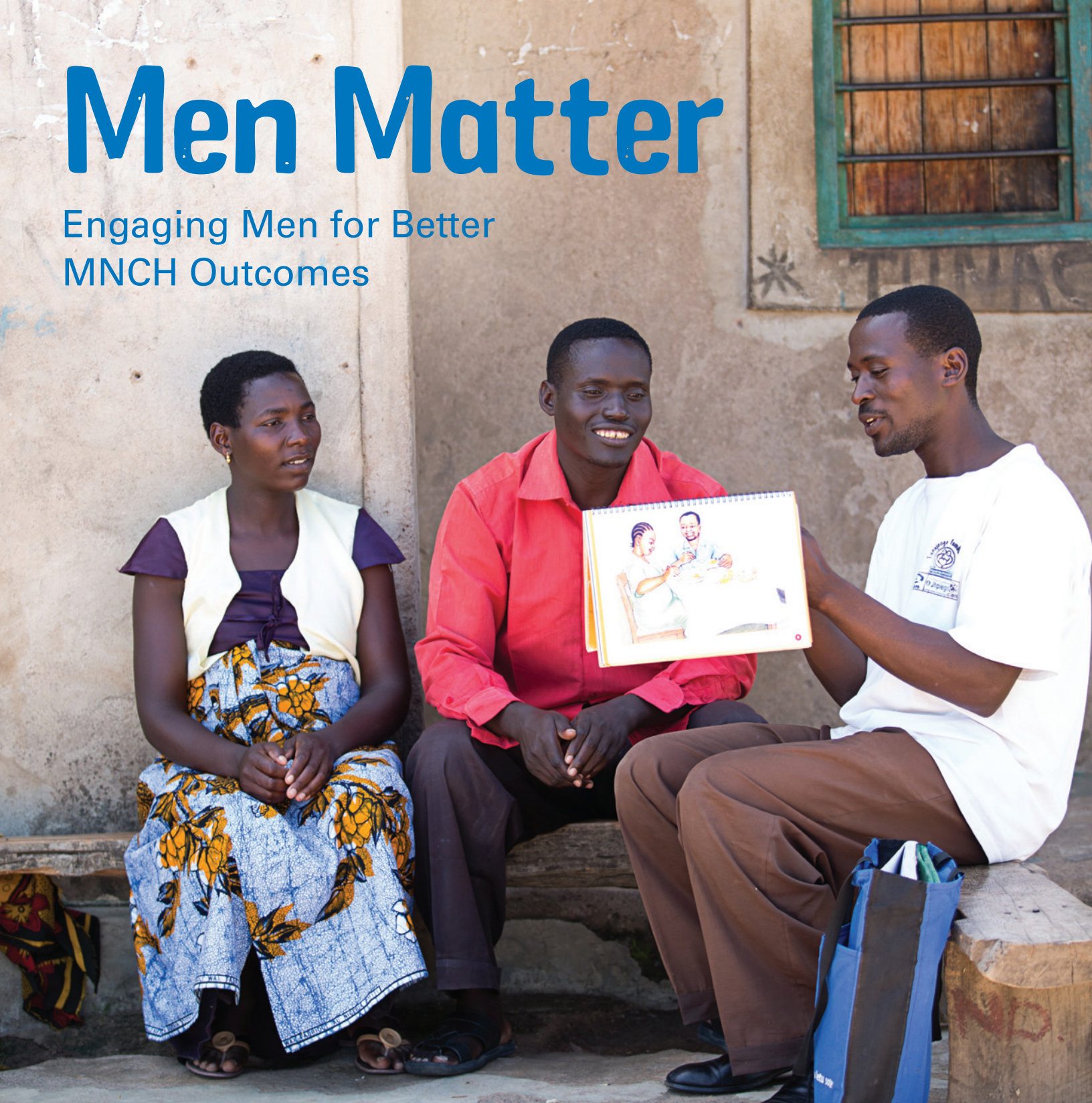


Men Matter

Engaging Men for Better
MNCH Outcomes



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the world**

Credits

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Abstract

Male engagement in maternal, newborn and child health (MNCH) is a promising strategy to improve MNCH and gender equality outcomes. There has been an upswell of interest in male engagement in MNCH which is currently being promoted and adopted at the global, national and subnational levels through policy and program planning. Yet the direct links between male engagement and MNCH outcomes have not been well documented in the global literature. A recent systematic review found quality evidence for the impact of male engagement interventions on MNCH outcomes, including care-seeking outcomes, was low.¹ In this context, there is a need to improve understanding of the relationship between male engagement and MNCH outcomes.

A multi-country, primary qualitative research study was conducted of two existing Plan Canada supported MNCH programs with male engagement components – Women and Their Children’s Health (WATCH) and Wazazi na Mwana – that are currently being implemented in Bangladesh, Tanzania, and Zimbabwe. The study investigated the relationship between male engagement and MNCH outcomes as well as effective strategies to engage men in MNCH and factors to sustain male engagement in MNCH.

Male and female participants identified many benefits associated with male engagement in MNCH, including improved health outcomes for women, newborns and children as well as increased couple communication and improved relationships, reduced maternal workload and increased maternal nutrition and rest during pregnancy, and increased value of girl children. Both male and female participants also reported that they valued male engagement in MNCH, although some participants did not desire men’s participation in some tasks.

In addition to the overarching findings from this research, the findings of this study have confirmed and added to, several elements of good practice in male engagement programming that have been recognized in previous literature on this topic. These implications for good practice can usefully guide policymakers and program planners who aim to increase male engagement in MNCH.

Table of contents

- Acronyms** 6
- Key definitions** 7
- Executive summary** 8
- Introduction and background** 10
 - What is male engagement in MNCH?** 10
 - Why engage men in MNCH?** 10
 - Effects of male engagement in MNCH** 11
 - Critical gaps in the evidence base** 12
 - Male engagement in Plan Canada’s MNCH programming** 13
 - Plan Canada’s strategic approach to male engagement in MNCH 13
 - Male engagement in selected Plan Canada supported MNCH projects 14
 - What this research seeks to contribute** 16
- Methodology** 17
 - Definition of male engagement used in this study** 17
 - Study design** 17
 - Study setting** 18
 - Site selection 18
 - Site characteristics 20
 - Study population** 20
 - Focus group discussions and in-depth interviews 20
 - Key informant interviews with relevant stakeholders 21
 - Study procedures** 21
 - Research team 21
 - Research tools 21
 - Data collection 22
 - Data management 22
 - Data analysis 22
 - Ethical considerations** 23
 - Limitations** 24

Findings	25
Participant characteristics	25
Evidence for the contributions of male engagement	26
Contributions of male engagement to outcomes related to MNCH	26
Contributions of male engagement to MNCH outcomes	31
Motivating and engaging men to improve MNCH outcomes: effective program strategies and approaches ..	35
Considerations in assessing effectiveness	35
Effective program strategies and approaches in engaging men	36
Key factors to sustain male engagement in MNCH	45
Reduced shaming at community level	45
Support from older generations	47
Motivation from positive personal experience	48
Male engagement perceived as progressive	48
Conclusions	49
References	53

List of Figures

Figure 1: Plan Canada’s strategic approach to engaging men in MNCH	13
Figure 2: Research objectives and research questions	16

List of Tables

Table 1: Overview of WATCH and Wazazi na Mwana project sites	18
Table 2: Selected study sites and rationale for selection	19
Table 3: Socio-demographic characteristics of study participants in the FGDs and IDIs	25

Acronyms

ANC	Antenatal care
BCC	Behaviour change communication
CEmONC	Comprehensive emergency obstetric and newborn care
CeSHHAR	Centre for Sexual Health and HIV/AIDS Research-Zimbabwe
CHTC	Couples HIV testing and counselling
CHW	Community health worker
CSBA	Community skilled birth attendant
DFATD	Canadian Department of Foreign Affairs, Trade and Development
FGD	Focus group discussion
GBV	Gender-based violence
HTC	HIV testing and counselling
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
IDI	In-depth interview
IHI	Ifakara Health Institute, Tanzania
KII	Key informant interview
MINCH	Maternal, newborn and child health
NGO	Non-Governmental Organization
PMF	Project Measurement Framework
PPTCT	Prevention of parent-to-child transmission of HIV
RO	Research Objective
SMS	Short Messaging Service
STI	Sexually-transmitted infection
TBA	Traditional birth attendant
T4D	Theatre for Development
WATCH	Women and their Children's Health
WCBA	Women of childbearing age
WHO	World Health Organization
WnM	Wazazi na Mwana

Key definitions

This report uses terminology consistent with Plan International's approach to gender equality. The three key terms, gender, gender equity and gender equality, are described below as defined in Plan International's gender equality policy.

Gender

The concept of gender refers to the norms, expectations and beliefs about the roles, relations and values attributed to girls and boys, women and men. These norms are socially constructed; they are neither invariable nor are they biologically determined. They change over time. They are learned from families and friends, in schools and communities, and from the media, government and religious organizations.

Gender equality

Gender equality means that women and men, girls and boys enjoy the same status in society, have the same entitlements to all human rights, enjoy the same level of respect in the community, can take advantage of the same opportunities to make choices about their lives, and have the same degree of power to shape the outcomes of these choices. Gender equality does not mean that women and men, or girls and boys are the same. Women and men, girls and boys have different but related needs and priorities, face different constraints, and enjoy different opportunities. Their relative positions in society are based on standards that, while not fixed, tend to advantage men and boys and disadvantage women and girls. Consequently, they are affected in different ways by policies and programs. A gender equality approach is about understanding these relative differences, appreciating that they are not rigid but can be changed, and then designing policies, programs and services with these differences in mind. Ultimately, promoting gender equality means transforming the power relations between women and men, girls and boys in order to create a more just society for all.

Gender equity

Gender equity means being fair to women and men, girls and boys. To ensure fairness, measures are put into place to address social or historical discrimination and disadvantages faced by girls relative to boys. A gender equity approach ensures equitable access to, and control of, the resources and benefits of development through targeted measures. Scholarships for girls are one example of an equity approach that contributes to all children, boys and girls, accessing school and equally benefiting from education opportunities. Increased gender equity is only one aspect of a strategy that contributes to gender equality.

Executive summary

Male engagement in maternal, newborn and child health (MNCH) is a promising strategy to improve MNCH and gender equality outcomes. There has been an upswell of interest in male engagement in MNCH, and it is currently being promoted and adopted at the global, national and subnational levels through policy and program planning. Yet the direct links between male engagement and MNCH outcomes have not been well documented in the global literature. A recent systematic review found that the quality of evidence for the impact of male engagement interventions on MNCH outcomes, including care-seeking outcomes, was low¹. In this context, there is a need to improve understanding of the relationship between male engagement and MNCH outcomes.

The Burnet Institute, in collaboration with the Centre for Sexual Health and HIV/AIDS Research-Zimbabwe (CeSHHAR), Ifakara Health Institute (IHI) in Tanzania and International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), was contracted by Plan Canada to examine the relationship between male engagement and MNCH outcomes through a multi-country qualitative research into two existing MNCH programs with male engagement components - Women and Their Children's Health (WATCH) and Wazazi na Mwana. Plan Canada is currently implementing these initiatives in Bangladesh, Tanzania, and Zimbabwe.

Including men in services relevant to MNCH can contribute to improvements in health behaviours and utilization of health services. Additionally, engaging men in caregiving and other health-promoting activities can make a powerful contribution to MNCH results, men's health and wellbeing, and gender equality outcomes. This study aims to improve an understanding of activities designed to increase male engagement in MNCH in three countries (Bangladesh, Tanzania, and Zimbabwe), in order to advance understanding of strategies and factors likely to increase the acceptability, sustainability, and potential contribution to MNCH of male engagement activities in a range of contexts.

The study was designed to gather information to respond to the following research questions:

- RQ1.** What are the contributions of male engagement to MNCH results in selected Plan-supported projects and countries?
- RQ2.** What are the effective program strategies and approaches used in selected Plan-supported projects and countries in motivating and engaging men in achieving improved MNCH outcomes in the context of gender, social, and cultural norms?
- RQ3.** What key factors are needed to sustain male engagement in MNCH in the long-term in selected Plan-supported project areas?

Primary qualitative research (focus group discussions, in-depth interviews and key informant interviews) was conducted at two purposively selected study sites in each country (Bangladesh, Tanzania, and Zimbabwe). Four focus group discussions and four in-depth interviews were conducted at each study site, with at least six key informant interviews conducted in each country. Field data collection was conducted between October 2014 and February 2015. Research participants were male and female target beneficiaries of male involvement program activities, as well as non-beneficiary stakeholders who have been directly involved with the implementation of the male involvement interventions.

The study found reported increases in male engagement in MNCH following Plan programs, which were linked by study participants with improved MNCH outcomes. A broad range of strategies was identified to be effective in motivating and engaging men in MNCH, including peer education and outreach, home visits, edutainment or entertainment, and strategies delivered through existing structures such as health facilities and community meetings. Factors to sustain male engagement in MNCH were identified at community, household/family, and individual levels.

¹World Health Organization, 2015.

Participants identified many benefits associated with male engagement in MNCH, including improved health outcomes for women, newborns and children as well as increased couple communication and improved relationships, reduced maternal workload and increased maternal nutrition and rest during pregnancy, and increased value of girl children. Both male and female participants reported that they valued male engagement in MNCH, although some participants did not desire men's participation in certain tasks.

In addition to these overarching findings, the findings of this study have confirmed and added to, several elements of good practice in male engagement programming that have been recognized in previous literature on this topic. These implications for good practice can usefully guide policymakers and program planners who aim to increase male engagement in MNCH.

Introduction and background

What is male engagement in MNCH?

There is no globally-agreed, single definition of male engagement in maternal, newborn and child health (MNCH)². This study is premised on an understanding of male engagement that emphasizes men's subjective experiences, motivations, relationships and active participation, rather than taking specific actions as indicative of engagement³. This focus on men's agency and relationships is taken as the substantive definition of male engagement, as distinct from male participation or involvement, which can be understood to be more passive. Male engagement in MNCH can thus be defined as men taking an active role in protecting and promoting the health and wellbeing of their partners and children. Importantly, this concept is broader than a list of actions or decisions in which men should participate.

At the same time, there is evidence to support specific ways in which men's active roles can support improved MNCH. This informs the broad scope of male engagement in MNCH as supported by the current evidence base, as summarized in a recent review⁴. On this basis, male engagement includes men making informed decisions with their partners about family planning, and encouraging appropriate health behaviours and care during pregnancy, childbirth and postpartum.

Additionally, male engagement includes men promoting good nutrition and reduced workload during pregnancy, assisting with birth preparations, and providing emotional support. Male engagement includes men's contributions towards creating a gender equitable family environment, for example by taking on household care work, supporting equal access to health services for male and female children, improving couple communication or reducing violence. Male engagement also encompasses the participation of expectant fathers or new fathers in clinical services, such as antenatal care (ANC) or childbirth care. Yet it is important to recognize that male engagement

includes the wide variety of actions that men can take to support and protect the health of their family at both household and community levels and should not be viewed as limited to men's involvement in clinical care.⁵

From this broad evidence base, we have developed a working concept of male engagement in MNCH as defined by men's active participation in relationships with partners and children, encompassing the following domains: shared workload (including care work) and resources, emotional support, communication and decision-making, financial support, physical support, and gender norms. Men's active participation to promote the health and wellbeing of their partners and children in these areas is recognized to have the potential to improve MNCH outcomes⁶.

Why engage men in MNCH?

Globally, gender inequality is one of the most important drivers of poor health and wellbeing outcomes for women and their children⁷. Engaging men in programs designed to influence MNCH outcomes provides a means to address gender inequality within households and couple relationships. Programs that engage men can support them in challenging gender roles and norms; for example gender norms relating to masculinity, intimate partner relationships and parenting⁸. Male engagement also influences the socialization of the next generation. When men are actively involved in providing care and support to their partners and children, children develop more gender-equitable attitudes⁹.

Additionally, engaging men is a means to leverage men's existing involvement in the lives of their partners and children in order to maximize the positive impacts of this involvement on MNCH outcomes. In many communities worldwide, men tend to be the decision-makers within families and therefore play a key role in decisions integral to MNCH. Men are often responsible for decision-making on family planning and use of contraceptives¹⁰ and program experience suggests that encouraging contraceptive use among men can be a more effective strategy than engaging

²Montgomery E, van der Straten, A & Torjesen, K 2011.

³Comrie-Thomson, L, Tokhi, M, Ampt, F, Portela, A, Chersich, M & Khanna, R, et al. nd.

⁴Davis, J, Luchters, S & Holmes, W 2012.

⁵Ibid.

⁶Davis, J, Luchters, S & Holmes, W 2012; World Health Organization 2015.

⁷Caro, D 2009; Gill, K, Pande, R & Malhotra, A 2007; UNFPA 2010; UNICEF 2011.

⁸Barker, G 2014.

⁹Ibid.

¹⁰Bawah, AA 2002; Dutta, M, Kapilashrami, MC & Tiwari, VK 2004; Fayemi, M, Momoh, G, Oduola, O, Delano, G, Ladipo, O & Adebola, O 2011; Ko, IS, You, MA, Kim, ES, Lee, TW, Kim, S & Kim, YM, et al. 2010; Link, CF 2011; MacPhail, C, Pettifor, A, Pascoe, S & Rees, H 2007; Montgomery, ET, van der Straten, A, Chidanyika, A, Chipato, T, Jaffar, S & Padian, N 2011; Natta bi, B, Li, J, Thompson, S, Orach, C & Earnest, J 2011; Shattuck, D, Kerner, B, Gilles, K, Hartmann, M, Ng'ombe, T & Guest, G 2011; Yue, K, O'Donnell, C & Sparks, PL 2010.

women alone¹¹. Family planning, including delaying first pregnancy, adequate birth spacing, reduction of unplanned pregnancies and limiting the total number of pregnancies, positively impacts maternal health and reduces maternal deaths¹². Men also play a key role in determining women's access to critical health services, including ANC and care during delivery¹³, through such mechanisms as determining the availability of transport for women to reach a clinic¹⁴ and decisions that affect whether a woman can be successfully referred to a higher-level facility if required¹⁵. Men also play a role in decisions relating to breastfeeding¹⁶, childhood immunization¹⁷, and care-seeking for childhood illness¹⁸. Supporting men to make informed decisions about MNCH and provide appropriate care and support to their partners and children can therefore promote the health and wellbeing of all.

Furthermore, research indicates that many men and women would like to see greater male engagement in maternal and child health services¹⁹. Studies in diverse settings have found that men would like to be included in clinical services such as ANC²⁰, that men want more information regarding women's and children's health²¹, and that men respond positively to attempts to engage them²².

Engaging men may also have benefits for maternal mental health. A recent review²³ found that perinatal mental health disorders are common in low and lower-middle-income countries and that these disorders were more common among women who experienced difficulties in the intimate partner relationship, including having a partner who was unsupportive and uninvolved.

Finally, there is evidence that engaging men in MNCH has health and wellbeing benefits for men as well. Importantly, men's participation in activities relating to MNCH provides a means to reach men with essential health services²⁴, including sexual and reproductive health services. Additionally, results from a large multi-country study show that men

who participate in caregiving report higher quality affective relationships, although men also reported negative experiences associated with stigmatisation of their engagement with care work²⁵.

Effects of male engagement in MNCH

In 2014, a World Health Organization (WHO)-commissioned global systematic review of the effect of male involvement interventions on MNCH care-seeking outcomes identified 13 intervention studies in low- and middle-income countries²⁶. Despite limited data from rigorously-evaluated intervention studies, the review concluded that involving men in MNCH education and services could positively influence MNCH-related behaviours including antenatal care attendance, use of health facilities and a skilled attendant at birth, birth preparedness, maternal nutrition, and workload²⁷. Yet the quality of the evidence was low and inconsistent. No studies assessing the effects of male involvement in MNCH on essential health outcomes such as birth weight, infant mortality or maternal mortality were found and while it is plausible that male involvement has benefits for maternal mental health; no intervention studies measuring such effects were identified. Although the review found minimal evidence relating to gender equality outcomes²⁸, some studies indicate that involving men in MNCH can promote equitable couple communication and decision-making²⁹ and another recent review of gender-integrated interventions in reproductive and maternal-child health indicated that addressing gender dynamics can positively influence MNCH behaviours³⁰.

The effects of male engagement in MNCH on HIV prevention and treatment are much clearer. Involving men in efforts to prevent parent-to-child transmission of HIV (PPTCT) can increase the proportion of pregnant women (and couples) testing for HIV³¹ and help avoid domestic disputes relating to HIV testing and disclosure³². Among HIV positive pregnant women, male involvement can promote condom use or abstinence to prevent HIV transmission within the couple³³,

¹¹Fayemi, M, Momoh, G, Oduola, O, Delano, G, Ladipo, O & Adebola, O 2011; Kamal, IT 2002; Mehta, M 2002.

¹²Singh, S, Darroch, J, Vlassoff, M & Nadeau, J 2003.

¹³Abosse, Z, Woldie, M & Ololo, S 2010; Brunson, J. 2010; Danforth, E, Kruk, M, Rockers, P, Mbaruku, G & Galea, S 2009; Dutta, M, Kapilashrami, MC & Tiwari, VK 2004; Gross, K, Alba, S, Glass, TR, Armstrong Schellenberg, J & Obrist, B 2012; Milligan, R, Wingrove, BK, Richards, L, Rodan, M, Monroe-Lord, L & Jackson, V, et al. 2002; Mpembeni, RN, Killewo, JZ, Leshabari, MT, Massawe, SN, Jahn, A & Mushi, D, et al. 2007; Mrisho, M, Schellenberg, JA, Mushi, AK, Obrist, B, Mshinda, H & Tanner, M, et al. 2007; Olayemi, O, Bello, FA, Aimakhu, CO, Obajimi, GO & Adekunle, AO 2009; Pembe, AB, Urassa, DP, Darj, E, Carlsted, A & Olsson, P 2008; Waiswa, P, Kemigisa, M, Kiguli, J, Naikoba, S, Pariyo, GW & Peterson, S 2008.

