# FROM FAMILY PLANNING TO FATHERHOOD:

## ANALYSIS OF RECENT **MALE INVOLVEMENT INITIATIVES** AND SCALE-UP POTENTIAL

USAID
FROM THE AMERICAN PEOPLE

Tékponon Jikuagou

© 2013. Institute for Reproductive Health, Georgetown University

**This briefing paper was prepared by the Institute for Reproductive Health at Georgetown University for the Male Involvement Technical Consultation.**

This publication was made possible through support provided by the United States Agency for International Development (USAID) for the Tékponon Jikuagou Project under the terms of the Cooperative Agreement No. AID-OAA-A-10-00066. The contents of this document do not necessarily reflect the views or policies of USAID or Georgetown University.

**Tékponon Jikuagou Project**
Institute for Reproductive Health
Georgetown University
4301 Connecticut Avenue, N.W., Suite 310
Washington, D.C. 20008 USA

irhinfo@georgetown.edu
www.irh.org/projects/tekponon_jikuagou/

# TABLE OF CONTENTS


I. Introduction ..... 4

II. Male Involvement Consultation: Objectives, Key Questions and Review Methods ..... 5

III. Overview of Projects ..... 7

A. Family Planning/Sexual and Reproductive Health ..... 7

B. Fatherhood and Maternal and Child Health ..... 14

C. HIV/AIDS and Gender-Based Violence Prevention ..... 16

D. Adolescent Programs ..... 18

IV. Summary Overview Of Strategies, Approaches and Evaluation Methods ..... 24

Program Strategies ..... 25

Evaluation Approaches ..... 27

V. Framing the Consultation: Scaling Up Promising Practices ..... 29

References ..... 33

Appendix A: Key Informants ..... 36

Appendix B: Evaluation Indicators from Projects Reviewed by SRH Theme ..... 38

Appendix C: Learning Agenda for Male Involvement in Family Planning Proposed during Key Informant Interviews ..... 39

# I. INTRODUCTION

The popularity of initiatives to involve men in sexual and reproductive health (SRH) has waxed and waned over the last 30 years. However, there is growing recognition that positive male engagement in SRH has significant potential to improve the lives of both women and men. Evidence suggests that male involvement programs can improve spousal communication, gender-equitable attitudes, and family planning (FP) use (Becker 1996, Kraft et al 2007, Lundgren et al 2012). Research also suggests that programs working with boys and men can impact the social norms that underlie behaviors related to SRH, such as intimate partner violence (Becker 1996). Until relatively recently however, men were most often engaged as simply another beneficiary group, without recognition of the multiple benefits of applying a gender transformative approach, which includes efforts to transform gender roles and promote more gender-equitable relationships between men and women.

There is abundant evidence that gender norms – social expectations of appropriate roles and behaviors for men (and boys) and women (and girls), as well as the social reproduction of these norms in institutions and cultural practices – directly influence SRH-related behaviors (Barker, et al. 2007; Courtenay 2005, Varga, 2003, Greene 2011). Increasingly, the FP community recognizes that men as well as women have gender-related vulnerabilities and that programs must address underlying social norms in order to achieve widespread, lasting change. In many settings, for example, "being a man" means being tough, brave, risk-taking, aggressive and having many children. Risk-taking behaviors, including substance abuse and unsafe sex, may be seen as ways to affirm manhood. Young and adult men in violent, low income or conflict-affected settings may suffer even more from a sense of helplessness and fatalism that contributes to lower rates of safer sex and health-seeking behavior (Barker 2005). If prevailing notions of manhood often increase men's own vulnerability to injuries and other health risks, they also create considerable risk for women and girls. "Everyone – boys and girls, men and women – is therefore made vulnerable by gendered attitudes and behaviors" (Greene and Levack 2010). Moreover, recent research suggests that gender norm change works as a "gateway factor" for improving a broad range of outcomes. Since more equitable, respectful or egalitarian attitudes can give rise to many important health-related behaviors, these attitudes may be lead to desired health outcomes such as improved communication, shared decision-making, condom use, contraceptive use, access to health services, and non-violence (Greene and Barker 2010). The evidence seems clear: programs must address the social constructions of both femininity and masculinity. Indeed, male involvement initiatives increasingly view men as gendered individuals, rather than

### WHAT ARE GENDER TRANSFORMATIVE PROGRAMS?

In 2007, the World Health Organization published a systematic review of evidence which defined gender transformative programs as:

> "Programs which aim to transform gender roles and promote more gender-equitable relationships between men and women. They seek to critically reflect about, question or change institutional practices and broader social norms that create and reinforce gender inequality and vulnerability for men and women" (Barker, et al. 2007).

oppressors, self-centered, disinterested or violent and are seeking ways to address underlying gender structures and social norms that limit the ability of women and men to achieve full SRH.

