated as follows: (Number of male clients who received a referral for vasectomy/Total number of male clients ages 15–54 served at the site during the reporting period) x 100

6. Number or percent of facilities that offer vasectomy services

Definition: Among the health facilities in a given area that provide FP services, the number or percentage currently offering vasectomy services on-site during a specified time frame (e.g., one year or at the time of data collection). This

indicator can be disaggregated by geographic location, type of facility, type of vasectomy (conventional or no-scalpel), or type of service (i.e., routinely offered at a facility or periodically).

Calculation: As a percentage, this indicator is calculated as follows: (Number of facilities currently offering vasectomy services on-site/Total number of surveyed facilities providing FP services) x 100

7. Number of vasectomies performed

Definition: The number of male sterilizations, i.e., "vasectomies," that have been performed within a given time frame. This indicator should be disaggregated by type of vasectomy (non-scalpel or conventional) and location of procedure (e.g., private facility, public facility, or community-based event). It can also be disaggregated by age (of patient) and geographic location.

8. Inclusion of vasectomy in family planning guidelines/strategies, regulations, or policies

Definition: In countries with formal FP or RH guidelines, strategies, regulations, or policies, this indicator assesses whether vasectomies are specifically included in these documents, and to what extent. These documents should be evaluated to make sure they are technically sound, based on scientific evidence, and grounded in informed choice. The assessment should include the extent to which the national FP strategy or policy has a strategic or long-range plan in place to increase access to and use of long-acting/permanent methods, including vasectomy. To measure changes over time, the indicator should consider only those policies developed or modified during a specific reference period, such as the last calendar year. This indicator can be disaggregated by stage (proposed, drafted, or adopted).

9. Percent of men who support the use of modern contraception for themselves or their partners

Definition: The percentage of men who support the use of modern FP methods for their own use or for their partners' use. "Supportive" can be operationally defined as attitudes toward use of modern FP method, responses to hypothetical situations, and reported actions/behaviors. Modern methods of contraception are hormonal pills, female and male sterilization, intrauterine device, injectable, male and female condoms, diaphragm, foam/jelly, and emergency contraception. In contrast, traditional or "non modern" methods are periodic abstinence, withdrawal, and folk methods. A proposed question is, "Do you support the use of modern contraception for yourself or your partner?" Where the detail is available, the indicator can be disaggregated by the specific types of modern FP methods the men support as well as by relevant socioeconomic and demographic factors, such as men's age, education level, income, and urban/rural residence.

Calculation: (Number of men who support their own or partners' use of modern contraception/Total number of men surveyed) x 100

10. Percent of men who share in the decision making of reproductive health issues with their spouse or sexual partner

Definition: The percentage of men who report joint decision making with their wife or sexual partner about various aspects of their sexual and reproductive health. Where the detail is available, the indicator can be disaggregated by the specific types of sexual and reproductive health practices for which there is shared decision making, as well as by age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location (urban/rural residence).

Calculation: (Number of men in target population surveyed/interviewed who report that they share in making sexual and reproductive health decisions/Total number of men surveyed/interviewed) x 100

11. Percent of men who disagree that contraception is a woman's business and a man should not have to worry about it

Definition: The percentage of men ages 15–54 years who respond negatively to the statement "contraception is a woman's concern, and a man should not have to worry about it." This indicator can be disaggregated by age, marital status (all men, currently married men, or sexually active unmarried men), and geographic location.

Calculation: (Number of men surveyed or interviewed who report they disagree with the above statement/Total number of men surveyed or interviewed) x 100

12. Evidence of engagement of men in family planning incorporated in national health standards or policies

Definition: Instances in which there is concrete evidence of engagement of men in existing national/subnational policies or strategic plans that promote FP services and information. Policy implementation is the process of carrying out and accomplishing a policy, in this case, male engagement in FP. This may require the creation of an implementation plan, policy, or strategy guidelines, and a budget line item to ensure that the policy, or strategy is carried out in the manner that policymakers intended. This indicator can be disaggregated by stage (proposed, drafted, or adopted).

13. Attitudes towards gender norms (GEM Scale)

Definition: Attitudes toward gender norms in intimate relationships or differing social expectations for men and women, and boys and girls, using the Gender-Equitable Men (GEM) Scale. The GEM Scale has 24 items in two subscales. The 17 items in Subscale 1 measure "inequitable" gender norms (e.g., the belief that "it is the man who decides what type of sex to have") and the seven items in Subscale 2 measure "equitable" gender norms (e.g., "A couple should decide together if they want to have children"). Where the detail is available, disaggregation of the indicator by men's age, number of children, education, income, urban/rural status, and other relevant factors may contribute to the interpretation of findings.

Calculation: Responses are scaled as: Agree = 1; Partially Agree = 2; and Do Not Agree = 3 for the inequitable subscale and scores are inverted for the equitable subscale, resulting in a higher score for greater gender equity. Scores of the inequitable norm and the equitable norm subscales are calculated separately and can be combined or used individually.

For the GEM Scale and other gender scales see: https://www.c-changeprogram.org/content/gender-scales-compendium/about.html.

14. Number of family planning providers trained on gender equity and sensitivity

Definition: A "provider" is any health worker (e.g., a physician, nurse, or community health extension worker). "Training" can refer to any type of gender equity and sensitivity training event, regardless of its duration or location. It involves a trainee attaining a thorough understanding of the essential knowledge required to perform the job and progressing either from lacking skills or having minimal skills to being proficient. "Gender equity" is the equally fair treatment of women and men and girls and boys. To ensure fairness, some societies adopt measures to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. Gender-equity strategies eventually attain gender equality. "Gender sensitivity" is the way service providers treat male or female clients and thus affects client willingness to seek services, continue to use services, and carry out the health behaviors advocated by the services. This indicator can be disaggregated by sex, type of provider, location, and type of training (pre-service or in-service). If targeting and/or linking to inequity, classify trainees by areas served (poor/not poor) and disaggregate by area served.

15. Number of national-level programs/policies/advocacy campaigns that address gender equity

Definition: Number of programs/policies/advocacy campaigns that address gender equality or nondiscrimination for women or girls at the national or subnational level. For the purposes of this indicator, "policy" is meant broadly to include any official document issued by a government (e.g., law, policy, action plan, constitutional amendment, decree, strategy, or regulation) designed to promote or strengthen gender equality or nondiscrimination based on sex at the national or subnational level. This indicator can be disaggregated by program/policy/campaign, stage (drafted, proposed, or adopted), or geographic location (for subnational levels).

Calculation: Provide the number (count) of relevant programs/policies/advocacy campaigns drafted, proposed, or adopted during the reporting period. Count only once in each stage; do not report on the same program/policy/advocacy campaign across multiple reporting periods unless it has advanced to the next stage. If it is a program (or project or intervention) that is addressing gender equity, it should be counted only one time—the reporting period where program implementation begins.

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