¹⁴Olayemi, O, Bello, FA, Aimakhu, CO, Obajimi, GO & Adekunle, AO 2009; Waiswa, P, Kemigisa, M, Kiguli, J, Naikoba, S, Pariyo, GW & Peterson, S 2008.

¹⁵Pembe, AB, Urassa, DP, Darj, E, Carlsted, A & Olsson, P 2008.

¹⁶Khan, ME & Patel, BC 1997; Prasanna, ST 2011

¹⁷Babirye, JN, Rutebemberwa, E, Kiguli, J, Wamani, H, Nuwaha, F & Engebretsen, IM 2011.

¹⁸Carter, M 2004; Dutta, M, Kapilashrami, MC & Tiwari, VK 2004; Khan, ME & Patel, BC 1997.

¹⁹Mullick, S, Kunene, B & Wanjiro, M 2005; Natoli, L 2012.

²⁰Natoli, L, Holmes, W, Chanlivong, N, Chan, G & Toole, MJ 2012.

²¹Engelbrechtsen, IM, Moland, KM, Nankunda, J, Karamagi, CA, Tyleskar, T & Tumwine, JK 2010; Natoli, L 2012; Natoli, L, Holmes, W, Chanlivong, N, Chan, G & Toole, MJ 2012.

²²Kamal, IT 2002; Mehta, M 2002; Natoli, L, Holmes, W, Chanlivong, N, Chan, G & Toole, MJ 2012; Sternberg, P & Hubley, J 2004.

²³Fisher, J, Cabral de Mello, M, Patel, V, Rahman, A, Tran, T & Holton, S, et al. 2012.

²⁴Kunene, B, Beksinska, M, Zondi, S, Mthembu, N, Mullick, S & Ottolenghi, E, et al. 2004; Sahip, Y & Turan, JM 2007.

²⁵Barker, G 2014; Kato-Wallace, J, Barker, G, Eads, M & Levto, R 2014.

²⁶Tokhi, M, Comrie-Thomson, L, Davis, J, Portela, A, Chersich, M & Luchters, S nd.

²⁷ibid.

²⁸ibid.

²⁹Kunene, B, Beksinska, M, Zondi, S, Mthembu, M, Mullick, S & Ottolenghi, E, et al. 2004; Sahip, Y & Turan, JM 2007; Sinha, D 2008; Varkey, LC, Mishra, A, Das, A, Ottolenghi, E, Huntington, D & Adamchak S, et al. 2004.

³⁰Kraft, JM, Wilkins, KG, Morales, GJ, Widyono, M & Middlestadt, SE 2014.

³¹Mbonye, AK, Hansen, KS, Wamono, F & Magnussen, P 2010.

³²Aarnio, P, Olsson, P, Chimbiri, A & Kulmala, T 2009.

can lead to greater adherence to drug prophylaxis regimes and recommended infant feeding practices, and subsequently increase HIV-free survival among their infants³⁴.

Like all interventions, programs to promote male engagement carry risks that must be carefully assessed, and avoided or mitigated³⁵. Involving male partners in MNCH will not always be in the best interests of a pregnant woman or a child³⁶ and promoting men's involvement without addressing widespread gender inequality relating to sexual and reproductive health can reinforce norms relating to men's control over women's health³⁷. For example, a nationwide mass media campaign in Zimbabwe that sought to encourage men's responsibility and engagement with family planning by depicting sports people delivering family planning messages, inadvertently resulted in more men believing they had sole responsibility for decisions regarding family planning³⁸. In the case of ANC, some women may fear their partner being involved³⁹ particularly in relation to sexually-transmitted infection (STI) or HIV testing when a positive test result can lead to additional negative consequences for women, such as violence or divorce⁴⁰. Women who do attend with a partner may be less able to discuss sensitive issues such as sex, HIV and STIs, and domestic violence if their male partner is present, requiring a combination of individual and couples counselling⁴¹. In encouraging men to attend ANC, program managers and health workers should also avoid unintentionally discouraging or preventing unpartnered or unaccompanied women from attending, and to avoid stigmatising women who do attend without a partner⁴². Male involvement programs therefore need to carefully minimize or avoid potential risks associated with engaging men more in MNCH. This requires that programs carefully identify risks, involve women in program design, carefully pilot test communication materials and strategies, explicitly advocate for shared and equitable

decision-making relationships between men and women, and systematically measure and report any harms associated with male engagement⁴³. When promoting male engagement in MNCH, health services and programs must respect women's bodily autonomy and support women's rights to take care of themselves and make decisions about their own health⁴⁴.

Critical gaps in the evidence base

Despite emergent literature on the subject of male engagement in MNCH, critical gaps in the evidence base include:

- Comparative data about the current nature and extent of men's involvement in MNCH, and societal expectations around men's involvement⁴⁵;
- An understanding of which elements of good practice in male engagement programming are common across varied cultural settings, and which are context-specific⁴⁶;
- Factors that lead to program success or program failure when targeting male engagement in MNCH;
- How to institutionalize successful male engagement programs within health systems, including both public and private sectors, and which stakeholders need to be involved in scaling up successful programs;
- An understanding of how male engagement programming influences gender norms and gender roles at individual, household and community levels;
- Standardized measures and reliable indicators for male involvement that focus not only on behavioural or knowledge results but also health and epidemiological outcomes⁴⁷; and
- Closer scrutiny of potential risks associated with male involvement and analysis of strategies to manage these risks.

³³Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010; Farquhar, C, Kiarie, JN, Richardson, BA, Kabura MN, John, FN & Nduati, RW, et al. 2004.

³⁴Aluisio, A, Richardson, BA, Bosire, R, John-Stewart, G, Mbori-Ngacha, D & Farquhar, C 2011; Becker, S, Mlay, R, Schwandt, HM & Lyamuya E 2010; Bolu, OO, Allread, V, Creek, T, Stringer, E, Forna, F & Bulters, M, et al 2007; Farquhar, C, Kiarie, JN, Richardson, BA, Kabura, MN, John, FN & Nduati, RW, et al 2004; Msuya, SE, Mbizvo, EM, Hussain, A, Uriyo, J, Sam, NE & Stray-Pedersen, B 2008; Peltzer, K, Sikwane, E & Majaja, M 2011; Theuring, S, Mbezi, P, Luvanda, H, Jordan-Harder, B, Kunz, A & Harms, G 2009.

³⁵Greene, M, Mehta, M, Pulerwitz, J, Wulf, D, MBankole, A & Singh, S, 2004.

³⁶Maman, S, Moodley, D & Groves, AK 2011.

³⁷Barker, G, Ricardo, C & Nascimento, M 2007.

³⁸Kim, Y & Kols, A 2002.

³⁹Maman, S, Moodley, D & Groves, AK 2011.

⁴⁰Maman, S, Moodley, D & Groves, AK 2011; Mohlala, BK, Boily, MC & Gregson, S 2012; Njau, B, Watt, MH, Ostermann, J, Manongi, R & Sikkema, KJ 2011; Reece, M, Hollub, A, Nangami, M & Lane, K 2010.

⁴¹Kim, Y & Kols, A 2002.

⁴²Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010; Kululanga, LI, Sundby, J & Chirwa, E 2012.

⁴³Greene, M, Mehta, M, Pulerwitz, J, Wulf, D, MBankole, A & Singh, S, 2004; Barker, G, Ricardo, C & Nascimento, M 2007.

⁴⁴World Health Organization 2015.

⁴⁵UNFPA, Promundo, MenEngage 2010.

⁴⁶Barker, G, Ricardo, C & Nascimento, M 2007.

⁴⁷Kamal, IT 2002; Montgomery, E, van der Straten, A & Torjesen, K 2011.

Male engagement in Plan Canada’s MNCH programming

Plan Canada’s strategic approach to male engagement in MNCH

Plan Canada recognizes that gender inequality and gender-related barriers are key determinants of MNCH access and outcomes. Women’s lack of access to and utilization of MNCH services are the result of several complex – and often interconnected – barriers at the family, community and health facility levels. Gender-related barriers are the most pervasive of these, although their effects differ by context. Some of the recurrent and pervasive gender-related barriers to MNCH identified in Plan Canada-supported projects are:

- Women’s lack of access to and control of financial resources and decision-making at the household level.
- High rates of gender-based violence, even during pregnancy.
- Lack of support for family planning by male partners.
- Lack of support during pregnancy, delivery and post-natal care by male partners.
- High rates of early marriage and adolescent pregnancy.
- Low levels, or even the complete absence, of women’s representation and influence in community and higher-level health governance.

- Low mobility and agency of women and dependency on men.
- Inadequate and inappropriate health services that do not meet the needs of women and their male partners.

Plan actively promotes gender equality in all areas of programming. A key dimension of promoting gender equality to transform the condition and position of women is engaging men and boys as partners for change.

In conjunction with interventions to promote gender-responsive health services and empowering women and girls in MNCH, Plan addresses the gender determinants of maternal and child health by engaging men as change agents. Plan’s approach is geared towards attitudinal and behavioural change at all levels and in various settings. Its approach is premised on promoting gender equality and the empowerment of women and girls so that they are able to take and shape decisions at the household and community levels. Plan’s work toward male engagement occurs broadly through three intersecting gender-transformative strategies straddling the demand and supply sides of MNCH (Figure 1).

Figure 1: Plan Canada’s strategic approach to engaging men in MNCH

Engaging proactive male agents of change	Engaging male gatekeepers	Creating an enabling environment
<ul style="list-style-type: none"> • Education and outreach are conducted with men’s groups and individual men through designated gender equality champions, peer educators or role models 	<ul style="list-style-type: none"> • Dialogue, education and mobilization are conducted with traditional and religious leaders, who have influence over community beliefs and behaviours 	<ul style="list-style-type: none"> • Men and women are educated on health issues through broad public behaviour change communication (BCC) messaging that highlights the role of men in MNCH • Community health workers are trained to include male partners in their consultations with women • Health service providers are sensitized on gender-related barriers affecting MNCH and on how to create a welcoming and inclusive environment for men that accompany their partners to facilities

Male engagement in selected Plan Canada supported MNCH projects

Two core Plan Canada-supported MNCH projects include male engagement interventions. The Women and Their Children's Health (WATCH) project and Wazazi na Mwana (WnM) are both funded by the Canadian Department of Foreign Affairs, Trade and Development under the Muskoka Initiative Partnership Program on MNCH, from 2011 to 2015.

The WATCH project

The three-and-a-half-year WATCH project was designed to reduce maternal, neonatal and child mortality amongst underserved populations in 26 districts and sub-districts of five priority countries (Bangladesh, Ethiopia, Ghana, Mali, and Zimbabwe).

Broad male engagement activities implemented under WATCH includes:

- Training of male and female community health workers (CHWs) to engage men in their household visits and counselling.
- Men-only education and behaviour change communication group sessions.
- Formation, capacity building and mobilization of male groups and gender equality champions/male role models to carry out peer-to-peer outreach.
- Couples counselling focused on nutrition, family planning and birth preparedness.
- Engagement with and mobilization of traditional, religious and other community leaders.
- Community-level campaigns/behaviour change communication (BCC) highlighting the importance of gender equality, focusing on male engagement for improved MNCH outcomes.
- Health service providers' sensitization on gender issues affecting MNCH, including men in counselling and encouraging men's role in MNCH.

WATCH in Bangladesh

Research in Bangladesh has shown that husband's positive engagement in MNCH is associated with women's use of ANC and childbirth service⁴⁸. In one study, women utilising skilled birth attendants were more likely to have husbands

who were engaged in MNCH, believed medical care was necessary during childbirth, and provided support to their wives compared with women who did not use professional childbirth services⁴⁹. Male involvement in reproductive health services in Bangladesh has been positively associated with the husband's education level and employment status, wife's education and employment status, number of living children, lengthy marital duration, more open spousal communication, and access to media⁵⁰. Some cultural factors, myths, and men's discomfort discussing reproductive health matters with service providers and their wives act as barriers to greater men's involvement with their wives in reproductive health services⁵¹.

In addition to the general activities implemented under WATCH as outlined in the previous section, the WATCH project in Bangladesh implements the following specific male engagement activities:

- CHWs trained on gender equality, male engagement and MNCH issues conduct men-only BCC group sessions, focused on issues related to gender equality, MNCH and men's role in MNCH;
- Male and female CHWs conduct home visits with couples, individual male partners or family members;
- Change-Maker Groups comprising community leaders and other influential figures such as religious leaders, teachers and journalists trained on gender and MNCH issues and supported to share this information in the community;
- Integrated gender equality and male engagement messages delivered through a wide range of BCC activities including community theatre for development (T4D), community radio (in Barguna), and community meetings;
- Health facilities supported to establish appropriate amenities for male partners accompanying women for MNCH services including appropriate waiting areas and separate washrooms for women and men;
- Community Skilled Birth Attendants (CSBAs) trained in gender and MNCH issues and the importance of male engagement;
- Improvements to referral systems to respond to gender issues; and
- Community health committees are sensitized on gender and MNCH issues and the role of men in MNCH.

⁴⁸Tokhi, M, Comrie-Thomson, L, Davis, J, Portela, A, Chersich, M & Luchters, S nd.

⁴⁹Story, WT, Burgard, SA, Lori, JR, Taleb, F, Ali, NA & Hoque, DE 2012.

⁵⁰Shahjahan, M, Mumu, SJ, Afroz, A, Chowdhury, HA, Kabir, R & Ahmed, K 2013.

⁵¹Shahjahan, M & Kabir, M 2006.

WATCH in Zimbabwe

Analysis of Zimbabwe's 2010 Demographic and Health Survey data indicates that approximately 32% of men attended at least one ANC visit with their partner⁵². Male partner attendance at ANC has been prioritized in Zimbabwe by policymakers and program planners at the national and subnational levels given that research has shown an association between partner support and women's consistent use of HIV prevention methods⁵³ and partner support and adherence to PPTCT regimes⁵⁴.

In addition to the general activities implemented under WATCH described above, the WATCH project in Zimbabwe implements the following specific male engagement activities:

- Capacity building on gender issues, MNCH and male engagement for village health workers who facilitate local community care groups that carry out outreach to communities;
- Gender and MNCH issues and the importance of male engagement are integrated into training of care groups;
- Care group Lead Mothers' and Lead Fathers (voluntary positions) conduct home visits with men and women and educate men as regards accompanying women to health facilities;
- Two male Gender Equality Champions per community promote male engagement through discussions in community settings or men's natural spaces such as churches, bars, and fellowship structures;
- Dialogue with and mobilization of local traditional and religious leaders to encourage men's role in MNCH from their platforms;
- Gender and MNCH issues and importance of male engagement is integrated into training for health service providers and planning and implementation of infrastructure projects (for example, maternity waiting homes);
- Work with the government to provide official guidance to health service providers on gender issues and the importance of male engagement in MNCH;
- Health worker supervision and health system referral pathways are supported to account for gender and male engagement issues; and
- Sensitization of community health committees on gender issues and male engagement.

Wazazi na Mwana in Tanzania

In Tanzania, a husband's support for facility delivery and the couple's agreement on the need for skilled care during childbirth have been shown to be important determinants of women receiving skilled care during childbirth⁵⁵, while lack of husband support for care-seeking has been identified as a barrier to timely antenatal care enrolment⁵⁶. Some traditional gender norms, such as lack of communication within couples about pregnancy and pregnancy outside of marriage have been identified as barriers to men's engagement in MNCH. However, recent studies have highlighted changing gender norms and increasing expectations of male engagement in MNCH, particularly clinical MNCH services⁵⁷. Previous studies have shown low rates of partner involvement in PPTCT services; in one study only 12.5% of partners of HIV positive pregnant women attended voluntary counselling and testing⁵⁸. Those women whose partners came for HIV testing and counselling (HTC) were more likely to adhere to treatment and breastfeeding guidelines. Despite general acceptance of male involvement in ANC and PPTCT⁵⁹, other research has identified a range of barriers to men's participation in ANC/PPTCT including lack of knowledge, lack of time, not prioritising attendance, perceptions of services as a female responsibility, and fear of HIV-test results⁶⁰.

The project has two major components: upgrading rural health facilities and promoting better health practices at the community level. The involvement of men is a key element of the community level component. Specific activities include:

- Peer educators trained on gender equality, positive masculinities and male engagement in MNCH carry out discussion sessions with groups of men in the community;
- Local religious leaders involved and sensitized on gender issues and male engagement and who are supported in spreading these messages in their respective congregations;
- BCC materials and sessions delivered, with integrated gender and MNCH issues and an emphasis on the importance of male engagement;
- CHWs trained in gender and MNCH issues and the importance of male engagement conduct door-to-door counselling of women and men using specific BCC materials on the continuum of care and male engagement;

⁵²S Jennings, L, Na, M, Cherewick, M, Hindin, M, Mullany, B & Ahmed, S 2014.

⁵³Montgomery, ET, van der Straten, A, Chidanyika, A, Chipato, T, Jaffar, S & Padian, N 2011; Skovdal, M, Campbell C, Nyamukapa C & Gregson, S 2011.

⁵⁴Aluisio, A, Richardson, BA, Bosire, R, John-Stewart, G, Mbori-Ngacha, D & Farquhar, C 2011; Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010; Bolu, OO, Allread, V, Creek, T, Stringer, E, Forna, F & Bulterys, M, et al. 2007; Farquhar, C, Kiarie, JN, Richardson, BA, Kabura, MN, John, FN & Nduati, RW, et al. 2004; Msuya, SE, Mbizvo, EM, Hussain, A, Uriyo, J, Sam, NE & Stray-Pedersen, B 2008; Peltzer, K, Sikwane, E & Majaja, M 2011; Theuring, S, Mbezi, P, Luvanda, H, Jordan-Harder, B, Kunz, A & Harms, G 2009; Waisiva, P, Kemigisa, M, Kiguli, J, Naikoba, S, Pariyo, GW & Peterson, S 2008.

⁵⁵Danforth, EJ, Kruk, ME, Rockers, PC, Mbaruku, G & Galea, S 2009.

⁵⁶Gross, K, Alba, S, Glass, TR, Armstrong Schellenberg, J & Obrist, B 2012.

⁵⁷Gross, K, Mayumana, I & Obrist, B 2013.

⁵⁸Msuya, SE, Mbizvo, EM, Hussain, A, Uriyo, J, Sam, NE & Stray-Pedersen, B 2008.

⁵⁹Theuring, S, Nchimbi, P, Jordan-Harder, B & Harms, G 2010.

⁶⁰Theuring, S, Mbezi, P, Luvanda, H, Jordan-Harder, B, Kunz, A & Harms, G 2009.

- Gender and MNCH issues and the importance of male engagement integrated into health service providers’ technical training;
- Infrastructure development support (for example, comprehensive emergency obstetric and newborn care [CEmONC] centres) ensures consideration of the needs of women and their male partners during planning and implementation;
- Strengthened emergency transportation and referral systems that respond to the needs of women and men;
- Advocacy with national and district level government health departments on the integration of gender issues and male engagement; and
- Sensitization of community health governance committees on gender issues and male engagement.

What this research seeks to contribute

The study aims to improve understanding of activities designed to increase male engagement in MNCH in three countries (Bangladesh, Tanzania, and Zimbabwe), in order to advance an understanding of strategies and factors likely to increase the acceptability, sustainability, and potential impact of male engagement activities in a range of contexts. The study aims to capture the experiences of men and women at a number of sites where MNCH programs with male engagement components have been implemented. Importantly, the study is intended to build understanding of how male engagement in MNCH can be experienced by men and women, and is not intended to generate generalizable findings about male engagement in MNCH.

The study is guided by five research objectives, which structured research activities in each of the three study countries. The research objectives are to:

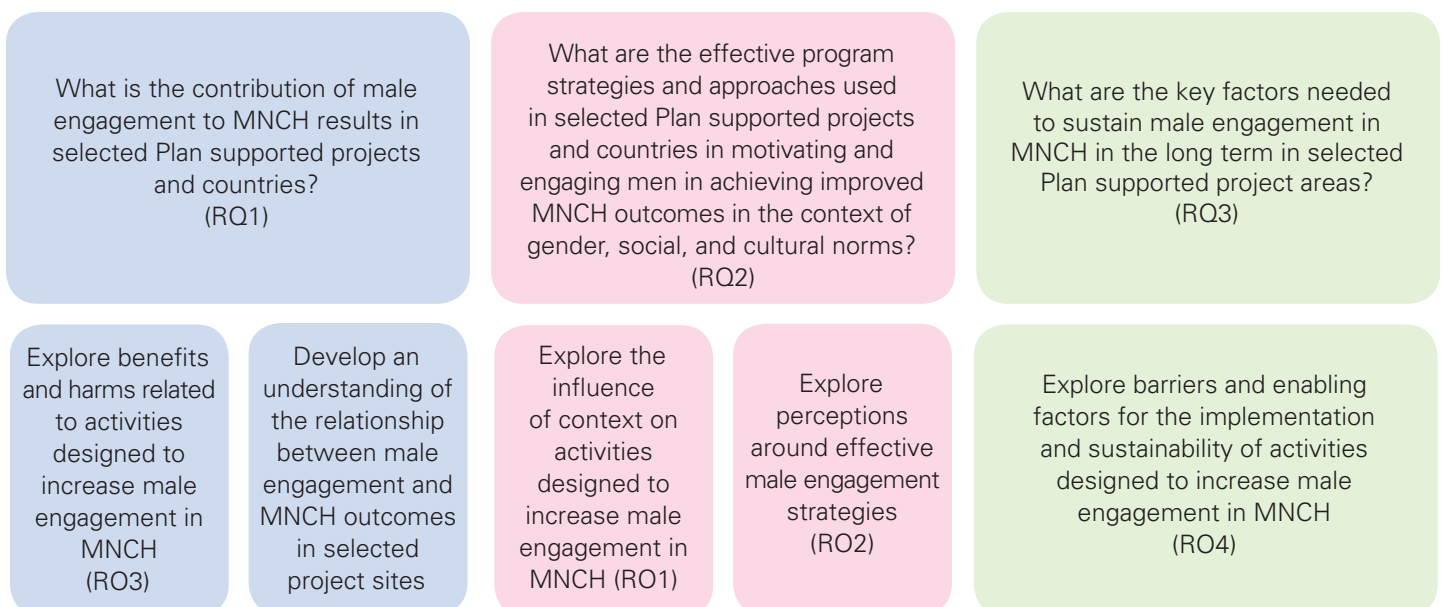
- RO1.** Explore the influence of context on activities designed to increase male engagement in MNCH;
- RO2.** Explore perceptions around effective male engagement strategies;
- RO3.** Explore benefits and harms related to activities designed to increase male engagement in MNCH;
- RO4.** Explore barriers and enabling factors for the implementation and sustainability of activities designed to increase male engagement in MNCH; and
- RO5.** Develop an understanding of the relationship between male engagement and MNCH outcomes in selected project sites.