Despite the rich and varied experiences of involving men in SRH, evidence is lacking on what qualifies as promising practices for engaging men. Moreover, there is an even greater knowledge gap regarding how to scale up successful male involvement programs –especially gender transformative initiatives –and how to assess program impact. This briefing paper examines 19 recently completed or on-going interventions and projects that employ a variety of approaches to engage men and adolescent males in SRH, including FP, maternal and child health (MCH), HIV prevention, gender-based violence (GBV) prevention, and fatherhood. Particular attention is given to emerging themes related to promising practices and the scalability of approaches. This review aims to lay the groundwork for advancing discussion on applying a gender-informed, systems lens to consider ways to expand male involvement programs for meeting the SRH needs of men and women.

# II. MALE INVOLVEMENT CONSULTATION: OBJECTIVES, KEY QUESTIONS AND REVIEW METHODS

This briefing paper and the technical consultation it precedes are part of an initiative funded by the U.S. Agency for International Development (USAID), and led by the Institute for Reproductive Health (IRH) at Georgetown University to convene researchers and practitioners engaged in male involvement to share experiences and results and reflect on the scalability of these transformative male involvement programming for SRH.

The objectives of this paper and related meeting are to:

- Review approaches for engaging men in SRH within diverse programs, countries and contexts;
- Consider methods for evaluating the effectiveness, acceptability, feasibility and scalability of male involvement approaches for improving SRH outcomes;
- Identify results, common themes and lessons learned related to identified promising practices; and
- Discuss successes and challenges of scaling up these efforts.

The key questions to be considered:

- What elements of the initiatives were the most effective, acceptable and feasible to implement and scale up?
- How is a successful scale-up of a male involvement program measured, and what is the evidence for its impact on desired outcomes?

- What happens to an effective male involvement program when scaled up? Are their transformative components maintained? Do they have the same impact on outcomes?
- What are the main challenges and barriers to scaling up male involvement pilot programs and what can be done to overcome them?
- What are recommendation for future research and programs on male involvement and scale-up?

An iterative process was used to review male involvement projects and interventions related to SRH, including:

- Identification of researchers, implementers and gender specialists working in the field of male involvement in SRH;
- Interviews with key informants to discuss on-going, recently completed and/or planned male involvement programs;
- In-depth exploration of relevant projects and interventions on adult and adolescent male involvement in FP, fatherhood and MCH, HIV prevention and GBV prevention; and
- Analysis of strategies and approaches, evaluation methodologies and results, promising practices and levels of scalability.

Recommendations from researchers, project implementers and gender specialists from USAID and IRH partner organizations resulted in a preliminary list of programs and interventions on male involvement in SRH. Review of publications in journals and web searches complemented this list with additional male involvement initiatives. As a result, 19 key informants based in the U.S. and abroad were interviewed (Appendix A). An interview guide was used to elicit supplemental information on projects and to identify additional programs for consideration. As programs were identified they were added to a matrix that organized initiatives according to technical area, implementing organization, timeframe, objectives, overview of approaches, evaluation methods, results and extent of scale-up. In total, 19 programs were identified and documented.

Additionally, online searches for published documents, project reports and presentations were conducted to supplement information obtained from key informants. The interview notes and additional sources of information were reviewed and analyzed according to technical areas and then by project strategies, evaluation methodologies, common themes in promising practices, and scalability.

It is important to note that there are surely many other noteworthy male involvement programs underway at this time. The programs included here are simply those which emerged during our rapid review which were very recent or ongoing, and for which it was likely that someone involved in the program could participate in a consultation to identify lessons learned related to scalability across initiatives. Furthermore, there are many ongoing programs involving men in broader areas related to reproductive health, for example in the areas of fatherhood and sexual violence. For the purpose of this review we focused on programs with close links to FP.