Information gathered under these research objectives is used to respond to three overarching research questions:

- RQ1.** What is the contribution of male engagement to MNCH results in selected Plan-supported projects and countries?
- RQ2.** What are the effective program strategies and approaches used in selected Plan-supported projects and countries in motivating and engaging men in achieving improved MNCH outcomes in the contexts of gender, social, and cultural norms?
- RQ3.** What are the key factors needed to sustain male engagement in MNCH in the long-term in selected Plan-supported project areas?

The relationship between the three research questions and the five research objectives is summarized in Figure 2, below.

Figure 2: Research objectives and research questions



Methodology

Qualitative methods including focus group discussions (FGDs), in-depth interviews (IDIs), and key informant interviews (KIIs) were used to gather information in the three countries. Qualitative methods were used to explore in depth the attitudes and experiences relating to male engagement in MNCH of male and female target beneficiaries, as well as project implementers, health workers, and community leaders who have been directly involved with the projects. Focus group discussions are useful for exploring community norms, perceptions and expectations, for example those associated with strategies used for male engagement in MNCH. In-depth interviews are useful in collecting more in-depth information, for instance on sensitive topics that are less likely to be discussed in groups, such as potential harms related to male engagement. Key informant interviews are useful for gathering information based on particular knowledge and experience certain stakeholders might have, for example the lived experience of program implementers and their perspectives on the appropriateness, effectiveness, and sustainability of strategies to increase male engagement through WATCH or Wazazi na Mwana.

Definition of male engagement used in this study

As described above, this study is premised on an understanding of male engagement in MNCH as men's active participation in the health and wellbeing of their partners and children. This definition is necessarily abstract and intangible as it is focused on men's internal values and motivations. In order to effectively study male engagement, the concept was teased out into a series of specific, tangible, evidence-informed domains – i.e. domains in which available evidence indicates that changes in men's engagement are, or are likely to be, linked with changes in men's behaviour, and where these changes are, or are likely to be, linked with improvements in MNCH outcomes.

These domains are:

- Communication, shared decision-making (including breakdown in communication, and violence)⁶¹;
- Emotional support, affection⁶²;
- Shared workload (including care work, and work in and outside the home)⁶³;
- Allocation of household resources (including food, time, and money)⁶⁴;
- Financial support (including the means to procure transport)⁶⁵;
- Physical support, being physically present (including accompaniment to health facility)⁶⁶; and
- Gender norms (including values, attitudes and ideas about men, women, boys and girls)⁶⁷.

As detailed below, we used this unpacked concept of male engagement to inform the development of data collection tools and to follow up possible gaps in the findings during data analysis.

Study design

The study used various qualitative methods, including focus group discussions (FGDs), In-depth interviews with FGD participants, and Key Informant Interviews (KII). FGDs were conducted to identify societal norms and beliefs relating to gender roles, care-giving, and male engagement in MNCH, and to discern participants' shared understanding and perception of male engagement within WATCH and Wazazi na Mwana and its impacts. A variety of topics were explored including:

- Gender, social and cultural norms relating to male engagement in MNCH;
- The relationships between male engagement and MNCH results in WATCH or Wazazi na Mwana;

⁶¹Davis, J, Luchters, S & Holmes, W 2012; Kunene, B, Beksinska, M, Zondi, S, Mthembu, M, Mullick, S & Ottolenghi, E, et al. 2004; Sahip, Y & Turan, JM 2007; Sinha, D 2008; Varkey, LC, Mishra, A, Das, A, Ottolenghi, E, Huntington, D & Adamchak S, et al. 2004.

⁶²Fisher, J, Cabral de Mello, M, Patel, V, Rahman, A, Tran, T & Holton, S, et al. 2012.

⁶³Sinha, D 2008; World Health Organization nd.

⁶⁴Sood, S, Chandra, U, Mishra, P & Shailes, N 2004; Turan, JM, Tesfagiorgis, M & Polan, ML 2011; World Health Organization 2015.

⁶⁵Mullany, BC, Becker, S & Hindin, MJ 2007; Shefner-Rogers, CL & Sood, S 2004.

⁶⁶Davis, J, Luchters, S & Holmes, W 2012.

⁶⁷Barker, G, Ricardo, C & Nascimento, M 2007; Kato-Wallace, J, Barker, G, Eads, M & Levto, R 2014; Ricardo, C, Eads, M & Barker, G 2011.

- The extent to which men in the target population have been motivated and engaged through WATCH or Wazazi na Mwana;
- Effective strategies to sustainably engage men in MNCH;
- Barriers and enablers to male engagement in MNCH;
- Benefits from male engagement in MNCH; and
- Harms or risks from male engagement in MNCH.

In-depth interviews explored in detail a range of positive and negative experiences that beneficiaries self-identified as being attributable to the male engagement components of WATCH and Wazazi na Mwana. In particular, the in-depth interviews provided a confidential environment in which to discuss experienced harms, such as intimate partner violence and harmful child care practices that might have resulted from attempts to increase male engagement in MNCH. The in-depth interviews also facilitated detailed exploration of the experienced barriers, enablers, and perceived factors that are understood to be associated with positive or negative outcomes of male engagement.

Participants were encouraged to raise topics that were relevant to them; however as a guide, topic addressed during in-depth interviews included:

- Lived experience of benefits and/or harms – relating to MNCH, and more broadly – that the participant felt were attributable to the male engagement component of WATCH or Wazazi na Mwana, and why s/he perceived these benefits and/or harms to be attributable to the project;
- How local gender, social and cultural norms impacted the participant’s approach to MNCH, including caregiving and relationships with his/her children and co-parent, if applicable; and

- What (if any) barriers the participant faced in engaging with WATCH or Wazazi na Mwana and sustaining his/her engagement, and if and how these barriers were overcome.

Key informant interviews were particularly aimed to elicit participants’ perspectives on the appropriateness, effectiveness, and sustainability of strategies to increase male engagement through WATCH or Wazazi na Mwana. Topics addressed varied depending on the informant, but included among others:

- The relationships between male engagement and MNCH results in WATCH or Wazazi na Mwana;
- Gender, social and cultural norms relating to male engagement in MNCH, and the extent to which WATCH or Wazazi na Mwana was designed to take these into account;
- The extent to which men in the target population were motivated and engaged;
- Effective strategies to sustainably engage men in MNCH;
- Barriers and enablers to male engagement in MNCH;
- Benefits from male engagement in MNCH; and
- Harms or risks from male engagement in MNCH.

Study setting

Site selection

This qualitative inquiry was conducted in purposively selected sites in Bangladesh, Tanzania, and Zimbabwe. Study sites were selected from the project sites of WATCH and Wazazi na Mwana (Table 2). In Bangladesh, sites were selected from union⁶⁸ level project sites. In Tanzania and Zimbabwe, sites were selected from village-level project sites.

Table 1: Overview of WATCH and Wazazi na Mwana project sites

	Bangladesh (WATCH)	Tanzania (Wazazi na Mwana)	Zimbabwe (WATCH)
Implementation of male engagement activities	Union level	Village level	Village level
Total number of union-/village-level project sites	400 (55 unions)	511	180
Average number of union-/village-level project sites per project district	100	100	60
Number of union-/village-level project sites per project district	Barguna: 102 Dinajpur: 116 Lalmonirhat: 61 Nilphamari: 121	Illemela: 98 Kalambo DC: 101 Nkasi: 87 Sengerema: 124 Sumbawanga: 101	Chipinge: 49 Mutare: 65 Mutasa: 66

⁶⁸Unions are the smallest rural administrative and local government units in Bangladesh.

The two study sites in each country were selected in consultation with Plan country office staff within the limits of the following inclusion and exclusion criteria:

Inclusion criteria:

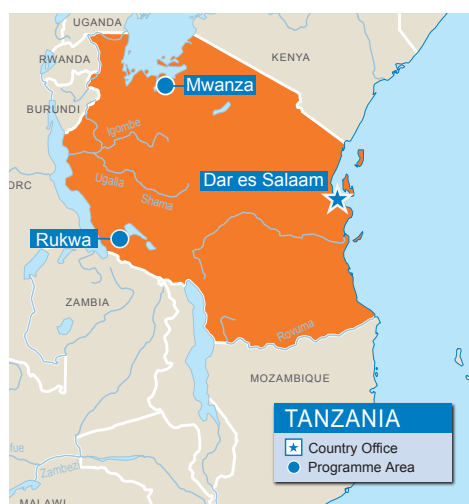
- The site is a WATCH or Wazazi na Mwana project site (at union level in Bangladesh and at village level in Tanzania and Zimbabwe);
- One or more male engagement components of WATCH or Wazazi na Mwana were being implemented; and
- Selected unions/villages were separated by natural boundaries (geographical or distance) or by buffer

villages that were not WATCH or Wazazi na Mwana project sites to ensure that WATCH or Wazazi na Mwana project activities at one study site were highly unlikely to affect the study population at the other site.

Within these criteria, the study sites were purposively selected to capture a broad range of findings relating to male engagement in MNCH. Site selection was determined by country-specific variables that enabled exploration of the diversity between selected project sites within each country (Table 2).

Table 2: Selected study sites and rationale for selection

Sites	District	Village/union	Justification for selection
Bangladesh			
Site 1	Lalmonirhat	Gutamari	Northern part of country; generally poorer compared with Barguna site with differing socio-demographic characteristics and health behaviours
Site 2	Barguna	Aylapatakata	Southern part of country; generally less poor compared with Lalmonirhat site with differing socio-demographic characteristics and health behaviours
Tanzania			
Site 1	Rukwa	Milepa	Rural site; different male engagement strategies used from Mwanza site
Site 2	Mwanza	Igumamoyo	Peri-urban site; different male engagement strategies used from Rukwa site
Zimbabwe			
Site 1	Mutare	Nyamhere	Closer to city centre; generally less poor compared with Chipinge site
Site 2	Chipinge	Kaguvi	Very remote; generally poorer compared with Mutare site; stronger concepts of masculinity and more rigid gender norms compared with most Zimbabwean communities



Site characteristics

Bangladesh

The study was carried out in Aylapatakata union of Barguna Sadar upazila of Barguna district, and Gutamari and Borokhatha union in Hatibandha upazila under Lalmonirhat district. Barguna is one of the coastal districts of Bangladesh situated in the southern end of the country and bordered by the Bay of Bengal. Lalmonirhat district is situated in the northern part of the country close to the Indian border. Roads within the Aylapatakata study site were usually kaccha (muddy road), while those at the Gutamari study site were mostly paved with brick and concrete. In both study sites, most people were primarily involved in agriculture although some people worked in wage employment. Women and girls in Gutamari are generally more visible in public and more independently mobile due to increased bicycle use compared with women and girls in Aylapatakata. There may be a number of reasons for this, including sociocultural conservatism in Barguna and Lalmonirhat's proximity to India, where women's use of bicycles is common. There were 15 NGOs implementing programs in Aylapatakata compared with three in Gutamari, including multiple MNCH programs and a small number of male involvement activities built into MNCH programs. Many study participants in both study sites were involved with activities implemented by non-governmental organizations (NGOs) other than Plan.

Tanzania

The study was carried out in Milepa village and Igumamoyo Street, where male engagement activities are implemented by the Wazazi na Mwana project. Milepa village is located around shores of Lake Rukwa, in Sumbawanga rural district, Rukwa region, western Tanzania. It is located approximately 130 kilometres from Sumbawanga town along the main road. Igumamoyo street is located in Sangabuye ward, Ilemela municipal, in Mwanza city, northwest Tanzania. Sangabuye ward is among the rural-based wards in Mwanza city. Igumamoyo Street is located approximately 45 kilometres from Mwanza city, close to Lake Victoria. In this study, Igumamoyo was regarded as a peri-urban site while Milepa was considered a rural site. However, despite its location relatively close to an urban centre, Igumamoyo Street has access to health and education services comparable to rural areas of Tanzania.

In both study sites, farming is the predominant economic activity; other economic activities are fishing and livestock rearing. Furthermore, male domination in both sites is prevalent, with strong adherence to traditional gender roles, including activities related to women and children's health.

Zimbabwe

The study was carried out in Kaguvi in Chipinge district and Nyamhere in Mutare district, both in Manicaland province, where male engagement activities are carried out under WATCH. Kaguvi is more remote and borders Mozambique, while Nyamhere is located approximately 60 kilometres from Zimbabwe's eastern city, Mutare, and is closer to the main road. Kaguvi is relatively poorer than Nyamhere and is characterized by pole and dagga huts, while most Nyamhere main houses are built from burnt mud bricks and are roofed with asbestos or corrugated sheets, indicators of relative affluence. Chipinge district contains communities with stronger concepts of masculinity and more rigid gender norms compared with most Zimbabwean communities. Mutare district contains the highest number of Apostolic groups in Zimbabwe, although no Apostolic members were recruited in the study, which potentially reflecting religious sanctions against members participating in any health-related programs, including health-related research⁶⁹. Both study sites are characterized as patriarchal, with defined gender roles and norms; for example, women take care of the children and men generally do not go to the clinic. Taboos are also important to community members in both sites. For example, the belief that witnessing a woman delivering causes blindness, or that if a man holds a newborn he will develop Parkinson's disease. In both study sites, the impact of social norms is strong: society has an important influence on people's behaviour.

Study population

Focus group discussions and in-depth interviews

At each study site, FGDs were separately conducted with male and female target beneficiaries. FGDs were conducted separately for young men, young women, older men, and older women. In order to be eligible for the FGDs or IDIs, participants needed to adhere to the following inclusion criteria:

⁶⁹According to community and religious norms within these Apostolic groups, the aetiological agent of any health-related problem is always characterized as spiritual and seeking medical services is strongly sanctioned.

Male participants:

- Resident in study site for a minimum of 12 months;
- Was directly exposed to male engagement activities delivered through WATCH or Wazazi na Mwana; and
- Female partner was pregnant or had a child in the previous 12 months (18 months in Zimbabwe).

Female participants:

- Resident in study site for a minimum of 12 months; and
- Was pregnant or had a child in the previous 12 months.

FGD participants were recruited from the target beneficiary population at each study site, identified by the local Plan program unit or implementing partner. IDI participants were identified either by local Plan program staff, implementing partners, or community members who had delivered male engagement components of WATCH or Wazazi na Mwana. No IDI participants were included in FGDs.

Key informant interviews with relevant stakeholders

Key informant interviews were conducted with stakeholders selected in collaboration with Plan country office staff, and involved those who had been directly involved with WATCH or Wazazi na Mwana in selected study sites. Key informants were selected to include project staff employed by Plan or implementing partners, as well as community members who were involved in implementing the project as volunteers.

Study procedures

Research team

This study was designed and implemented jointly. Data collection teams consisted of an in-country principal investigator from the respective research institutes and 2-4 research assistants. In Bangladesh and Tanzania, the principal investigators were female. In Zimbabwe, the principal investigator was male. Attention was paid to ensure that male data collectors were available to facilitate the male discussion groups and female data collectors were available for female discussion groups. With one exception, each FGD, IDI, and KII was led by a trained facilitator of the same sex as the participants.

The training of facilitators was conducted separately in each country. Training was conducted over three days in Tanzania and over five days in Bangladesh and Zimbabwe. At minimum, facilitators were trained in:

- Gender-sensitive interview practices;
- Age-appropriate interview practices, with a focus on interview techniques appropriate to adolescents;
- Discussing sensitive topics, including appropriate approaches to probing and managing risk for individual participants in FGDs;
- Data safety and management, including the specific procedures to be used in this study;
- Maintaining ethical principles in conducting research, with reference to international ethical guidelines; and
- Referral procedures as appropriate to the referral options available at each study site location.

Research tools

Preliminary question guides were developed in English by Burnet Institute staff in collaboration with the in-country investigators from CeSHHAR, IHI, and icddr,b, as well as with inputs from Plan Canada. Before pre-testing, data collection tools were translated into the languages used by the study population at the selected study sites, including local dialects. Back-translation to English was not completed, although in each country researchers fluent in local language(s) and English reviewed the translated data collection tools. These tools were further reviewed and amended by the data collection teams during the training workshops. Each in-country research team pre-tested the FGD, IDI, and KII question guides in one community near the selected study sites. Pre-testing was used to explore a range of issues associated with the content of the different sections of the discussion guides and interview guides, including the identification of topics that required particular sensitivity. This process was also used to guide the forms of language and expressions in the questions and probes to ensure that words and expressions were widely understood in the study sites.

The following data collection tools were developed and administered (see Appendix C for study tools used):

- Brief questionnaires administered prior to FGDs, IDIs, and KIIs;
- Interview guides for FGDs (separate guides for male and female participants);
- Interview guides for IDIs (separate guides for male and female participants); and
- Interview guides for KIIs.

Question guides developed for each group of study participants included between seven and ten broad questions, with suggested probes. The unpacked definition of male engagement, described above, informed probes in data collection tools to assist researchers in fully exploring the concepts during data collection. This was particularly relevant where participants found it difficult to understand the concept of male engagement, as researchers could ask about a range of specific, tangible things.

Data collection

Data was collected between October 2014 and February 2015 by three teams, with each undertaking research activities in a single country, ensuring research was conducted in the appropriate local language. FGDs, IDIs, and KIIs with key informants based in study areas were conducted during field trips. KIIs with Plan staff based in urban areas were held before or after field trips.

A trained facilitator, either the in-country investigator or a delegate, supported by one or two note takers, led each FGD. Each comprised between six and 12 participants of the same sex and took approximately two hours. IDIs and KIIs had one facilitator and one note taker and took approximately one hour on average⁷⁰.

Informed consent for the study was obtained from all eligible participants who agreed to participate before any data was collected.

Immediately prior to commencing the interviews, the research team member administered a brief structured questionnaire designed to collect non-identifying socio-demographic information about each participant. For all participants, this questionnaire collected information on relevant socio-demographic characteristics including sex and age. In the FGDs and IDIs, additional information was obtained on the number of children, whether or not the participant lives with his/her children, relationship status, and locally-relevant characteristics, including one or more poverty markers. The KIIs gathered non-identifying information about how the key informant had been involved with WATCH or Wazazi na Mwana.

The location of FGDs was decided in consultation with local Plan staff or implementing partners. For IDIs, location was determined separately for each interview by the country research team, with consideration given to potential sensitivities and risks relevant to each participant.

Key informant interviews were conducted in person or remotely via telephone or Skype if an in-person interview was not possible. In Tanzania, in addition to interviews with individual key informants, one FGD was held with key informants to facilitate discussion and follow up detailed findings. Similar to IDIs, the location of key informant interviews was determined separately for each interview by the country research team with consideration given to potential sensitivities and risks relevant to each participant. FGDs, IDIs and KIIs were recorded using a digital recorder.

Data management

Questionnaires administered during field research prior to the commencement of FGDs, in-depth interviews and key informant interviews were kept secure at all times in locked document storage facilities such as lockable folders or filing cabinets, accessible only to authorized members of the research team. No personal identifiers were recorded on the questionnaires.

All digital audio files and any notes taken during FGDs and interviews were stored securely. Audio files and notes were defined by a unique identifier previously assigned to each participant rather than by any information that could identify the participants. Only authorized research team members had access to the files containing recordings and notes. Transcription of audio-recordings was undertaken by one or more members of the country research team, noting any relevant non-verbal communications. With one exception, transcribed data from all study sites was translated verbatim into English. The exception was data from the second study site in Bangladesh, where delays to field data collection due to political unrest resulted in insufficient time to translate all transcriptions into English.

Signed informed consent forms were kept separately from questionnaires, interview transcripts and audio-recordings, and stored securely at all times in locked document storage facilities. Only authorized research team members have access to the signed consent forms.

Data analysis

Findings were analysed separately for each country under a unified coding strategy. The five research objectives were taken as categories of interest for all countries, and codes and sub-codes responding to these categories were identified separately in each country. In Tanzania and Zimbabwe, codes were initially generated based on detailed analysis of a sub-set of transcripts and then applied to the remaining transcripts,

⁷⁰In Tanzania, the female principal investigator facilitated an additional FGD with younger men in order to determine that male research team members were using probing effectively.

with additional codes identified as they emerged. In Bangladesh, detailed analysis was completed of all transcripts with codes identified and then crosschecked after the completion of analysis. Coding was completed manually in all countries. In Zimbabwe, coded transcripts were stored using NVivo.

After the completion of all in-country research and analysis, country-specific results were synthesized during a three-day data analysis and interpretation workshop attended by 1-2 investigators from each of the four research institutes. For each research objective, country-specific findings and counter-findings were presented and illustrated with quotes from transcripts. The research team assessed findings for gaps or silences in the data as they were presented, informed by the unpacked definition of male engagement. Apparent gaps or silences were tested back against country-specific data to verify whether relevant findings had indeed been captured during data collection but not well captured in the country-specific coding framework.

Country-specific findings were compared using a structured, collaborative process to group country-specific findings in order to identify emerging similarities and differences between and within countries. These emerging findings were then tested back against country data. Potential gaps or silences in the data were also tested back against the data in order to understand whether a concept had not been picked up or whether there was a gap in the findings.

Once cross-country findings and counter-findings were established and verified against the data, themes captured under various research objectives were drawn together in order to respond to the evaluation questions (refer to Figure 2). At this stage, findings were also situated with reference to the global literature in order to facilitate interpretation of the findings.

Ethical considerations

Ethical approval was obtained from ethical committees in Australia (The Alfred Hospital Human Ethics Committee), Bangladesh (icddr, b internal Institutional Review Board), Tanzania (Ifakara Health Institute internal Institutional Review Board and the National Institute for Medical Research) and Zimbabwe (Medical Research Council of Zimbabwe). Data collection in each country did not begin until approval was received from Australia and the relevant in-country ethical committee(s).

Care was taken to prepare culturally appropriate and comprehensible explanations about the study, including aims and objectives, any potential risks and benefits, and with particular emphasis on the participants' right to withdraw from participation at any time. Researchers also discussed the use of digital recorders with participants at the start of each consultation, prior to obtaining consent. As noted above, informed consent was obtained from all participants.

Measures were taken to ensure the privacy, respect, and dignity of all participants. Identities of participants in the FGDs, in-depth interviews and key informant interviews remain anonymous. All members of the research team (including data collection teams) received intensive training in research ethics, including confidentiality. Confidentiality was also emphasized at the beginning of each FGD, in-depth interview and key informant interview and a statement agreeing to maintain confidentiality was included as part of the participant consent forms. Informed consent forms have been delinked from all data collected and are stored separately. All documents and recordings were, and will continue to be, stored securely in lockable document storage facilities, such as locked folders or locked filing cabinets, and password-protected documents accessible only to authorized members of the research team. All primary data collected through research will be destroyed within five years, or within seven years if unpublished.

The risks of participating in the study were minimal but could have included a potential breach of confidentiality, and embarrassment or discomfort discussing sensitive issues. No such instances have been reported to the research team.

No direct benefits accrued to participants taking part in this research. However, through participation in the FGDs and in-depth interviews participants might have become aware of a range of services available through WATCH and Wazazi na Mwana project activities that could be of benefit to their health and wellbeing. Additionally, participation in interviews might provide benefits in terms of increased self-awareness, knowledge, understanding and decision-making capacity. All participants were provided with refreshments as considered appropriate by each country research team. For ethical reasons, other remuneration was not provided.

Limitations

As with any research, there are limitations. Notably, we recognize that the number of sites (two per country) might have limited the number of people whose experiences and perspectives have been recorded. We note, however, that a diversity of experiences and perspectives were reported at each study site, including differences in experiences between different sex and age groups. We consider that there was sufficient depth and diversity across the six study sites to be able to identify and understand commonalities across experiences, as well as to identify and understand context-specific drivers of diversity in the experiences of men and women. Although FGDs and IDIs aimed for saturation of information, it is likely this was not always possible across all aspects of interest.

Second, recruitment in the field was conducted via Plan or implementing partners as per the initial design. Although there were clear logistical benefits to this approach, it also meant that the research team was unable to independently recruit participants. As such, the recruitment strategy could have led to more likely enrolment of participants with positive views, because people with more negative perspectives may have been less likely to participate. This does not diminish the validity of participants' reported experiences, but at the same time, it is important to note that the study was limited in its capacity to capture negative experiences.

Similarly, the study population did not include people who had dropped out of the male engagement components of Plan supported programs or who had never participated in these components. As a result, the acceptability of male engagement is likely to be overstated, because researchers spoke only to people who have found program activities sufficiently acceptable to continue to participate. Additionally, the study could not capture the barriers to participation experienced by men who had dropped out or who had chosen not to participate in male engagement activities. Notably, this limits the capacity of the study to capture information about barriers to participation experienced by hard-to-reach men or to generate findings on how these barriers might be addressed.

Data collection tools were developed centrally and revised at country level. Because the primary purpose of the study

was not to generate locally-grounded understandings of male engagement, tools were developed on the basis of established domains of male engagement derived from the literature. This means that tools did not necessarily capture specific local understandings of male engagement beyond these domains and thus limits the ability to compare context-specific understandings of male engagement beyond this framework. This is particularly important as because male engagement is generally recognized to be a difficult concept to define in concrete terms. There is no single answer to the question, 'What does an engaged man look like?' This means that the approach taken to unpacking the concept of male engagement might have limited the scope of the study to findings only within these tangible domains. Tools were also less sensitive to locally-grounded understandings of abstract concepts relating to gender roles and norms.

The study investigated programs that had been implemented for a short period of time, with field implementation beginning between six months and two-and-a-half years prior to research activities. Consequently, it was difficult for participants to speak to those changes in men's engagement in MNCH following project activities that had or had not been sustained over time. Participants also found it difficult to hypothesize around the sustainability of current changes in men's engagement. Consequently, the study was limited in its capacity to capture substantial findings about the sustainability of the male engagement programs being studied.

It is also important to recognize that male engagement is more than actions taken by men. Male engagement in MNCH can be understood as a man's active interest in, support for, and collaboration with his partner and family in order to promote their health and wellbeing. This is not always well captured by specific actions. For example, a man can be engaged in his partner's health at the same time as the couple decides together that the woman will attend a health clinic alone while the man engages in other work. However, actions are most visible and easy to report on in a community. Consequently, because the study asked participants about changes in the community, participants might not have been able to report as fully on changes in other men's level of interest in, support for, and collaboration with their partners that were not expressed through visible actions.

Findings

Participant characteristics

Socio-demographic information was collected for all participants in the study. Summary information is presented in Table 3.

Table 3 : Socio-demographic characteristics of study participants in the FGDs and IDIs

Country and population group	Number of participants	Age, mean years (range)	Education, mean years (range)	Number of children, mean number (range)
Bangladesh				
FGD male participants	29	34 (22–50)	10 (2–17)	2 (1–4)
FGD female participants	29	26 (20–43)	8 (2–14)	2 (1–4)
IDI male participants	4	36 (30–44)	6 (0–12)	2 (1–3)
IDI female participants	4	26 (20–32)	9 (8–10)	2 (1–2)
Tanzania				
FGD male participants	35	28 (17–56)	9 (0–17)	2 (0–9)
FGD female participants	34	22 (15–38)	8 (0–12)	2 (0–10)
IDI male participants	4	32 (18–50)	8 (7–12)	3 (0–7)
IDI female participants	4	28 (16–40)	5 (0–7)	4 (0–10)
Zimbabwe				
FGD male participants	38	34 (15–76)	7 (3–11)	3 (0–12)
FGD female participants	48	26 (15–57)	7 (0–11)	3 (0–7)
IDI male participants	4	28 (19–47)	11 (11–11)	4 (1–10)
IDI female participants	4	28 (19–39)	7 (3–10)	4 (2–6)

Study sites in all countries were hard-to-reach, underserved areas with relatively marginalized populations. For example, religious minorities in each country were over-represented in several of the study sites. However, some important differences in context were identified in discussions between country research teams. These differences are detailed below, with some explanation of how this likely affected research findings.

Bangladesh is in the middle of a more rapid social and demographic transition compared with Tanzania and Zimbabwe. Three implications were raised as particularly relevant to this study:

- Greater access to information and communication technology that translate into more information channels, including for health information (e.g. health messages can be delivered to community members' personal mobile phones through SMS).

- Increasing trend of contraceptive use, low fertility leading to smaller family size, increased care of both boy and girl children, and other changes associated with reductions in family size might be occurring more quickly.
- High school enrolment for girls in primary and secondary education and an increased number of women in paid employment, suggesting that changes associated with women's economic empowerment – such as changes in gender roles and norms – could be developing more rapidly. Achievements in reducing maternal and child mortality and reducing gender disparity are also important considerations in analysing findings from Bangladesh sites.

For men and women who participated in the study, age differences between male and female partners tended to be smaller in Tanzania and Zimbabwe and larger in Bangladesh. In the broader literature, a larger age difference within couples has been linked with younger age of female

partner, older age of male partner, lower woman's autonomy or empowerment, and less equitable relationships⁷¹.

HIV-related programs are significantly more common in Zimbabwe and, to a lesser extent, Tanzania, compared with Bangladesh. This is due to an HIV prevalence of 15% and 5% in the general adult populations in Zimbabwe and Tanzania respectively, compared with less than 0.1% in Bangladesh⁷². This affects perceptions of health services (e.g. fear of being tested for HIV on attending a health clinic) and delivery of health services (e.g. HTC integrated with ANC) within the three study country settings.

It was found to be more acceptable to have long-term, multiple concurrent partnerships in Tanzania and Zimbabwe compared with Bangladesh. In Bangladesh, childbearing is accepted only in the context of marriage. Pre-marital sexual activity or partnership is not socially or culturally accepted. This means that Plan programs targeting unpartnered or unmarried mothers and unacknowledged fathers are more active in Tanzania and Zimbabwe compared with Bangladesh.

The number of NGOs delivering programs compared with the size of study population is higher in Bangladesh than Tanzania and Zimbabwe, suggesting that it is more difficult to observe changes contributed by Plan programs in Bangladesh compared with Tanzania and Zimbabwe.

While all countries use health volunteers, volunteer program implementers in Bangladesh tended to have other paid employment relative to Tanzania and Zimbabwe. Accordingly, the incentives, intensity of program delivery, and sustainability relating to volunteerism are different in Bangladesh compared with Tanzania and Zimbabwe.

Dowry (payment made to the groom's family from the bride's family) is common in Bangladesh whereas bride price (money paid to the bride's family from the groom's) is prevalent in Tanzania and Zimbabwe. However, country research teams agreed that both of these practices place gendered expectations on women, such as the expectation that a woman bear children for her husband's family and take care of these children when they are young. There were no clear findings from the study on how the difference between bride price and dowry might influence differences between countries.

While important distinctions were observed between countries, it is important to note that study participants at all six sites in the three countries reported gender-related norms, values and attitudes that discriminate against women and girls and constrain women's autonomy and agency. Rapid changes in use of information and communication technology, education of women and girls, and economic participation of women in Bangladesh, for example, do not necessarily indicate that prevailing gender norms are changing with equal rapidity.

Evidence for the contributions of male engagement

Changes were reported by participants in a range of outcomes, and linked by participants to increased male engagement following Plan programs. These outcomes included both direct health outcomes – mortality, morbidity, and utilization of health services – and outcomes that are known to indirectly contribute to improved health, such as improved couple communication, shared decision-making and reduced household work of women. These outcomes are reported separately below.

Contributions of male engagement to outcomes related to MNCH

Improved couple communication and shared decision-making

According to participants in all countries studied, male engagement activities under WATCH and Wazazi na Mwana have contributed to improved couple communication and decision-making related to MNCH and other household matters.

"Nowadays I can tell him that I need your 'thing' [I need something from you] and he doesn't refuse...or If I say, can you please give me some money I want to buy beans today, I'm tired with mboga [vegetables], he just provides, and that doesn't make him angry... I would say these are changes because in the past it was not like that. That is happening because of wahudumu wa afya [CHWs]." (Adult female IDI, Tanzania)

"I would say at least now communication has improved. You know, in the past, a wife may be six month pregnant and if you ask her, 'Are you pregnant?' she would say no, and you see her belly is so big, but now our wives are telling us even if the pregnancy is three months." (Adult male FGD, Tanzania)

⁷¹Jewkes, RK, Dunkle, K, Nduna, M & Shai, N 2010; Smith, LC, Ramakrishnan, U, Ndiaye, A, Haddad, L & Martorell, R 2003; UNICEF 2011.
⁷²UNAIDS 2013.

This finding echoes those established in the global literature. International research has shown that greater male engagement in MNCH can contribute to better couple communication and more equitable couple relationships⁷³. Spousal communication and shared decision-making has been significantly associated with a range of healthy behaviours, including contraceptive behaviour⁷⁴ and care-seeking for skilled antenatal and delivery care⁷⁵.

Participants in Zimbabwe and Bangladesh also reported improved communication and decision-making, relating specifically to family planning. Family planning is not strongly emphasized in Wazazi na Mwana in Tanzania.

“The changes that I am now seeing are that as we are raising children like... like the traditional practice that used to be done by older men whereby they would take out their organ when they were about to release sperms, he no longer does that. The very day he started attending the programme, he allowed me to take family planning [tablets]. From that day, I started taking family planning [tablets]; I am now raising my child [preventing pregnancy] through them.” (Adolescent female FGD, Zimbabwe)

“Both of us decided together to have our second child. My first child is 6 years old. If I want to take second child now my wife would be fine and baby would be healthy. So, we both decided together about having our second child.”
(Older male IDI, Bangladesh)

In some cases, greater couple communication regarding family planning meant that women who had been taking family planning pills without their husband's knowledge were able to take these pills with their husband's consent.

Reports by participants that efforts to increase male engagement in MNCH have contributed to changes in contraceptive use are supported by previous quantitative and qualitative research⁷⁶. For example, the Malawi Male Motivator project increased men's understanding and ability to discuss contraception and family planning, which in turn led to greater couple communication and consensus between partners on important issues such as family size and contraceptive use⁷⁷. The Men in Maternity Care project in New Delhi⁷⁸, India also found that involving men in antenatal counselling significantly improved couple communication and joint decision-making regarding important issues such as family planning.

Improvements in couple relationship and emotional support (including reduced violence)

Male and female participants both associated perceived improvements in couple communication with a reduction in domestic violence. This finding was reported in Tanzania and Zimbabwe by male and female participants but not reported in Bangladesh, although the research team in Bangladesh noted that domestic violence is a very difficult topic for participants to discuss due to prevailing social norms that restrict open discussion about matters within the household.

“It [the programme] also teaches men that they should live harmoniously with their wives, that one should do this and that if he is angry with his wife, things other than fighting each other...” (Adolescent male FGD, Zimbabwe)

“Plan has done some good things in our life. We have been taught to live in harmony with our husbands, for example in the past our husbands were beating us a lot...no matter how old you are, you will be beaten... I would say there is big changes.” (Adult female FGD, Tanzania)

The findings that male engagement activities under WATCH and Wazazi na Mwana may have contributed to reductions in gender-based violence (GBV) is in keeping with the international male engagement literature, which clearly demonstrates that men and boys can be effectively engaged in addressing harmful gender norms and attitudes that support GBV and that also negatively affect MNCH. Effective program examples, from many different countries, tend to be community-based and include programs that work with a wide variety of stakeholders, including adolescent girls and boys, men, in-laws and others⁷⁹.

In addition to reported changes in GBV, male and female participants in Tanzania also reported improvements in couple relationships as a result of improved communication and greater sharing of household tasks.

“Now we are living a happy life, when I'm helping her [with tasks], I think it comes to her mind that I love her. I didn't do that before. Now we are happy and we have peace in our house.”
(Adult male FGD, Tanzania)

“I can see even love has increased when we are walking together. I feel happy. I feel that he loves me because in all tasks we are helping each other.” (Adult female IDI, Tanzania)

⁷³Exner, TM, Mantell, JE, Adeokun, LA, Udoh, IA, Ladipo, OA & Delano, GE, et al. 2009; Kunene, B, Beksinska, M, Zondi, S, Mthembu, M, Mullick, S & Ottolenghi, E, et al. 2004; Lundgren, RI, Gribble, JN, Greene, ME, Emrick, GE & de Monroy, M 2005; Varkey, LC, Mishra, A, Das, A, Ot tolonghi, E, Huntington, D & Adamchak S, et al. 2004.

⁷⁴Bawah, AA 2002; Hartmann, M, Gilles, K, Shattuck, D, Kerner, B & Guest, G 2012; Ko, IS, You, MA, Kim, ES, Lee, TW, Kim, S & Kim, YM, et al. 2010; Link, CF 2011; MacPhail, C, Pettifor, A, Pascoe, S & Rees, H 2007.

⁷⁵Furuta, M & Salway, S 2006.

⁷⁶Exner, TM, Mantell, JE, Adeokun, LA, Udoh, IA, Ladipo, OA & Delano, GE, et al. 2009; Muralidharan, A, Fehringer, J, Pappa, S, Rottach, E, Das, M & Mandal, M 2014.

⁷⁷Lundgren, RI, Gribble, JN, Greene, ME, Emrick, GE & de Monroy, M 2005; Shattuck, D, Kerner, B, Gilles, K, Hartmann, M, Ng'ombe, T & Guest, G 2011.

⁷⁸Varkey, LC, Mishra, A, Das, A, Ottolenghi, E, Huntington, D & Adamchak S, et al. 2004.

⁷⁹Muralidharan, A, Fehringer, J, Pappa, S, Rottach, E, Das, M & Mandal, M 2014.

Although couple relationships and emotional support are relatively under-investigated in the literature on male engagement in MNCH⁸⁰, these findings align with the available literature. For example, a study in India engaged community mobilizers to conduct home visits and facilitate men-only community meetings which focused on ways men can support their pregnant partner, available maternal and child health services and the need to plan transport in case of emergency⁸¹. In a before-and-after analysis, this study found an increase in women reporting emotional support received from their husbands during pregnancy from 39.6% at baseline to 50.8% at end line⁸².

Male engagement in MNCH is also likely to have further benefits for maternal mental health⁸³, although such benefits were not reported by participants in this research. A recent review⁸⁴ found that perinatal mental disorders are common in low and lower middle-income countries. These disorders affect maternal wellbeing and the health and development of the baby. The authors note that when other factors were controlled for, higher rates of common perinatal mental disorders were observed among women who experienced difficulties in the intimate partner relationship, including having a partner who was unsupportive and uninvolved. Although participants did not report findings relating to mental health, their accounts of improved couple relationships – illustrated by the above references from male and female participants in Tanzania about feeling “happy” and “love” – could resonate with these established findings regarding improved maternal mental health.

It is worth noting here that although male engagement may improve couple relationships, we also found that participants in all countries reported that male engagement can contribute to intergenerational conflict, particularly with mothers-in-law⁸⁵.

Reduced workload during pregnancy

Male engagement activities have made it more acceptable for men to assist with household chores and have contributed to some reductions in maternal workload during pregnancy, according to participants in all countries studied. Participants reported that some men became more involved in childcare and household chores following male engagement program activities that emphasized the

importance of reduced maternal workload, including heavy lifting, during pregnancy.

“I’m saying that (pause) this kind of education has been very helpful to us because in the past you wouldn’t see a man participating in cooking or washing clothes, but now it is different. Men are highly participating in housework, some of them they even carry babies in their back but in the past even when a child tries to follow his father...he would say, ‘go back to your mother’, but now the story is different.” (Adolescent female FGD, Tanzania)

“My wife is pregnant, eight months... My responsibility now is to help her with tasks like fetching water. We don’t have tap water here... so I have to take the bucket and fetch water somewhere, and also collecting firewood...for sure I’m helping her [with] many tasks as I know when a woman is pregnant she is not supposed to do heavy duties, she can only manage simple tasks.” (Adolescent male FGD, Tanzania)

Notably, some female participants commented that they felt proud completing household chores and therefore did not want their husbands to help with all household chores all of the time.

“I enjoy washing my husband’s clothes. It would pain me to see him washing his own clothes when I am well and not tied up. As a woman I like it when my husband assists me when I am unable to do certain tasks but whenever I can do tasks such as washing or cooking, I will do them myself.” (Adolescent female FGD, Zimbabwe)

“In (a) real sense I don’t like my husband to cook at all (laugh) cooking...and other small activities, washing dishes, washing clothes I don’t like (short pause). Maybe it will depend with the age or time...maybe eight month [at eight months’ pregnancy duration], I might be very tired...” (Adolescent female IDI, Tanzania)

“Women are changed but not that much. For example, in [study site] still some women are believing that men are not supposed to do some chore; for example, collecting firewood. Women are thinking it is their duty. Some women also think fetching water is their task...” (Male KII, Tanzania)

⁸⁰Comrie-Thomson, L, Tokhi, M, Ampt, F, Portela, A, Chersich, M & Khanna, R, et al. nd.

⁸¹Sinha, D 2008.

⁸²Sinha, D 2008.

⁸³Fisher, J, Cabral de Mello, M, Patel, V, Rahman, A, Tran, T & Holton, S, et al. 2012; Kakyo, TA, Muliira, JK, Mbalinda, SN, Kizza, IB & Muliira, RS 2011.

⁸⁴Fisher, J, Cabral de Mello, M, Patel, V, Rahman, A, Tran, T & Holton, S, et al. 2012.

⁸⁵This topic is discussed in greater detail in Community-initiated bylaws and regulatory mechanisms, p.52

Importantly, these findings do not necessarily reflect a deeper questioning of gender roles, as highlighted below in the continuing description of household work as “women’s chores”. Participants reported that men may only be engaged in such work if a woman is pregnant, sick or otherwise incapable of managing all of the household chores.

“As a result of the [male engagement] program, men are now doing women’s chores when their wives are pregnant, including fetching water, firewood, and watering the garden.” (Adolescent male FGD, Zimbabwe)

“The current trend is, if wife is sick and she cannot wash her cloths after bath or if she cannot work, husband works out [outside the home] and also does household work.” (Older female FGD, Bangladesh)

These findings are in keeping with the available evidence that building husbands’ awareness of health needs during pregnancy can positively influence women’s workloads during pregnancy. In India, a community-based intervention that raised awareness of healthy behaviours during pregnancy observed an increase in the number of expectant fathers assisting with household work (from 27.4% to 41.7%) and assisting their wives to access health services (from 46.3% to 57.7%) over 18 months⁸⁶. Modest but significant increases in husbands helping were also observed in Pakistan⁸⁷ with significantly more women in intervention sites reporting reducing workload during pregnancy (25.3% versus 18.5%).

Additionally, however, some male participants from this study reported increased sharing of workload outside of pregnancy.

Interviewer: “Do you help her only when she is pregnant or any time?”

Participant: “Myself is all the time. When I see she is tired I tell her, ‘have a rest let me help you.’” (Adult male IDI, Tanzania)

Compared with findings relating to men taking on additional work during pregnancy, there is limited available evidence of men taking on additional work on an ongoing basis, although relatively fewer studies have examined changes

in workload allocation beyond pregnancy and the postnatal period. One study in Turkey⁸⁸ reported that men had taken on a greater proportion of the household workload – particularly work relating to care for their babies – at six months following a male engagement intervention. It is notable, however that this increase was self-reported by men and not corroborated by women, as were the findings from this study.

Improved nutritional intake and rest, and changes in allocation of household resources

In all countries, activities to engage men in MNCH may have contributed to men supporting better nutritional intake and increased rest for women during pregnancy and after delivery. Participants reported that these changes were achieved through changes in the allocation of household members’ time and household income.

“Nowadays, if a woman cannot eat holding a child, then they (men) say that I am holding the baby and you eat. Previously men used to say, ‘Hold the baby and you don’t need to eat now’.” (Older female FGD, Bangladesh)

“My idea is the same as my colleague has pointed out there; my role as husband is to make sure that I save money, therefore after delivery the food is plenty in the house, not only porridge...fish eeh and even during pregnancy I have to make sure food is available...meat...meat!” (Adult male FGD, Tanzania)

“When I gave birth to my recent child, he helped with washing dishes and cooking. When the sun was hot, he would actually say, ‘Go with the child indoors’. He would then cook and bring some food and I would eat.” (Adult female FGD, Zimbabwe)

In some sites where maternity waiting homes were accessible, male engagement programs had also reportedly led to a greater recognition of women’s need to rest later in pregnancy, which supported women’s use of maternity waiting homes.

“When delivery time approaches, the husband encourages his wife to go to the clinic... I would like to thank the programme that donated funds for the construction of the maternity waiting homes where mothers can sleep...” (Adult female FGD, Zimbabwe)

⁸⁶Sinha, D 2008.

⁸⁷Midhet, F & Becker, S 2010.

⁸⁸Sahip, Y & Turan, JM 2007.

The findings from this study that increased male engagement in MNCH can lead to men supporting improved maternal nutritional intake are similar to established findings in the global literature. Recent reviews of intervention studies⁸⁹ have found three studies in Pakistan and India that measured and reported nutrition outcomes for expectant mothers⁹⁰. In Pakistan, safe motherhood education for husbands demonstrated a non-significant increase in women who self-report improved dietary intake during pregnancy, and significant increases in women who received tetanus immunization and iron-folic acid supplementation⁹¹. Changes in maternal rest following increased male engagement in MNCH have not been comprehensively studied in the literature, although it is notable that improvements in maternal nutrition status can be attributed to not only improved quality and quantity of dietary intake but also to increased rest⁹².

Changes in the perceived value of girl children

There were relatively fewer findings reported by participants relating to abstract changes in gendered perceptions, attitudes or values, compared with more tangible changes such as allocation of household chores or utilization of health services. However, changing community perceptions about the value of girl children were noted by some participants in Tanzania and Bangladesh. In Tanzania, participants directly attributed these changes to Plan's male engagement strategies.

"We were neglected when we give birth to baby girls, because they wanted us to bring boys rather than girls. When you bring a boy at least he can provide something... if you have many girl that will result in conflict but nowadays even if it is a baby girl they still provide for us and the babies." (Adult female FGD, Tanzania)

"...what I can say is that, in the past, when a woman gave birth to a female baby, he [the father] start thinking on the bride price only, but nowadays things have changed; any of the child – either a daughter or a son – they're all treated the same." (Adult male FGD, Tanzania)

In Bangladesh, however, participants noted similar increases in the value given to girl children, but these were attributed to the work of multiple NGOs and general social change in addition to Plan programs.

"It was natural in old days to have gender discrimination where sons were given more priority, because boys were thought to be the bread winner. They are the head [of household]. This view does not prevail now. Now all children get same rights... They [boy and girl children] get the same treatment...because people are more aware and the literacy rate has increased. Now different NGO workers come and make us understand. I would like to say about Addin [WATCH], Safe Bangladesh, Save the Children, etcetera, there is no village where they don't come two-to-four times a month. There is always a meeting. They make us aware of everything... that how should be girls treated and taken care of. How much they should be educated and married off at what age..." (Younger male FGD, Bangladesh)

We are not aware of studies in the international literature regarding the engagement of men in MNCH to have reported outcomes relating to men valuing or engaging with their female children. However, working with families and communities to address gender norms is an effective strategy for increasing girls' education attainment⁹³, preventing early marriage, and increasing age at marriage for girls and young women⁹⁴. These changes can have very real, long-term impacts on MNCH. Importantly, a recent review funded by the United Kingdom's Department for International Development found that working with boys to address gender equality can positively impact boys' gender-related attitudes and behaviours and contribute to girls staying at school for longer⁹⁵. This finding is a reminder that working with men and boys to address gender inequalities affecting MNCH is most effective when men and boys are engaged throughout the lifecycle with messages and strategies specific to their life stage⁹⁶.

⁸⁹Muralidharan, A, Fehringer, J, Pappa, S, Rottach, E, Das, M & Mandal, M 2014; Tokhi, M, Comrie-Thomson, L, Davis, J, Portela, A, Chersich, M & Luchters, S nd.

⁹⁰Fullerton, JT, Killian, R & Gass, PM 2005; Maternal, Newborn and Child Health and Nutrition Practices in Select Districts of Jharkhand 2012; Midhet, F & Becker, S 2010; Sinha, D 2008.

⁹¹Midhet, F & Becker, S 2010.

⁹²Shell-Duncana, B & Yungb, SA 2004.

Contributions of male engagement to MNCH outcomes

Participants in this study associated male involvement with a range of MNCH outcomes. This section outlines both perceived contributions of male involvement on mortality and morbidity, as well as changes in uptake of health services that are likely to lead to MNCH benefits.

Reduction in maternal and newborn mortality

Many participants in Zimbabwe and Tanzania, both male and female, associated male engagement initiatives with a reduction in home births or births with a traditional birth attendant (TBA) and an increase in births in health facilities, contributing to fewer maternal and newborn deaths.

“Results are good because in the past we were delivering at home but now we are delivering (at a) hospital, so we are safe.”
(Adult female FGD, Tanzania)

“...when some women gave birth, some lost a lot of blood and the traditional birth attendants were unable to offer any assistance. Some women ended up dying and sometimes their babies died as well as there was no proper care.”
(Adolescent male FGD, Zimbabwe)

“I think our husbands are happy when we are pregnant. In the past, many pregnant women died giving birth. There was high death rate to pregnant women but now we are educated. When you get labour pain, you go to the health centre to give birth safely.” (Adult female FGD, Tanzania)

Some male participants linked these changes in care during childbirth with greater understanding among men of the importance of facility-based birth and skilled birth assistance.

“I can say we have changed a lot. Now we accompany our wives and our children to the clinic and there [in the facility] we have been taught the importance of health facility delivery – that’s why infants death has decreased in our area as well as vifo vya uzazi [maternal death]. Since this project started I can say I didn’t hear of any [maternal] deaths associated with home delivery.”
(Adult male FGD, Tanzania)

Recent reviews on the effect of male engagement interventions on MNCH in low- and middle-income countries⁹⁷ and on gender transformative programs and health outcomes⁹⁸ found evidence of positive effects

of male involvement on care-seeking, but no evidence on essential health outcomes such as birth weight, infant mortality or maternal mortality. Another recent review of gender transformative programs and health outcomes also found no evidence of male engagement programs improving maternal mortality⁹⁹. However, the sample size and/or the duration of intervention required to demonstrate significant differences in such health outcomes are likely to be prohibitive. Therefore, although findings from this study are not generalizable or independently verifiable, they add to the existing literature by indicating that the participants perceived a direct link between increased male engagement and reduced maternal and newborn mortality.

Reduced stillbirths

A perceived link between increases in men’s understanding of health needs during pregnancy, reduced maternal workload during pregnancy, and reduced risk of miscarriage was reported in Tanzania, mainly by men.

“I was much interested to learn about dangerous signs like bleeding [during pregnancy]. I remember my wife had that experience, bleeding, and then miscarry two times. I thought may be because of the heavy workload, they told me how to assist her during pregnant, I did that and never had that experience again. I’m so happy.” (Adult male IDI, Tanzania)

“...after [being educated by] peer educators we understood the importance of helping each other during pregnancy. That means nowadays we get a lot of benefits as we get children without worries because in the past many pregnancies got miscarried...” (Adult male, FGD Tanzania)

As described above, recent reviews of the effect of male engagement interventions on MNCH outcomes found no evidence of effect on essential health outcomes, including stillbirth¹⁰⁰. This study therefore complements the existing evidence base by documenting the perception of a direct link between male engagement activities and reduced stillbirths or miscarriages. It is, however, critical to note that these findings have been generated through a study that is not designed to capture verifiable or generalizable changes in this outcome.

⁹⁷Tokhi, M, Comrie-Thomson, L, Davis, J, Portela, A, Chersich, M & Luchters, S nd.

⁹⁸Muralidharan, A, Fehring, J, Pappa, S, Rottach, E, Das, M & Mandal, M 2014.

⁹⁹Kraft, JM, Wilkins, KG, Morales, GJ, Widyono, M & Middlestadt, SE 2014.

¹⁰⁰Tokhi, M, Comrie-Thomson, L, Davis, J, Portela, A, Chersich, M & Luchters, S nd.

Changes in uptake of antenatal and childbirth services

Men were reportedly more likely to accompany their pregnant wives to the clinic in all three countries as a result of male engagement activities. In all countries, participants reported that greater male engagement in MNCH had contributed to an increase in utilization of clinic services during pregnancy and childbirth and a decrease in home-birth and birth with a traditional birth attendant. Importantly, these changes were reported in the context of increasing understanding in the broader community of the importance of facility birth, and other initiatives to increase health service utilization.

“Now Plan WATCH program is working here. They tell us to check up our wives during pregnancy. I took my wife for ANC three, four times – at four months, six months, seven months and then few days ago...” (Younger male IDI, Bangladesh)

“The change that I have witnessed is that most women would give birth in the homes. They would not go to the clinic to have their pregnancy checked or for examination to see whether or not the baby was well-positioned and kicking but that is no longer happening...” (Adolescent female FGD, Zimbabwe)

“Most of us used to give birth at traditional healers and traditional birth attendants’ dwellings. However, with the launch of this program, people were discouraged from going to local traditional birth attenders and encouraged to go to the clinic. They say that you contract ... (stammering) ... (background: tetanus) tetanus at the local midwives’ place. ... There is a huge change, and not many people are dying.” (Adult female FGD, Zimbabwe)

“...because in the past when a pregnant woman was in labour before going to the hospital, they would tell her do not go to the hospital, they would start giving her traditional herbs. When Mkunga [TBA] has failed they will take her to the hospital and at that time she might be in a critical condition, the unborn baby may die...she might fail to deliver and die but after giving education to the community, when they labour start they rush to the hospital for delivery.” (Female KII, Tanzania)

While participants in Bangladesh also reported reductions

in home births, these were attributed to broader efforts by government and NGOs, including the WATCH project, but not to increased male engagement alone.

“Now we see husbands are bringing their wives here to deliver baby; rate is increasing. It was not so usual before. And the way we are motivating mothers; we are saying that this is her life. She will have to suffer if anything goes wrong. After such motivation and counselling, people are receiving health services more from the facility centre than before.” (Male KII, Bangladesh)

The finding that male engagement might be associated with increases in antenatal and intrapartum care-seeking is in line with international research results suggesting that interventions to engage men in MNCH can increase pregnant women’s use of ANC services in intervention studies elsewhere. Increases in ANC attendance have been found following interventions to increase male engagement in MNCH in Eritrea¹⁰¹, India¹⁰², and Nepal¹⁰³, but not in Pakistan¹⁰⁴. Men’s engagement in MNCH has also been associated with increases in women’s knowledge of maternal and child health in Eritrea and Nepal¹⁰⁵.

Male engagement activities have demonstrated positive effects on intrapartum care in a variety of settings¹⁰⁶. The Indonesian Suami SIAGA (‘I’m an alert husband’) program, which was focused on behaviour change among men, demonstrated a 14.7% increase in skilled birth attendance rates¹⁰⁷, and a Tanzanian safe motherhood promotion program¹⁰⁸ reported a 17.3% increase between post-exposure and pre-exposure groups. However, a facility-based intervention in Nepal¹⁰⁹ and a community-based intervention in Pakistan¹¹⁰ did not find any effect on intrapartum care.

¹⁰¹Turan, JM, Tesfagiorgis, M & Polan, ML 2011

¹⁰²Varkey, LC, Mishra, A, Das, A, Ottolenghi, E, Huntington, D & Adamchak S, et al. 2004.

¹⁰³Mullany, BC, Becker, S & Hindin, MJ 2007.

¹⁰⁴Midhet, F & Becker, S 2010.

¹⁰⁵Turan, JM, Tesfagiorgis, M & Polan, ML 2011; Mullany, BC, Lakhey, B, Shrestha, D, Hindin, MJ & Becker, S 2009

¹⁰⁶Sood, S, Chandra, U, Mishra, P & Shailes, N 2004; Turan, JM, Tesfagiorgis, M & Polan, ML 2011.

¹⁰⁷Shefner-Rogers, CL & Sood, S 2004.

¹⁰⁸Mushi, D, Mpembeni, R & Jahn, A 2010.

¹⁰⁹Mullany, BC, Becker, S & Hindin, MJ 2007.

¹¹⁰Midhet, F & Becker, S 2010.

Participants also reported that government-, community- or clinic-initiated activities to promote male engagement in MNCH, implemented in the same communities as Plan-supported programs, appear to discourage some unmarried and unaccompanied women from accessing health services. Separately from Plan programming, in Tanzania some local communities have introduced a policy of *first service* for women who attend with their male partner, while health centre requirements in Zimbabwe stipulate that women disclose the name of an unborn baby's father. Participants reported that these initiatives act as barriers to use of services by unpartnered and unaccompanied women.

"What happens is that some young women conceal pregnancies ... these young women are impregnated by married men and they don't want it to be known so they conceal the pregnancy until full term. They don't go to the clinic because at the clinic, they are asked to bring along the man responsible for the pregnancy so they choose to go to the village midwife [TBA] who keeps it a secret..." (Male KII, Zimbabwe)

The finding that community- or clinic-initiated efforts to promote male engagement in antenatal care may be unintentionally discouraging or preventing unpartnered or unaccompanied women from attending is supported by research in Tanzania and Malawi. A randomized controlled trial of couple counselling for HIV in antenatal clinics in Tanzania found that half the women invited to bring their partners did not return to the ANC clinic, despite a study context where most women return for subsequent antenatal visits¹¹¹. The observed reduction in re-attendance may have been partly due to HIV-related stigma but highlights the need to clearly communicate to women that they are encouraged to attend antenatal care even if they are unable or disinclined to bring their male partner. In Malawi, qualitative research into the involvement of men in ANC has found that a policy of 'first and fast' service for couples attending ANC together can result in stigmatisation and unfair treatment of women attending without a male partner¹¹².

Increased uptake of HIV testing and treatment, including PPTCT

In Tanzania and Zimbabwe, participants reported that an increase in men attending ANC with their pregnant partners had the added benefit of increasing HIV testing among men.

"It is happening nowadays. It was difficult initially but men are now accompanying their wives and getting tested [for HIV]." (Adult male FGD, Zimbabwe)

"...It has been helpful because through Wazazi na Mwana we are now attending clinic and we check our health status, and if you have a problem the doctor will tell you how to go about it, whether you start treatment or you have to wait for sometimes. Now we are quite sure that you can live 20 years [with HIV/AIDS] and be able to raise up your unborn child until he becomes independent." (Adolescent male FGD, Tanzania)

This finding is supported by the international literature, which clearly demonstrates the benefits of engaging men in PPTCT efforts, including male involvement in ANC and HIV testing. Engaging men in PPTCT efforts can increase the proportion of pregnant women and couples testing for HIV¹¹³, help avoid domestic disputes relating to HIV testing and disclosure¹¹⁴, promote condom use or abstinence to prevent HIV transmission within the couple¹¹⁵, lead to greater adherence to drug prophylaxis regimes and recommended infant feeding practices, and subsequently increase HIV-free survival among their infants¹¹⁶.

At the same time, some participants highlighted that men attending ANC clinics do not always participate in HIV testing.

"...that is still a problem with our husbands; he would agree to accompany you to the clinic...but when that time reach [for HIV testing] he would leave you there...going back home." (Adult female FGD, Tanzania)

¹¹¹Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010.

¹¹²Kululanga, LI, Sundby, J & Chirwa, E 2012.

¹¹³Mbonye, AK, Hansen, KS, Wamono, F & Magnussen, P 2010.

¹¹⁴Aarnio, P, Olsson, P, Chimbi, A & Kulmala, T 2009.

¹¹⁵Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010; Farquhar, C, Kiarie, JN, Richardson, BA, Kabura, MN, John, FN & Nduati, RW, et al. 2004.

¹¹⁶Aluisio, A, Richardson, BA, Bosire, R, John-Stewart, G, Mbori-Ngacha, D & Farquhar, C 2011; Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010; Bolu, OO, Allread, V, Creek, T, Stringer, E, Forna, F & Bulterys, M, et al. 2007; Farquhar, C, Kiarie, JN, Richardson, BA, Kabura, MN, John, FN & Nduati, RW, et al. 2004; Msuya, SE, Mbizvo, EM, Hussain, A, Uriyo, J, Sam, NE & Stray-Pedersen, B 2008; Peltzer, K, Sikwane, E & Majajja, M 2011; Theuring, S, Mbezi, P, Luvanda, H, Jordan-Harder, B, Kunz, A & Harms, G 2009; Waiswa, P, Kemigisa, M, Kiguli, J, Naikoba, S, Pariyo, GW & Peterson, S 2008.

Improvements in care-seeking for childhood illness

Some participants also highlighted an increase in care-seeking for childhood illnesses resulting from greater male engagement. In Zimbabwe, this change was attributed to more collaborative decision-making within couples as well as husbands being more supportive of their wives taking children to health services, while in Tanzania, participants reported that men were more likely to physically accompany a sick child to the clinic as a result of activities to increase male engagement in MNCH.

“I will also assess the child and establish the severity of the illness. We will then agree that, ‘We can’t continue to stay with a child in this state. Let us take him/her to the clinic.’”

(Adolescent male IDI, Zimbabwe)

“I’m so thankful for male involvement because in the past men were very little involved in these issues...but nowadays if the child is sick the father is the first person to say, ‘Let’s go to the hospital or let me [the father] go to the hospital and you just stay at home.’ Fathers have been very much responsible.”

(Adult female FGD, Tanzania)

“We are doing very well in vaccinations. Before it was women who were taking children for vaccine, therefore if the woman would not take the child that means the child would miss the vaccine, but now men are fully participating in vaccination, and I can tell you we get many children nowadays.”

(Male KII, Tanzania)

“...when the child is sick we cooperate in taking him to the hospital. We get treatment and, going back home, we help each other.” (Adolescent female IDI, Tanzania)

The findings that some men might be more engaged in care-seeking for childhood illness are in keeping with the findings of a recent review that found that male engagement programs have increased fathers’ involvement in caring for their children¹¹⁷.

Engaging men may also positively influence timely care-seeking for childhood illness due to the importance of a father’s role in decisions about care-seeking. Studies in

diverse settings show that fathers play an important role in decision-making around care-seeking for children¹¹⁸. In a study in a slum-dwelling community in Delhi that involved semi-structured interviews with men, none of the 400 men interviewed believed that the wife alone was responsible for decisions about taking an ill child to hospital¹¹⁹. Some 58% thought the husband alone should make this decision and 35% thought both the husband and wife should make this decision together. Such findings have been supported by other studies¹²⁰.

Greater male participation in birth preparedness

Some participants reported greater involvement in birth preparedness activities – such as providing money, organising transport, and buying clothes and supplies required for birth – as a result of male engagement activities in Tanzania and Zimbabwe. In both countries, men and women both reported experiences of this to similar degrees. In these contexts, organising supplies for birth is essential, even if a mother gives birth in a health facility, as participants reported that health workers will not provide care for a mother unless she is able to supply essential materials such as plastic gloves.

“I have to participate fully from the beginning to the end. I must make sure that I’m very close to my wife during pregnancy. I provide the money for delivery, like for transport issues... I have to think which health facility my wife will deliver at. I have also to think who will accompany her; if I will go myself, who will take care the house in my absence.” (Adolescent male FGD, Tanzania)

“First he is considering that my wife is approaching delivering, that means I should prepare important things to help her or to save her life, like money for transportation, caution money, delivering items and clothes for her, which she is supposed to go with [to the health facility].” (Adult female FGD, Tanzania)

“I realized that it [program] changes things. Even when I needed to register [for ANC], he gave me the money that was needed, US\$1. After that, he bought future [things for the forthcoming child]. Also, the day I experienced labour pains we went to the clinic together, he made sure that I had arrived there safely and he went back home.” (Adult female FGD, Zimbabwe)

¹¹⁷Muralidharan, A, Fehring, J, Pappa, S, Rottach, E, Das, M & Mandal, M 2014.

¹¹⁸Carter, M 2004; Dutta, M, Kapilashrami, MC & Tiwari, VK. Knowledge, 2004; Khan, ME & Patel, BC 1997.

¹¹⁹Dutta, M, Kapilashrami, MC & Tiwari, VK. Knowledge, 2004.

¹²⁰Khan, ME & Patel, BC 1997.

Notably, however, some participants reported counter-findings about the range of birth preparedness support provided by men.

“Yes they try to participate in birth preparedness on issues like gloves, clothes but providing the money in case of emergency life referral we still have problems; they do not do that.”
(Male KII, Tanzania)

From this study, it is unclear whether this perceived increase in men’s involvement in birth preparedness activities contributes to an increase in perceived birth preparedness overall. It is, however, established in the broader literature that engaging expectant fathers during the antenatal period can lead to improvements in birth preparedness and assistance when complications arise during birth. In a randomized controlled trial of engaging men in antenatal care in South Africa¹²¹, significantly higher proportions of women in the intervention group reported receiving assistance from their partner during pregnancy emergencies. Common actions taken by men included taking their partners to the clinic or doctor, or arranging transport. In Indonesia, the Suami SIAGA program targeted men with print, radio and TV messages about birth preparedness and trained health workers counselled couples on making preparations for birth¹²². Husbands exposed to the campaign via media messages were more likely to report new knowledge and more likely to take action towards becoming an alert husband (helping a woman with birth complications, participating in a Suami SIAGA community education activity or encouraging others to participate in community education activities) than those not exposed to the campaign. In a study in Nepal¹²³, women who received antenatal education with their husbands were more likely to report making three or more birth preparations than women who received education alone, although this difference was not statistically significant. It is therefore plausible that the reported increase in male participation in birth preparedness in this study is reflective of greater birth preparedness overall.

Motivating and engaging men to improve MNCH outcomes: effective program strategies and approaches

Considerations in assessing effectiveness

Participants reported their perceptions of strategies and approaches that had been effective in increasing men’s engagement for them personally and within their communities. This suggests that the study generated findings around strategies and approaches that were perceived to have achieved change in behaviours and attitudes.

When interpreting these findings, however, it is important to consider two questions that are beyond the scope of this study but that have important implications for program planning.

First, is a program or approach effective if it changes men’s behaviours, but also has potentially harmful consequences? As described below, participants reported that government-, community- and/or clinic-initiated preferential treatment at health facilities for women accompanied by their male partners was effective in increasing male attendance at health clinics. Yet participants also reported that this provides a disincentive for unaccompanied women to access health services. From a more holistic perspective, therefore, this is not an effective strategy to increase access to essential MNCH services.

Second, is a program or approach effective if it changes men’s behaviours, without necessarily changing the underlying causes of these behaviours? As detailed below, participants reported that regulatory measures were an effective way to change men’s behaviours but that these changes were also the result of social sanctions and were not necessarily associated with changes in men’s attitudes or beliefs.

These questions relate to the application of the study findings, and did not emerge directly from the study itself. Below are summarized study findings about strategies and approaches that were perceived by participants to be effective.

¹²¹Kunene, B, Beksinska, M, Zondi, S, Mthembu, M, Mullick, S & Ottolenghi, E, et al. 2004.

¹²²Shefner-Rogers, CL & Sood, S 2004.

¹²³Mullany, BC, Becker, S & Hindin, MJ 2007.

Effective program strategies and approaches in engaging men

Appropriate messaging

Some participants reported that certain messages delivered through male engagement activities were not taken up because they were not socially or culturally acceptable. This was found in all countries, although the precise content that was found to be unacceptable was context-specific. In Zimbabwe, in most cases it was men who reported that some messages were perceived to be inappropriate.

In Zimbabwe, for example, the action of a man washing dirty nappies is promoted by some gender equality champions but was reported by participants to be unacceptable.

Participant: "We also teach them that when your wife falls ill, you help with fetching water and also washing nappies. If you don't wash the nappies when your wife is ill, who will wash them?"

Interviewer: "So what will these men say?"

Participant: "They say that [washing nappies] is impossible. They say that is impossible because their culture does not allow that." (Male KII, Zimbabwe)

"Even if the sun rises from the west and sets in the east, I do not see myself washing nappies..." (Adolescent male IDI, Zimbabwe)

Other messages, for example around male engagement in newborn care, directly contravened taboos.

"Our fathers warned us that witnessing child birth or holding a newly-born baby leads to blindness and nhetemwa [Parkinson's disease]." (Adult male FGD, Zimbabwe)

When participants encountered messages that were difficult to accept, such as the two described above, they reported that this reduced the acceptability of the male engagement activities in their communities. Messages that are not in direct contrast to existing strong taboos or socio-cultural preferences are more likely to be acceptable.

Social stigma and taboos relating to pregnancy and child birth, and a reluctance among men to discuss 'women's matters' publicly, are established as important barriers to male engagement in MNCH¹²⁴. Our finding that messages need to be locally appropriate is unsurprising and has been well documented elsewhere¹²⁵. For example, a study from southern Nigeria found that local beliefs, traditional practices, and cultural and gender norms can both limit and encourage specific ways for men to engage in MNCH¹²⁶. The authors recommend that messages should be culturally specific, by emphasising health-promoting aspects of local cultural beliefs related to maternal health and using cultural analogies to impart meaning¹²⁷.

It is, however, important to consider that an incremental goal of male engagement programming is to challenge existing taboos and community standards about unacceptable or inappropriate messages, where these existing taboos and standards are based on and perpetuate gender inequality or reduce men's positive engagement in MNCH. One participant in Bangladesh described how family planning was considered to be unacceptable when it was first introduced.

"When family planning was introduced in our society, it was not accepted and was thought to be anti-Islamic. It was not acceptable by most people. So family planning workers were not welcomed in the house." (Younger male FGD, Bangladesh)

By contrast, family planning was now considered to be broadly acceptable by participants from Bangladesh.

Similarly, in Tanzania, some men reported that Wazazi na Mwana messages about men sharing workload with women were eventually adopted despite the fact that they were considered to be incompatible with pre-existing tradition and culture.

"...[T]hese issues of tradition and culture is difficult because at the first place I said we do not help a woman, and if you do that [help] you need to be strong because people will say you are not a good person, your wife made you to do these tasks, you cook food, you are dominated. But when (you) are in this department [join Wazazi na Mwana activities] and you accept that these important things, you just achana [leave, stop] issues of tradition and culture." (Adolescent male FGD, Tanzania)

¹²⁴Nasreen, HE, Leppard, M, Al Mamun, M, Billah, M, Mistri, SK & Rahman, M, et al. 2012.

¹²⁵Barker, G, Ricardo, C & Nascimento, M 2007; Greene, M, Mehta, M, Pulerwitz, J, Wulf, D, MBankole, A & Singh, S, 2004.

¹²⁶Adeleye, OA, Aldoory, L & Parakoyi, DB 2011.

¹²⁷Adeleye, OA, Aldoory, L & Parakoyi, DB 2011.

"You know in our tradition and customs...for sure fetching water was like sumu [poison]...to carry the bucket to collect water from wells or washing clothes honestly it is [was] sumu, but nowadays you can tell mama [a wife], 'Give me clothes to wash and you can take the bike and go to the well to collect water!'"

(Adult male FGD, Tanzania)

This illustrates how health program messages can become more acceptable over time, and following sustained interventions, even where they were originally considered to be inappropriate. At the same time, however, based on participants' reports from this study, male engagement activities were less effective where they began with less acceptable messages.

Additionally, some participants reported that messages that were difficult to comply with were less acceptable and may be disregarded. For example, the message that a man should accompany his partner to every ANC appointment was considered by some participants to have a high opportunity cost for the household.

"Well, I will be doing menial jobs elsewhere to raise money for the family so instead of me taking time off what I will be doing, I task my wife to take the child to the clinic."

(Adolescent male IDI, Zimbabwe)

"This season the rainy has started here. If you attend clinic that means you leave shamba [do not work in a farm] because of going to clinic; I wonder if a woman can't provide the feedback? This is challenging..." (Adult male FGD, Tanzania)

This finding aligns with lessons from the broader literature that social and economic factors, such as the inability to take time off work due to financial constraints or lack of flexibility of working arrangements, can be major barriers to male engagement in MNCH¹²⁸. In the context of these barriers, messages may be more appropriate and effective when they include some flexibility for men and their partners to decide together how to allocate their time; for example in order to both work and access health services.

Home visits to men and women

Participants from Tanzania and Zimbabwe identified home visits as an effective strategy, where these visits were conducted by CHWs or peer educators to a small number of households to provide private counselling to men and women and follow up if women had not taken agreed

health actions such as attending ANC. In Bangladesh, the equivalent cadre of health worker has a catchment area of a larger number of households.

Participants from Tanzania and Zimbabwe reported that home visits were effective because they afforded privacy to discuss sensitive topics and provided sufficient time for in-depth discussion focused on the needs of the individual man and woman.

"I think most of us would prefer home visits as you get enough time to discuss issue thoroughly." (Adult male FGD, Tanzania)

However, some participants in these two countries also reported that CHWs and peer educators were not always able to spend as much time as participants thought was necessary to fully explain the information and messages they were delivering.

"Those people [CHWs and peer educators] spend very little time during the visit. It would be good if they at least spend half an hour in one household." (Adult male IDI, Tanzania)

Participants also reported that home visits allowed CHWs or peer educators to deliver messages in an environment that was comfortable and familiar for men and women, and that people may be more willing and able to listen to messages during the times when they are at home.

"Household visits is good unlike meeting people in the streets, some of them are drunk...do not want to listen, keeping arguing...but at home you find people there just waiting for you." (Male KII, Tanzania)

Home visits were also identified as an effective way to reach pregnant women and their male partners with targeted messages during pregnancy. Participants reported that accessing the home allowed target men and women to be reached.

"I do counselling with the husband of pregnant woman. If I don't get him during home visit, then I say, 'Sister it would be good if your husband is also present there.' The pregnant mother says that you will get him (at) that time. Then I visit that home when the husband is available and talk with the husband."

(Female KII, Bangladesh)

¹²⁸UNFPA, Promundo, MenEngage 2010.

Similarly, home visits were reported to be an effective strategy for follow-up of women and men if targeted behaviours were not changing. This was reported to be particularly effective to follow-up with households when women were not using health services during pregnancy, as this is something that is very easy for the CHWs or peer educators to monitor.

"Their [lead mothers'] real job is to educate their groups. She will have a group of 10 people, 10 households and she has the responsibility of observing whether or not there is a pregnant woman in her group and if she has gone for registration..."

(Male KII, Zimbabwe)

"I think household visits is best as a community health worker can do follow (up) if he/she observe that things are not changing to the people who attend sessions. So he/she can plan to do three or more visits in the certain topic, to make sure that those people understand well..." (Female KII, Tanzania)

Reviews of interventions to engage men in MNCH have found home visits to be an effective strategy for engaging men¹²⁹. Home visits may be especially useful with hard-to-reach groups who might distrust the health system and may be less experienced in accessing health facilities¹³⁰.

Importantly, although unsurprisingly, participants reported that home visits were not effective as a strategy when men are unlikely to be at home. This was applicable to all settings, but it was also influenced by context. Participants in Bangladesh reported that many men were at work during the day and socialising outside the home in the evening.

Reach men where they gather

Participants identified the effectiveness of delivering messages to groups of men at public places where they regularly gather. In all countries, this was reported to be a pragmatic and feasible way of accessing men to deliver messages. Participants also reported that this was a way to reach men who could not be reached through home visits.

For example, in Bangladesh, female CHWs routinely conducted home visits with pregnant women. During these home visits the CHWs aimed to build awareness among male partners of appropriate care-seeking during pregnancy and for childbirth. However, participants reported

that male partners were often not home during these visits. In response, the WATCH program began using male CHWs to make contact with the men, particularly husbands of pregnant women and fathers of young children, in common meeting places frequented by men during their leisure time to deliver information to groups of men using BCC materials.

"...it was found that male are busy at day time. Then we change our modality... we target how to catch the male like, there is a male gathering in a shop, tea stall, or in a Machan [seating platform] ... and we try to catch them by the male CHW."

(Male KII, Bangladesh)

Similarly, in Tanzania, men were not found at home when CHWs conducted visits to pregnant women. In this context, gender roles are highly emphasized; women are responsible for household chores, farming activities and child care in or near the home, while men spend much time working outside the home as well as drinking and socialising outside the home. Therefore, the program was adjusted in order to reach men where they are more often present – such as in drinking places, at football matches and vijiwani (where young people gather in the evening) – through male peer educators.

"Because men were not found at home, they only get women there so we thought reaching them in their own places such as vijiwani, drinking place will be the effective way."

(Female KII, Tanzania)

In Zimbabwe, participants also reported that conducting outreach to men was an appropriate way to access and engage groups of men.

"... reaching out to men is actually easier when you reach out to them in their natural states in the community, using the dare (traditional men's court) concept whereby we know that in every village there is somewhere where men meet and discuss critical issues." (Male KII, Zimbabwe)

This finding from all three countries is aligned with results in the global literature. Engaging men in settings where they commonly congregate has long been a recommendation of the male engagement literature¹³¹ and prior research indicates that men prefer to be engaged in places where they meet socially¹³².

¹²⁹Davis, J, Luchters, S & Holmes, W 2012.

¹³⁰UNFPA, Promundo, MenEngage 2010.

¹³¹Greene, M, Mehta, M, Pulerwitz, J, Wuif, D, MBankole, A & Singh, S, 2004; World Health Organization 2002.

¹³²Nasreen, HE, Leppard, M, Al Mamun, M, Billah, M, Mistry, SK & Rahman, M, et al. 2012.

An important counter-finding was reported in Zimbabwe, however. Outreach to groups of men at drinking places in Zimbabwe was reported to not be an effective way to engage men in meaningful discussion, as participants reported that men were generally less open to discussing MNCH during drinking episodes and also sometimes less able to take in messages while drinking due to the influence of alcohol.

"..those that drink beer...say, 'This is not our stuff'"
(Male KII, Zimbabwe)

This counter-finding is also supported by the literature. While some authors have suggested peer education outreach to men at drinking sessions¹³³, one randomized controlled trial examining the effect of peer education on HIV-prevention strategies in the beer halls of Zimbabwe failed to show any reduction in episodes of unprotected sex with extramarital partner in the previous 6 months or other HIV risk behaviours¹³⁴.

Participants also reported that in Bangladesh there were one-on-one and follow-up group sessions conducted by male CHWs at places where groups of men gather. This was reported to be an effective way to allow men to discuss sensitive topics.

Engaging men in one-on-one sessions outside a health centre may encourage greater participation. In a randomized controlled trial in Democratic Republic of Congo¹³⁵, male partners of pregnant women attending ANC were randomized to receive an invitation to participate in voluntary counselling and testing at different venues. Of the three venues proposed, participation was significantly higher in HIV testing and counselling hosted in a bar (26% of those invited attended), but not significantly higher in church-based testing and counselling (21%), compared to health centre testing and counselling (18%). Uptake of HIV test results may also be higher if individuals or couples can test for HIV and receive results at home¹³⁶.

Deliver messages through existing leaders or institutions

This strategy – where traditional, community or religious leaders call meetings and/or deliver messages at meetings – was reported to be effective in all countries.

Participants reported that when leaders call meetings, community members attend. When describing why or how this strategy is effective, participants mentioned leaders' existing authority, and established mechanisms that exist for leaders to maintain and enforce their authority, such as fines.

"Yaa, the village head sometimes does that here. He tells men, 'If you don't come to the meeting, you will pay a fine in the form of a goat'" (Male KII, Zimbabwe)

Participants also reported, however, that this is not always the case for all community members. Hard-to-reach men may be particularly difficult to engage through this strategy.

"Even when the village head calls the meeting, some men who drink beer, some men do not come [to the meeting]; he ends up giving up." (Male KII, Zimbabwe)

Another reason why this strategy was reported to be effective is that when leaders deliver messages at established traditional, community or religious meetings, the messages are reinforced by the authority and acceptability of this existing mechanism for disseminating information or normative guidance about how community members should behave. In Bangladesh, for example, Muslim religious leaders deliver messages to their congregations after Friday prayers.

"When I give Friday sermons then men usually go there, I give them encouragement. I give tell them what special needs a pregnant woman need, what services they should take, what kind of care they should be given before and after delivery. I encourage them to bring them to clinic and talk to the representatives of [name of health facility] under Plan Bangladesh what we call WATCH project." (Male KII, Bangladesh)

In one study site in Tanzania, changes in behaviour are discussed and agreed on at Nzengo, a traditional form of community meeting. Many people respect this traditional meeting and therefore attend. The meetings are also an established mechanism for community members to meet and discuss different social issues, come to agreement, and agree on strategies to make people implement the agreement.

¹³³Cumberland, S 2010.

¹³⁴Fritz, K, McFarland, W, Wyrod, R, Chasakara, C, Makumbe, K & Chirowodza, A, et al. 2011.

¹³⁵Ditekemena, J, Matendo, R, Koole, O, Colebunders, R, Kashamuka, M & Tshetu, A, et al. 2011.

¹³⁶Njau, B, Watt, MH, Ostermann, J, Manongi, R & Sikkema, KJ 2011; Wolff, B, Nyanzi, B, Katongole, G, Ssesanga, D, Ruberantwari, A & Whitworth, J 2005.

"In Nzengo you will get many people, many people attend and also they have opportunity to ask questions."

(Female KII, Tanzania)

This strategy was also perceived to be effective given the leader's authority is respected and therefore makes the messages similarly authoritative. In Bangladesh, community and religious leaders are available to provide counselling or deliver messages to individuals or households.

"...Even, if there is someone who is not letting a mother come out of the home, then the Imam or a teacher is approached with that problem – that, 'Please help – cause I cannot bring her to the hospital.' Then that person goes over to the house and tells them that they are making a mistake..." (Male KII, Bangladesh)

These findings correspond with evidence from the global literature. Community meetings provide an array of opportunities for sharing information with men. Individuals may be open to receiving health information at a range of community forums¹³⁷, including at regular community events¹³⁸. Evidence also suggests that men may be more likely to follow advice when it is delivered by a respected or senior community member¹³⁹. In some settings, however, cultural norms may inhibit the asking of questions in a public meeting if the meeting is led by an older person or a traditional leader¹⁴⁰. Participants in this study did not raise this as a potential concern.

Edutainment and entertainment

Another effective strategy in reaching and engaging community members, participants reported, is to deliver messages in an entertaining way, such as through jingles or theatre, or when messages are preceded by entertainment, such as music or dancing.

Participants reported that there is not much entertainment in rural areas, so providing some entertainment is welcome and is therefore an effective way to reach people with the messages being delivered. Providing entertainment in a public place works to gather people.

"Showing stage play as and the video show has worked the most. There is announcement and they go very eagerly to watch the play regarding women and child health activity."

(Male KII, Bangladesh)

"Involvement of most of the community people could ensure by T4D [theatre] and documentary film show. This was very fruitful intervention in these remote areas than any other intervention. As it was arranged at evening when they have leisure time, huge [numbers of] people come to see it." (Male KII, Bangladesh)

"We use wanungule [traditional dance or ngoma] in order to attract men to participate in meetings. We were thinking on how to get people who might not attend in Nzengo meetings; we know people like traditional dance (pause). So when many people come to see wanungule we stop it and start to talk with people on reproductive health, I mean men involvement in reproductive health, so that is another way of making sure men are reached." (Male KII, Tanzania)

"The strategies we use that are making an impact are debates, dramas." (Male KII, Zimbabwe)

An important counter-finding, however, was that public performances were not accessible to all community members. In Zimbabwe, for example, participants reported that some hard-to-reach men could not be reached through entertainment.

"These men [who drink beer] do not come still because they just do not care about anything." (Male KII, Zimbabwe)

In Bangladesh, participants also reported that public entertainment could not reach everyone because for women it was less acceptable to be outside their homes in the evening. Yet participants from Bangladesh also reported that entertaining messages could be shared through social networks using information and communication technology, without women needing to leave their homes.

"... 88 of our CHWs – they go door to door. They show the people in (their) mobile phones how to get the [radio] station. The funny interesting thing is – the jingles ... are also given into the mobiles of our CHWs. Now you will see that maximum number of people have Android – whoever is a bit aware – use them. ... There we are giving them the jingles via Bluetooth. Say you are a pregnant woman – so they give five jingles to her. They say – if you have time apa, then listen to the jingles – they are like songs given here. So, the messages are there. So the jingles are going..." (Male KII, Bangladesh)

¹³⁷Kululanga, LI, Sundby, J, Malata, A & Chirwa, E 2011; Barker, G, Ricardo, C & Nascimento, M 2007.

¹³⁸Holmes, W & Otto, B 2009.

¹³⁹Azmat, SK 2011; Kululanga, LI, Sundby, J, Malata, A & Chirwa, E 2011.

¹⁴⁰Kululanga, LI, Sundby, J, Malata, A & Chirwa, E 2011.

Participants further reported that providing entertainment that directly engages the audience works to engage people in the opportunities for change that are presented and also supports retention of messages.

"... it's tough to forget those things easily from their mind. For example you have watched a drama two years before and that is matched with your own life, you will not forget that rest of your life." (Male KII, Bangladesh)

Providing public entertainment was also reported to assist messages in reaching a broader cross-section of the community compared with home visits or other strategies that are more targeted to pregnant women and their male partners.

"It's difficult to reach, to get adolescents in the household visits. In these meeting you reach all people, young and old people." (Male KII, Tanzania)

"...even those sensitization meeting, many people attend." (Adult female FGD, Tanzania)

However, participants reported that providing entertainment did not necessarily mean that messages were delivered. If the entertainment or the information provided was perceived to be uninteresting or inappropriate (e.g., inappropriate for open discussion in a public setting) the strategy became less effective. In Tanzania, participants reported that some community members might leave once information started being delivered, or that the entertainment activities could potentially develop a bad reputation and so people would not attend.

"I just remember the way that woman dance...and she was almost naked, that is not good at all in the village like our village... also the topic...selected, doesn't fit to all age groups." (Male KII FGD, Tanzania)

"...dangerous signs during pregnancy such as bleeding, men involvement in reproductive health, how to prepare a woman before sexual intercourse...the main problem is that, their topics do not consider age differences...they are speaking inappropriate things to children." (Female KII, Tanzania)

"...some people leave the place after the entertainment because of the sensitive issues which they are talking." (Male KII, Tanzania)

There appeared to be little global literature regarding the effectiveness of edutainment in engaging men for MNCH. However, global evidence indicates that mass media campaigns can be effective in improving knowledge and changing cultural attitudes. A 2007 review of male engagement interventions identified seven mass media campaigns and found that all of these demonstrated some level of effectiveness¹⁴¹. The authors found that although mass-media campaigns on their own produce limited behaviour change, they can generate significant change in men's behavioural intentions and men's perceptions of their capacity to change¹⁴².

In many settings, mass media is a significant source of sexual and reproductive health information for men¹⁴³. In Indonesia, the Suami SIAGA campaign promoted greater male involvement in ensuring safe motherhood via television and radio segments and print materials. A post-intervention survey revealed that husbands were significantly more likely to report new knowledge if they were exposed to television content or printed material than if they were not exposed to the campaign. Similarly, an evaluation of the VISION Project, a large Nigerian mass-media campaign focused on increasing use of HIV, family planning and child health services, found that individuals exposed to the campaign were more likely to discuss HIV with a partner than those not exposed to the campaign¹⁴⁴. Individuals with high exposure to the campaign were also roughly twice as likely to know that condom use reduces the risk of HIV transmission as those not exposed.

Work with local health clinics or staff

Participants reported that men get involved when local health clinics or clinic staff (nurses) are included in the program.

While men do not traditionally attend antenatal clinics, our finding that men do participate in clinic services when invited is mirrored by experiences in many countries, including Lao PDR, India, and South Africa, where studies have found that men are keen to attend clinical services when encouraged to do so¹⁴⁵. Not surprisingly, program

¹⁴¹M Barker, G, Ricardo, C & Nascimento, M 2007.

¹⁴²Barker, G, Ricardo, C & Nascimento, M 2007.

¹⁴³Char, A, Saavala, M & Kulmala, T 2011.

¹⁴⁴Keating, J, Meekers, D, Adewuyi, A 2006.

¹⁴⁵Kunene, B, Beksinska, M, Zondi, S, Mthembu, M, Mullick, S & Ottolenghi, E, et al. 2004; Natoli, L, Holmes, W, Chanlivong, N, Chan, G & Toole, MJ 2012; Varkey, LC, Mishra, A, Das, A, Ottolenghi, E, Huntington, D & Adamchak S, et al. 2004.

experience also suggests that focusing on inviting men to attend ANC (via letters, posters or announcements) and focusing those invitations on local health concerns might be more effective in engaging men in antenatal care. A study in South Africa compared the effect of providing pregnant women with a written invitation for their male partner to attend antenatal care and either HTC or a pregnancy information session. In couples that received an invitation to antenatal care and HTC, 35% of expectant father attended the antenatal clinic, compared to 26% of expectant fathers invited to attend antenatal care and a general pregnancy information sessions¹⁴⁶.

Participants in the study reported that this strategy was perceived to be effective because clinic staff have authority in the community, and so men listen to what they have to say. For example, if men are instructed by clinic health staff to buy baby clothes or provide money, they generally do it.

"Many men now are participating in the clinics, and there they tell us that your wife is supposed to rest at some point during pregnancy, or she will need difference types of food. Then we know that in the past we were doing many things in wrong way." (Adult male FGD, Tanzania)

"Before, we used to go to the clinic with nothing but now the nurses make a follow up saying, 'When your wife is delivering, we need this and that and we need you to accompany her to the clinic.' So they [men] end up accepting it and they prepare in time and buy those things and when we deliver, our babies will be having some stuff to wear." (Adult female FGD, Zimbabwe)

This finding from the study can be understood with reference to the global literature. Evidence on the effectiveness of verbal invitations for men to attend ANC is mixed: while some studies report an increase in male attendance, other research reveals that verbal invitations to men to attend antenatal clinics passed on through their pregnant wives may be unsuccessful¹⁴⁷. Findings from this study indicate that a direct communication from clinic staff may be more effective as a strategy to increase men's participation in clinical services.

Participants in Zimbabwe and Tanzania noted that this strategy was also an effective way to reach the male partners of pregnant women with HIV testing, although some participants noted that this was not always successful.

"...that is still a problem with our husbands; he would agree to accompany you to the clinic...but when that time reach [for HIV testing] he would leave you there...going back home." (Adult female FGD, Tanzania)

Our finding that clinic-based strategies to engage men in MNCH can increase men's uptake of HIV testing is supported by the available literature. An invitation from a health worker might be particularly effective for HTC or PPTCT services when many women feel they do not have the authority to request their partner to attend¹⁴⁸. In a study in Rwanda, men were more likely to participate in couples HIV testing and counselling (CHTC) if they received an invitation from someone known to them or from an influential person and if an invitation was received following a public endorsement of CHTC¹⁴⁹. For couples living together, participation was more likely if the invitation was delivered to the couple, and in the home. Testing men is also likely to be more effective in reducing unprotected sex during pregnancy than men receiving information about pregnancy and the risks of STI¹⁵⁰. However, it has been suggested that ANC couple visits should not be promoted as an HIV-related visit but as an opportunity to screen and treat for a range of infectious diseases, including sexually transmitted infections and tuberculosis, and to discuss pregnancy and birth preparedness plans¹⁵¹. While CHTC allows health care workers to identify and counsel discordant couples and to offer prophylaxis to HIV positive pregnant women, it is also an important opportunity to engage men in relation to reproductive, maternal and newborn health care more broadly.

However, there is strong evidence to suggest that women should be able to choose whether their male partner is also involved in antenatal services and CHTC¹⁵². In clinic-based activities, risks include male partners taking tighter control over choices that influence women's and children's health, women feeling less free to discuss confidential information with health workers, or the risk of violence or divorce when men learn information about their partners' STI, HIV, contraceptive, or other health status¹⁵³. In many cases, including men in part of an antenatal consultation, while including only the pregnant woman in the remainder of the consultation, will be the best way to protect women's privacy while educating men on pregnancy and childbirth¹⁵⁴.

In the study, participants in Tanzania and Zimbabwe reported that health services were easier to access for women

¹⁴⁶Mohlala, BK, Boily, MC & Gregson, S 2012.

¹⁴⁷Engelbrechtsen, IM, Moland, KM, Nankunda, J, Karamagi, CA, Tylleskar, T & Tumwine, JK 2010.

¹⁴⁸Falnes, EF & Moland, KM, Tylleskar, T, de Paoli, MM, Msuya, SE & Engelbrechtsen, IM 2011.

¹⁴⁹Wall, K, Karita, E, Nizam, A, Bekan, B, Sardar, G & Casanova, D, et al. 2012.

¹⁵⁰Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010; Mohlala, BK, Boily, MC & Gregson, S 2012.

¹⁵¹Holmes, W 2001.

¹⁵²Shepherd, B 2004.

¹⁵³Kim, Y & Kols, A 2002; Maman, S, Moodley, D & Groves, AK 2011; Njau, B, Watt, MH, Ostermann, J, Manongi, R & Sikkema, KJ 2011; Shepherd, B 2004.

¹⁵⁴Shepherd, B 2004.

from the recommendations from the global literature, described above, that women be able to decide whether their male partner is involved in clinical services. This difference in the accessibility of services for women accompanied by their male partner is not a strategy adopted or promoted by Plan but is initiated by local authorities and/or clinics in these countries. In Tanzania, for example, participants described two components of this differential access: delay in ANC services to women who are not accompanied by a male partner or relative (in both study sites); and not to provide service to women who are not accompanied and do not have a letter from a village authority indicating that they are not married (in one study site only).

Participants reported that this strategy of differential access was effective in changing men's behaviour. Clinics offer valued services, and the fact that women would not receive services or would receive less convenient services was reported to provide an incentive for men to change their behaviour, and to provide an incentive for women to encourage their partners to change their behaviour.

"Nowadays many men are attending the clinic when their wives are pregnant, especially the first clinic we have to go together... because if the woman will attend alone the issue there is the first service for women who are accompanied; many men [will] attend the first clinic for that." (Adult male FGD, Tanzania)

"During the clinic we speak it to women openly that we will start with women who are accompanied by their partner. If you came alone you have to wait. That motivates them to come with their partners." (Female KII, Tanzania)

However, participants also reported a contrasting finding that this strategy provides a disincentive for unmarried women, or women with husbands who do not agree to attend, to use health services. Participants reported that some women use TBAs instead. Other women pay men to accompany them to the appointment as their husbands.

"These bylaws are of forcing to be accompanied by men, some women do not go for clinic children because I'm not married but I have kids, so I have to report to mtendaji [village leader] to get a letter which explains that, and I have to do so every clinic date, I see this is usumbufu [trouble]." (Adult female FGD, Tanzania)

"What happens is that some young women conceal pregnancies ...these young women are impregnated by married men and they don't want it to be known, so they conceal the pregnancy until full term. They don't go to the clinic because, at the clinic, they are asked to bring along the man responsible for the pregnancy. So they choose to go to the village midwife who keeps it a secret..." (Male KII, Zimbabwe)

As detailed above, where a strategy discourages some women from accessing health services it may not be appropriate to consider this strategy as effective. The risks and benefits associated with incentives to increase male engagement in clinic-based care have been extensively explored in the literature. The global evidence clearly indicates that health workers involved in clinic-based activities to promote male engagement in MNCH must be careful not to dissuade women from using clinical services alone. In a randomized controlled trial in Tanzania¹⁵⁵, roughly 1,500 women attending ANC were randomized to receive individual HTC on the spot or CHTC at a later date. Of those randomized to CHTC, only 16% returned for counselling, testing and results with a partner, while 23% returned alone and completed testing (39% total in the CHTC arm) compared to 71% in the individual on-the-spot HTC arm. The observed reduction in re-attendance may have been partly due to HIV-related stigma but nonetheless this highlights the need to clearly communicate to women that they are encouraged to attend antenatal care even if they are unable or disinclined to bring their male partner. When given a choice of attending CHTC or individual HTC, women in many settings are likely to elect to come alone¹⁵⁶. Therefore, while highlighting the benefits of CHTC and couples antenatal clinic visits, clinic staff and policymakers must be careful not to dissuade women from accessing services alone. Additionally, women may be less able to discuss sensitive issues such as sex, HIV and STIs and domestic violence if their male partner is present, requiring a combination of individual and couples counselling¹⁵⁷.

Establishing separate men's clinics might overcome some of the challenges associated with trying to engage men in clinic activities. Migende Rural Hospital in Papua New Guinea, a men's clinic that ran once per week at the time of publication of a UNICEF case study¹⁵⁸, attracts men for HIV and syphilis testing and for couples counselling. The clinic is publicized through announcements in churches,

¹⁵⁵Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010.

¹⁵⁶Farquhar, C, Kiarie, JN, Richardson, BA, Kabura, MN, John, FN & Nduati, RW, et al. 2004.

¹⁵⁷Kim, Y & Kols, A 2002.

¹⁵⁸Khan, ME & Patel, BC 1997.

through community leaders and public awareness campaigns, through invitation through partners who attend ANC, and via peers. While holding separate clinic days for men and/or couples might encourage greater male participation in reproductive health in some settings (especially where service usage by men is very low), establishing stand-alone men's clinics could be prohibitively expensive and ultimately unsustainable. In 2001, a meeting of WHO Regional Advisors in Reproductive Health on Programming for Male Involvement in Reproductive Health concluded that men-only clinics have enjoyed limited success and recommended that services for men be integrated into existing reproductive health services to aid sustainability¹⁵⁹.

Community-initiated bylaws and regulatory mechanisms

Participants in Tanzania and Zimbabwe also commented on the perceived effectiveness of regulation or bylaws, initiated by local governments or community leadership, regarding men's engagement in MNCH (e.g. women attending ANC must be accompanied by the expectant father and men are required to pay a fine if they do not follow the bylaws). Importantly, all bylaws and regulatory mechanisms reported by participants related to use of clinical services, such as ANC and facility-based childbirth. These bylaws are not Plan strategies but are instead developed and enforced through existing community mechanisms. In one study site in Tanzania, penalties are community-initiated and managed. In other study sites in Tanzania and Zimbabwe, penalties are set and enforced by community leaders.

Participants perceived this strategy to be effective in catalysing changes in men's behaviour. Participants reported that men changed their behaviour in response to regulation because they were required to do so and did not necessarily wish to adopt new behaviours.

"I would say in a hundred percent, a small per cent has accepted accompanying their wives to clinic willingly, [but] most of them are still reluctant. They attend because of that bylaw. They would like this [clinic attendance] to change." (Male KII, Tanzania)

Participants also identified that this regulation was built upon established, accepted mechanisms for setting and enforcing penalties.

"... if a woman delivered at home and it is approved it is because of the carelessness of the husband, he has to pay 20,000/=,

these amount of money is arranged in their own and it is working Nzenzo." (Female KII, Tanzania)

Additionally, some participants reported that regulations can provide men with an excuse to act in a way that is socially unacceptable, and that this can lead to men becoming more accepting of these behaviours once they start behaving differently.

"In the beginning, we had to set bylaws that a pregnant woman must come with her partner, if not she is not get the service, so men are coming because of that. We were forcing them. Slowly they understand the importance." (Male KII, Tanzania)

"In the beginning, we were forcing them but after understanding they see it as a normal thing." (Male KII, Tanzania)

"[After] setting our bylaws...then people saw cooperation as a normal thing... Now it is like bylaws do not exist, because men are doing activities and accompanying their wives; it is a normal thing." (Male KII, Tanzania)

Participants also noted that the enforcement of these regulatory mechanisms does not require women to say when their partners have not followed the bylaws. Context is important to this issue. In rural villages in Tanzania, for example, communities are sufficiently small and centralized that the woman will not need to report her husband's behaviour because everyone will already know. In settings where husbands or households would be penalized due to a woman providing information, this strategy could lead to increased violence.

As described above, potential harms associated with men's participation in clinical services have been well documented in the global literature and women should therefore be able to decide the extent of their partners' involvement in clinical care. In some cases, involving the male partner may not be in the best interests of a pregnant woman or a child¹⁶⁰. While it is important to invite men's attendance routinely, rather than on the basis of risk assessment, which may be stigmatising, it is important that women have the opportunity to decide if they want their male partner to attend. Some women may fear their partner being involved¹⁶¹, particularly in relation to STI or HIV testing when a positive test result can lead to additional negative consequences for women, such as violence or divorce¹⁶².

¹⁵⁹Kamal, IT 2002; Shepherd, B 2004.

¹⁶⁰Maman, S, Moodley, D & Groves, AK 2011.

¹⁶¹Ibid.

¹⁶²Maman, S, Moodley, D & Groves, AK 2011; Mohlala, BK, Boily, MC & Gregson, S 2012; Njau, B, Watt, MH, Ostermann, J, Manongi, R & Sikkema, KJ 2011; Reece, M, Hollub, A, Nangami, M & Lane, K 2010.

Male peer educators and CHWs

Participants reported that the use of male peer-educators and CHWs was an effective strategy to reach and engage men. Participants reported that this strategy responds to men's preference for receiving information from other men.

"Later on under the male engagement approach we then included the champion initiative when we saw that reaching out to men is actually easier when you reach out to them in their natural states in the community, using the dare [traditional men's court] concept whereby we know that in every village there is somewhere where men meet and discuss critical issues..."
(Male KII, Zimbabwe)

Participants also reported that men can relate more easily to their peers' experiences.

"... We have also seen it [male engagement program] is easier reaching to men and they are also forthcoming when they also hear it from other men, especially if they are acting as role models in terms of behaviour and using testimonials and case studies." (Male KII, Zimbabwe)

Some participants reported that male peer educators and CHWs were best able to reach men who were married and who were already having children, rather than younger or unmarried men.

"I can say those who accept this program are the elderly from around 30 years going onwards but in that group those who have jobs do not come because they say that is when they will be doing their jobs. Young people aged around 18 or 19 feel uncomfortable to come to the meetings, especially if they are not yet married or have just recently married."
(Male KII, Zimbabwe)

Participants who had been reached by male peer educators and CHWs also described being motivated to use their influence with their own peers to further spread program messages.

"After being educated by wahudumu wa afya [CHWs] and peer educators, I think for us who have changed we should just continue to educate other men through our actions..."
(Adult male FGD, Tanzania)

Global evidence indicates that peer educators can be successful in disseminating health information among men. Peer educators spread ideas and accurate information through one-on-one visits, group discussions and community events. In settings where men feel more comfortable receiving sensitive information from other men or perceive other men to be a more credible source of information, using male peer educators, outreach workers or health centre staff may be more effective¹⁶³. Such approaches have proven successful in promoting HIV and STI prevention among heterosexual men¹⁶⁴ and in increasing knowledge and use of contraceptives¹⁶⁵ in particular settings. One successful intervention example comes from the Malawi Male Motivator project in which researchers used a randomized control design to test the effect of peer education on contraception uptake among couples that were not practicing any contraception at the time of enrolment. Contraceptive use increased significantly in both the intervention and control arms, with a significantly greater increase in uptake of contraception in the intervention (male peer education) group¹⁶⁶. An intervention in Zambia has also demonstrated that peer-recruitment by couples who have previously undergone CHTC can be an effective method for recruiting new couples for CHTC¹⁶⁷.

Key factors to sustain male engagement in MNCH

Participants reported their experiences of barriers and supporting factors for male engagement before and during program implementation. From these findings it is possible to draw out a range of implications for the sustainability of male engagement and these are discussed below.

Reduced shaming at community level

Shame was a commonly-reported barrier to male engagement in MNCH. In all countries, some men reported feeling shamed or ridiculed, or actively being shamed or ridiculed by friends, neighbours and extended family members when they accompanied their wife to clinic or helped with work thought of as "women's chores". Some men reported that their concerns about being perceived as dominated by their female partners discouraged them from engaging in MNCH; conversely, some women reported that their concerns about being perceived as dominating their male partners meant that they did not want their partners to engage in MNCH.

¹⁶³Kululanga, LI, Sundby, J, Malata, A & Chirwa, E 2011.

¹⁶⁴Elwy, AR, Hart, GJ, Hawkes, S & Petticrew, M 2002; Leonard, L, Ndiaye, I, Kapadia, A, Eisen, G, Diop, O & Mboup, S, et al. 2000.

¹⁶⁵Mwaikambo, L, Speizer, IS, Schurmann, A, Morgan, G & Fikree, F 2011.

¹⁶⁶Shattuck, D, Kerner, B, Gilles, K, Hartmann, M, Ng'ombe, T & Guest, G 2011.

¹⁶⁷Chomba, E, Allen, S, Kanweka, W, Tichacek, A, Cox, G & Shutes, E, et al. 2008.

"The current trend is, if wife is sick...husbands take part and do household chores after coming back to home [from work]. If there are older people, then they can't tolerate that. The other male also cannot tolerate that. They make fun of him saying, 'He loves his wife, he washes her cloths, what kind of man he is!'"
(Younger female FGD, Bangladesh)

"As I told you that my friend was fetching water his father-in-law saw him and he was surprised, 'Why are you fetching water?' he asked him two times. Instead of this guy telling him that I take it home he said it is for watering the garden but his father-in-law was very much surprised." (Male KII FGD, Tanzania)

Some women in Zimbabwe and Tanzania reported feeling embarrassed when their husband accompanied them to clinic. Both male and female participants in Tanzania and Zimbabwe additionally reported that increased male engagement could create the perception that a woman has in some way enchanted her partner by using a traditional charm (a 'love potion') to give her power over him or to ensure that he is always by her side.

"Some men think that if you accompany your wife to the clinic or cook, you would have been given a love potion."
(Adolescent female FGD, Zimbabwe)

This finding regarding shame associated with male engagement in MNCH is echoed in the international literature. Beliefs that it is unnecessary or inappropriate for a man to be actively engaged during pregnancy and post-partum, and feeling shy, embarrassed, and out of place at MNCH clinics are widely reported barriers to male engagement in a variety of settings¹⁶⁸.

At the same time, many participants in this study clearly reported that shame did not prevent them from engaging in MNCH, or from welcoming their partner's increased engagement. Where this was reported, it was generally explained as valuing family members above social expectations.

"I will add a little to what my fellow said that your friends will talk about you that nowadays you are helping your wife; 'Stop helping her, she will make you fool' and so on. Aah, that is my agreement with my wife and because we have already agreed on that I can't break and follow other principles after in normal circumstance we must help each other." (Adolescent male FGD, Tanzania)

"There are some who gave up but others don't give up. For example, some people give up after being discouraged by people's words while others simply listen and ignore outsiders' words, they will just continue with their business."
(Adolescent female FGD, Tanzania)

"He doesn't care at all [about stigma], he just care about me and I care about him too." (Adult female IDI, Tanzania)

"When I used to take her [his daughter] to do breakfast, everyone used to humiliate me [saying] that, 'he has come to do breakfast with her daughter in his lap'. I used to take her to the shops and market. I don't want to make her sad."
(Younger male FGD, Bangladesh)

Importantly, participants also reported that shaming became less common as it became more common for men to take an active and supportive role in MNCH.

"It is now becoming common to see men accompanying their wives to the clinic [during ANC]. People no longer say, 'He was given a love potion'." (Adolescent male FGD, Zimbabwe)

"They [the men] felt shy to accompany his wife to health facility. They were concerned about what other people said if they took the wife to health facility... But when some early adopter started to do that, then other people also started to think differently."
(Male KII, Bangladesh)

One participant in Tanzania commented on the change had happened over the two years between project implementation beginning and the study.

"Life was so not easy before this project because I used to help my wife with chores and I was almost the only person who was doing that. Nowadays I'm relaxed because many men are participating in house work." (Adult male IDI, Tanzania)

This also aligns with findings from the broader literature. Qualitative research has shown how men's perceptions regarding MNCH can shift over time from something that women are responsible for and that does not involve men to an attitude of concern and support¹⁶⁹ as an area that men feel they should be engaged with¹⁷⁰.

Lessons about sustainability can be drawn from these findings. Shame was reported to be an important barrier to male engagement in MNCH, yet we found that many

¹⁶⁸C Babirye, JN, Rutebemberwa, E, Kiguli, J, Wamani, H, Nuwaha, F & Engebretsen, IM 2011; Falnes, EF & Moland, KM, Tylleskar, T, de Paoli, MM, Msuya, SE & Engebretsen, IM 2011; Mitra, R, Raju S, Leonard, A (eds) 2000; Mullany, BC 2006; Natoli, L 2012; Natoli, L, Holmes, W, Chanlivong, N, Chan, G & Toole, MJ 2012; Nkuoh, GN, Meyer, DJ, Tih, PM & Nkfusai, J 2010; Onyango, MA, Owoko, S & Oguttu, M 2010; Reece, M, Hollub, A, Nangami, M & Lane, K 2010; Story, WT, Burgard, SA, Lori, JR, Taleb, F, Ali, NA & Hoque, DE 2012; Theuring, S, Mbezi, P, Luvanda, H, Jordan-Harder, B, Kunz, A & Harms, G 2009.

¹⁶⁹Sinha, D 2008.

¹⁷⁰Varkey, LC, Mishra, A, Das, A, Ottolenghi, E, Huntington, D & Adamchak S, et al. 2004.

individual participants disregarded shame or stigma, and that shaming at the community level was reported to be mutable in response to changes in community members' behaviour. It is plausible that these three findings could create a cyclical effect. That is, increased male engagement in a community that leads to reductions in stigma and shaming for engaged men could be expected to substantially reduce barriers for more men to engage in MNCH in the future. We have not found literature that specifically addresses the medium-term effects of increased male engagement in MNCH on uptake of male engagement in MNCH by other men in the same community. However, available literature indicates that peer influence through interpersonal communication is an effective way to increase men's engagement in MNCH, including in birth preparedness¹⁷¹ and contraceptive use¹⁷². It is plausible that this interpersonal effect could also operate at a community level, although this has not been established in the literature.

Support from older generations

Participants identified older generations, particularly older family members, as being influential in their lives. They also reported experiencing pressure from parents and parents-in-law to conform with pre-existing socially- and culturally-defined gender roles, such as women maintaining a heavy workload during pregnancy.

"Some mothers-in-law will actually be saying, 'Let her [daughter-in-law] work. Isn't lobola [bride wealth] paid?' " (Adolescent female FGD, Zimbabwe)

"[I] had to make my in-laws and my husband understand again and again that if now [during pregnancy] I lift any heavy thing then it would be harmful for me. My in-laws are previous generation... During first pregnancy I did many risky works. They did not help me..." (Younger female IDI, Bangladesh)

Participants also reported that increased male engagement could lead to intergenerational conflict, including jealousy between the mother-in-law and a daughter-in-law perceived to result from the differences between recent changes and the experience of the mother-in-law.

"[The mother-in-law says], 'During our time we did not need all this care related to birthing!'" (Younger female FGD, Bangladesh)

"To be honest they [men] were laughed at and it reached the stage mothers-in-law were telling their sons that 'you are dominated for sure, you must have been eaten love potion, I will go to the witch doctor to see that dawa' [herb used in making love potion]..." (Female KII, Tanzania)

"He asked me, 'Where is my daughter? You are fetching water. What happened?' He was furious. I thought he is going to beat me, I decided to pour it in the garden." (Male KII FGD, Tanzania)

Conversely, participants reported that the influential position of older generations could be a supporting factor for increased male engagement.

"[No matter] how much busy my father might be, he would at least tell me to bring my wife to the hospital. If I was unable then he would have managed someone to take her to the hospital. Now we are conscious." (Younger male FGD, Bangladesh)

Based on findings from this study, the absence of discouragement and the presence of encouragement from older generations can be drawn out as important factors supporting male engagement in MNCH. Accordingly, it is plausible that sustained male engagement in MNCH would be supported by changes in attitudes towards male engagement among older generations.

Other research has highlighted the need to engage older people and community leaders, including religious leaders, in the design and implementation of culturally-acceptable innovations¹⁷³. Lack of support from community members, including older people, has also been highlighted as a potential barrier to greater male engagement. Ensuring that male engagement in MNCH does not lead to conflict with parents and parents-in-law is also important because of the influence that in-laws, particularly mothers-in-law, exert over appropriate care-seeking for MNCH in many settings. Evaluation of a male engagement project in India suggested that in patrilocal families, women who have better relationships with their in-laws are more likely to use antenatal care services¹⁷⁴. Conversely, the quality of familial relationships is an important factor influencing male engagement; that is, where affective relationships between family members are strong, men are more likely to be engaged in providing support and assistance to their partners and children¹⁷⁵.

¹⁷¹Shefner-Rogers, CL & Sood, S 2004.

¹⁷²Shattuck, D, Kerner, B, Gilles, K, Hartmann, M, Ng'ombe, T & Guest, G 2011.

¹⁷³Huber, D, Saeedi, N & Samadi, AK 2010. S

¹⁷⁴Allendorf, K 2010.

¹⁷⁵Carter, M 2002.

Motivation from positive personal experience

Perceived benefits from past male engagement were identified as motivating and supportive factors for future male engagement. Participants reported that male community members have perceived clear benefits from their own increased engagement in MNCH.

"...from the villages we have visited, there are some who like the program very much... and they say, 'What you taught us is good; we can see that the lessons are of benefit to us.'" (Male KII, Zimbabwe)

These perceived benefits, presented in detail above, include health benefits as well as for couples' relationships.

"...this education has great contribution....and we are benefited in various way (pause) our children are in good health and babies are born without any trouble and that is quite a significant contribution in our society." (Adolescent male FGD, Tanzania)

"In the past we were not participating in reproductive health but after been educated we have changed and that help us to have a family with good health and love that is different from our past experience." (Adult male FGD, Tanzania)

Men's subjective experiences of male engagement are under-investigated in the current evidence base for male engagement in MNCH¹⁷⁶. Available evidence, however, indicates that men generally value the health and wellbeing of their partners and children¹⁷⁷, and many men enjoy being engaged in providing care to their families¹⁷⁸. Considering the findings of this study, it is therefore feasible that positive personal experiences of male engagement, where direct benefits are perceived to have accrued from increased male engagement, would motivate men to remain engaged in MNCH.

Additionally, some male participants reported that these perceived benefits motivated them to encourage their peers to increase their own engagement in MNCH.

"After being educated by wahudumu wa afya [CHWs] and peer educators, I think for us who have changed we should just continue to educate other men through our actions in such a way friends who have not yet changed will learn from our actions..." (Adult male FGD, Tanzania)

Given the global evidence, described above, supporting the effectiveness of peer influence as a means of sharing health

information and engaging men in MNCH, it is plausible that men who are motivated by their own positive personal experiences to encourage their peers to engage in MNCH could support sustainability.

Male engagement perceived as progressive

Interestingly, in Tanzania, some participants – both male and female – considered male engagement in MNCH to be socially progressive or modern.

"As my fellow said, I would say nowadays civilisation has increased when I see my fellow (another man) is washing babies clothes or cleaning the baby...in my heart I will be thinking that this man is civilized for sure he is working that show we are now civilized...I desire one day to do like him at home, as you can see people are civilized." (Adult male FGD, Tanzania)

"For example, they [men who lack understanding] may find the husband is washing clothes, and he will start sneering at him how could you do washing while your wife is there. My husband would say, 'My household arrangements have nothing to do with you, if you are not washing in your household is up to you, we are up-to-date'" (Adult female FGD, Tanzania)

Insofar as social change is perceived to be desirable, this perceived link between male engagement in MNCH and being "civilized" or "up-to-date" could be identified as a potential supporting factor for people to begin adopting behaviours that are different from community or traditional norms.

At the same time, some participants in Tanzania reported that some community members did not desire change in gender norms and roles or increased women's empowerment and that this led those people to not support male engagement in MNCH.

"...some men in Nzengo are not happy for these kind of things to be discussed there as they think that at the end of the day women will raise up like men." (Adult male IDI, Tanzania)

This finding that male engagement in MNCH is perceived to be socially progressive was only reported in one country, and we have not found similar findings in the literature. However, the possibility that male engagement in MNCH can be perceived as modern and therefore appealing to people who desire social change has interesting implications and deserves further consideration.

¹⁷⁶Comrie-Thomson, L, Tokhi, M, Ampt, F, Portela, A, Chersich, M & Khanna, R, et al. nd.

¹⁷⁷Davis, J, Luchters, S & Holmes, W 2012.

¹⁷⁸Kraft, JM, Wilkins, KG, Morales, GJ, Widyono, M & Middlestadt, SE 2014.

Conclusions

Participants in this study identified many benefits associated with male engagement in MNCH. Although these benefits were not universally reported, many participants did report benefits including: reduced maternal and newborn mortality; increased care-seeking for essential MNCH health services (ANC, skilled birth assistance or facility-based birth, HIV testing and treatment, and care-seeking for child illness); increased couple communication and shared decision-making; improved couple relationships; reduced maternal workload; improved maternal nutrition and rest during pregnancy; and increased value of girl children. These findings echo and build on findings from the established literature.

Previous reviews of the effects of male engagement on MNCH have identified evidence of impact of male engagement on care-seeking outcomes and indirect MNCH outcomes. For example, a recent review of male engagement in MNCH interventions found that male engagement can contribute to increased partner support across a range of domains, including support for access to healthcare services, immunization, nutrition during pregnancy, reduced workload during pregnancy, support during labour, emotional concerns during pregnancy, and baby care¹⁷⁹. However, two recent reviews have not found evidence of an impact of male engagement in MNCH on essential MNCH outcomes including maternal and newborn mortality or stillbirth¹⁸⁰. While findings from this study cannot be independently verified and are not generalizable, it is notable that participants report links between increased male engagement in MNCH and improved essential MNCH outcomes.

Men and women who participated in this study reported that they value men's engagement in MNCH. This aligns with previous findings from the global literature¹⁸¹. Participants in this study reported that they valued not only the perceived effects of male engagement in MNCH, such as reduced maternal mortality, but also men's increased engagement for its own sake. It was notable that participants, both male and female, described how their own or their partner's increased engagement in

MNCH made them feel "happy" or "love[d]". Combined with the finding that men and women reported disregarding stigma associated with male engagement in MNCH because they valued their partner or child above existing gender norms and roles that limit men's engagement, this study illustrates that many women – as well as men – value the affective elements of male engagement in MNCH. These findings about the affective value of male engagement in MNCH are particularly important in light of a recent review of the evidence base for male engagement in MNCH that found a gap in current literature as to men's subjective experiences of their engagement in MNCH¹⁸².

While many participants reported that they valued male engagement in MNCH generally, both male and female participants reported that they did not want men to participate in some specific tasks. These tasks varied across participants. For example, some female participants welcomed their partner accompanying them to a health facility while others reported that this made them feel embarrassed, and some women welcomed assistance with household chores while others reported that they wanted to complete household chores according to established gender roles and norms. We could not discern any pattern in which participants reported not desiring men's participation in certain tasks. Overall, however, the fact that both male and female participants reported that they did not want men to engage in certain tasks illustrates findings from the broader literature that male engagement in MNCH often challenges existing norms, which many men and women have internalized and perpetuate within their own beliefs, attitudes and interpersonal relationships¹⁸³.

In addition to the overarching findings from this research, the results of this study have confirmed, and added to, several elements of good practice in male engagement programming that have been recognized in the current literature on this topic. These implications for good practice are highlighted below as considerations that can usefully guide policymakers and program planners who aim to increase male engagement in MNCH.

¹⁷⁹Tokhi, M, Comrie-Thomson, L, Davis, J, Portela, A, Chersich, M & Luchters, S nd.

¹⁸⁰Kraft, JM, Wilkins, KG, Morales, GJ, Widyono, M & Middlestadt, SE 2014; World Health Organization nd.

¹⁸¹Davis, J, Luchters, S & Holmes, W 2012.

¹⁸²Comrie-Thomson, L, Tokhi, M, Ampt, F, Portela, A, Chersich, M & Khanna, R, et al. nd.

¹⁸³Barker, G, Ricardo, C, Nascimento, M, Olukoya, A, Santos, C 2010; Greene, ME & Levack, A 2010.

In encouraging men to attend ANC it is important to avoid unintentionally discouraging or preventing unpartnered or unaccompanied women from accessing services. This principle is well established in the literature¹⁸⁴. This study has further illustrated that it is important to acknowledge the potential for harm, including reduced service utilization, from clinic-based enforcement of male attendance.

During consultations with stakeholders – including community leaders, clinic staff and health managers – clear messages should be provided around male engagement that include acknowledgement of the potential negative effect on service utilization or discouraging or preventing unpartnered or unaccompanied women from accessing health services.

In areas where clinic-based enforcement occurs, clinics should work with local government and community stakeholders to reduce stigmatisation and avoid preventing unpartnered or unaccompanied women from attending clinics.

The potential for greater male engagement in MNCH, including increased care and support provided by men to their partners and children, to lead to intergenerational conflict has been documented in the literature¹⁸⁵ and was raised by many participants in this study. This highlights the need to engage other household members in strategies to engage men in MNCH.

- Activities to promote male engagement should routinely engage older men and women, particularly mothers-in-law.
- Home visits could include counselling relevant to other key household members, particularly older men and women and mothers-in-law, to increase their understanding and acceptance of messages and changes in behaviour.
- Where group education and outreach is conducted, sex-specific elders' groups may be a useful strategy to reach older men and women, particularly mothers-in-law.

Stigma – including experienced shame and/or active shaming of men who engage in MNCH – is established in the literature as an important barrier to male engagement in MNCH¹⁸⁶. This study has illustrated, however, that the experience of feeling shame while engaging in MNCH, and the practice of active shaming of men who engage in MNCH, can change quickly once men's engagement in MNCH becomes more visible in the community.

Program planners should consider the possibility that a program could leverage from a small number of visibly-engaged men to achieve change at a larger scale in a community. Program planners might therefore wish to consider how men's engagement – including engagement beyond physical support – can best be highlighted within a community.

Although there is no universally-recognized definition of male engagement in MNCH¹⁸⁷, we can usefully understand male engagement as a concept that is broader than actions taken by men¹⁸⁸. Additionally, it is established in the broader literature¹⁸⁹ and illustrated by this study that specific actions that men can take – such as accompanying partners to health facilities, being present during childbirth, or completing specific household tasks – will not always be acceptable or appropriate for all men, women or households.

- Rather than promoting a single model of male engagement, defined in terms of specific actions across all settings, policymakers and program planners should consider how couples might be supported to decide together how men can best engage in MNCH. Program messages should be flexible and responsive to couples' decisions, where possible.
- In consultations with stakeholders to raise awareness of male engagement in MNCH, care should be taken to promote a holistic understanding of male engagement as a change in men's attitudes, values, and relationships, rather than men's specific actions alone.

¹⁸⁴Becker, S, Mlay, R, Schwandt, HM & Lyamuya, E 2010; Kululanga, LI, Sundby, J & Chirwa, E 2012; World Health Organization nd.

¹⁸⁵Das, Gupta, M, Jiang, Z, Li, B, Xie, Z, Chung, W & Hwa-Ok, B 2003; Rastogi, M & Therly, P 2006; Sahip, Y & Turan, JM 2007.

¹⁸⁶Babirye, JN, Rutebemberwa, E, Kiguli, J, Wamani, H, Nuwaha, F & Engebretsen, IM 2011; Faines, EF & Moland, KM, Tylleskar, T, de Paoli, MM, Msuya, SE & Engebretsen, IM 2011; Mitra, R, Raju S, Leonard, A (eds) 2000; Mullany, BC 2006; Nasreen, HE, Leppard, M, Al Mamun, M, Billah, M,

Mistri, SK & Rahman, M, et al. 2012; Natoli, L 2012; Natoli, L, Holmes, W, Chanivong, N, Chan, G & Toole, MJ 2012; Nkuoh, GN, Meyer, DJ, Tih, PM & Nkfusai, J 2010; Onyango, MA, Owoko, S & Oguttu, M 2010; Reece, M, Hollub, A, Nangami, M & Lane, K 2010; Shahjahan, M & Kabir, M 2006; Story, WT, Burgard, SA, Lori, JR, Taleb, F, Ali, NA & Hoque, DE 2012; Theuring, S, Mbezi, P, Luvanda, H, Jordan-Harder, B, Kunz, A & Harms, G 2009.

¹⁸⁷Montgomery, E, van der Straten, A & Torjesen, K 2011.

¹⁸⁸Comrie-Thomson, L, Tokhi, M, Ampt, F, Portela, A, Chersich, M & Khanna, R, et al. nd.

This study, and the broader literature¹⁹⁰, has found that messages about male engagement in MNCH are more acceptable to male and female community members when they are sensitive to sociocultural norms and taboos.

- Program planners and implementers may need to develop strategic messaging to make links more obvious for outcomes that are less clearly linked with male engagement given that it is likely to be more difficult for community members to perceive the connections between increased male engagement and improved health and wellbeing for some MNCH outcomes (such as maternal mortality or breastfeeding) compared with others (such as maternal rest, emotional support or gender norms).
- Efforts to demonstrate the effects of male engagement on MNCH outcomes as well as broader social outcomes for men, women and children will benefit from strong local data collected during rigorous monitoring and evaluation of male engagement programs. Data collected on a broad range of outcomes (including couple communication and shared decision-making, emotional support, shared workload, allocation of household resources, financial support, physical support and gender norms) could assist in making changes in male engagement and associated changes in MNCH outcomes more visible.

The current evidence base indicates that certain pathways to MNCH outcomes are likely to be more readily influenced by men's increased engagement, such as the use of skilled birth assistance or facility birth, HIV testing and treatment, and maternal workload in late pregnancy and shortly after delivery¹⁹¹. This aligns with participants' perceptions as reported in this study.

- Male engagement activities that target pathways that are more readily influenced by men's increased engagement are likely to achieve the quickest contributions to MNCH outcomes. At the same time, program planners and policymakers should recognize that efforts to target topics such as childbirth and HIV might be perceived as less acceptable to men, women and communities compared with less sensitive topics such as ANC attendance or care-seeking for child illness, and this could create barriers to implementation.
- Policies or programs that are designed to focus on certain pathways that link male engagement to MNCH outcomes should not be implemented with a focus on specific actions that men could take in isolation from their broader context. An approach focused on men's specific actions that is not situated within a broader strategic approach to male engagement in MNCH can preclude or undermine efforts to address underlying causes of poor MNCH outcomes and gender inequity¹⁹². Policies or programs intended to increase men's engagement with MNCH should be informed by a strategic approach that includes consideration of how activities to promote men's engagement relate to broader goals of improving the health and wellbeing of women, newborns and children, and promoting gender equity.

This study has highlighted barriers to the participation of hard-to-reach men in male engagement programs. Programs designed to engage men in MNCH should include special consideration for how to engage hard-to-reach men.

- As appropriate to the scale of programs, planners should consider including a specific needs assessment for socially-marginalized men and their families to identify needs related to harmful gender norms and practices, MNCH outcomes, and barriers to participation in community activities and peer networks.

¹⁹⁰Adeleye, OA, Aldoory, L & Parakoyi, DB 2011; Barker, G, Ricardo, C & Nascimento, M 2007; Greene, M, Mehta, M, Pulerwitz, J, Wulf, D, MBankole, A & Singh, S, 2004; Nasreen, HE, Leppard, M, Al Mamun, M, Billah, M, Mistri, SK & Rahman, M, et al. 2012; UNFPA, Promundo, MenEngage 2010.

¹⁹²Barker, G & Das, A 2004; Barker, G, Ricardo, C & Nascimento, M 2007; Greene, ME, Mehta, M, Pulerwitz, J, Wulf, D, Bankole, A & Singh, S 2004.

It is well established in the literature that women as well as men act to perpetuate gender roles and norms that influence MNCH¹⁹³, a finding that has also emerged in this study. Policymakers and program planners should adopt a gender-synchronized approach to male engagement in MNCH that includes complementary strategies or activities with men and women.

- In all settings, strategies and approaches to engage men in MNCH should include components that target men's female partners, mothers, and mothers-in-law.
- Attention should also be given to women who have important roles in MNCH prescribed by the local context. For example, in some settings a man's sister has an important role in advising and guiding his daughters.

Male engagement in MNCH is emerging as a key strategy for promoting the health and wellbeing of women and children, as well as gender equality. This study has captured the experiences of men and women in six sites across Bangladesh, Tanzania, and Zimbabwe where MNCH programs with male engagement components have been implemented. The experiences of these men and women, while not generalizable to all people participating in male engagement programs, indicate that men's engagement in MNCH is perceived as having a range of beneficial effects and is valued by many women as well as many men. Importantly, however, the experiences of study participants also indicate that men and women do not always desire certain types of engagement by men in MNCH, and that the degree and type(s) of engagement that are desired may be specific to individuals or couples. This aligns with the global consensus that men's engagement in MNCH should be contingent upon women's desire for men to be involved. The experiences of study participants also highlight elements of good practice to be considered in the design and implementation of male engagement programs.

¹⁹³Greene, ME & Levack, A 2010.

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