# III. OVERVIEW OF PROJECTS

This section presents brief descriptions of the projects included in this review, organized into four categories: 1) FP/SRH, 2) fatherhood and MCH, 3) HIV/AIDS and gender-based violence prevention and 4) adolescent programs. The projects are briefly described by their objectives, location, funding source, implementation strategies, evaluation design and results, according to the availability of this information. If applicable, information on expansion or potential for scale-up is also presented. An analysis of implementation strategies and evaluation designs across projects is also discussed.

## A. FAMILY PLANNING/SEXUAL AND REPRODUCTIVE HEALTH

### Clinic Café Timor Initiative

*Clinic Café Timor* (CCT) is a rural health service operated by Cooperativa Café Timor, an organic and fair-trade coffee cooperative of 20,000 member families in East Timor. In July 2012, CCT completed a 32-month project, funded by the Australian Agency for International Development (AusAID) and managed by FP New South Wales, aimed at working with men to improve reproductive health by enabling them to access and utilize FP and MCH services for themselves and their families. The project intervention included community peer education through Men's Health Groups (MHGs) and clinic-based health education and promotion activities. Young men in the community were selected to lead MHGs and trained using a structured manual. The health topics discussed included alcohol consumption, smoking, MCH, FP and STIs, as well as family decision-making and domestic violence. Additionally, nurses and community health workers were trained on effective engagement of men in these areas and were encouraged to include men in health promotion activities. Clinic staff also received orientation on ways to better integrate men's health issues into clinic and community health programs and on the importance of men's role in SRH.

The project was evaluated by an external independent consultant. MHG participants, peer educators and their partners were randomly selected and interviewed. Key results of the evaluation include:

- There was strong evidence of changes in knowledge, attitudes and practices in some areas, particularly related to MCH and FP. However, participants often showed poor knowledge retention of project topics and indicated a desire for more frequent trainings.
- Although condom messages were embedded in the FP and STI modules, there was little to no evidence of condom use. This is most likely due to lack of access to condoms in the community.
- Women's participation in MHGs had significant and unexpected benefits, though in some cases their attendance contributed negatively to the objective of reaching men.

At present, *CCT* is developing a proposal to expand this approach with improvements recommended by the evaluation team that will integrate men's health into their regular primary care services. The expansion process offers an opportunity to address scalability, sustainability, and a strategic process for moving beyond simply a "big pilot".

### Community-based Health Planning and Services (CHPS) Initiative

Innovations from an experimental study of the Navrongo Health Research Centre, a research unit of the Ghana Health Service, showed that comprehensive community-engaged primary health care could lead to substantial reductions in fertility and childhood mortality. Under the Ghana Community-based Health Planning and Service (CHPS) Initiative these innovations were scaled-up into a program of national community health care reform that seeks to improve the accessibility, efficiency and quality of health and FP services.

The key approaches of the Navrongo model include:

- Community Health Officers (CHOs): Reorienting existing clinical nurses on community outreach skills to enable them to provide community health care, including FP and MCH services and adolescent health and education
- The "*zurugelu*" ('togetherness' in the local dialect) approach: Mobilized cultural resources of chieftaincy, social networks, village gatherings, volunteerism and community support, including recruitment and management of male health-service volunteers

Under the recruitment and management of volunteers, activities were designed to build male leadership, ownership and participation in reproductive health services and expand women's participation in community activities that men had traditionally participated in. Male and female volunteers were designated by village health committees and trained to support CHOs with community education, counseling, basic first aid and preventive home-care services. Volunteers were given a start-up kit of essential drugs and training in managing services and revolving accounts in order for the flow of supplies to be sustainable and financed by the community. While female volunteers worked with women, male volunteers were trained to mobilize male support for FP.

Since the initiative's two approaches could be implemented independently, jointly or not at all, the evaluation design involved four experimental cells with the comparison condition representing the existing clinic-focused system of care. While the Navrongo pilot was successful in all parameters examined, the success of child survival indicators were attributed solely to CHOs, while FP success was conditional on work of both CHOs and volunteers. Results showed that volunteers played an essential part in building the participation of men in FP and developing gender outreach activities.

After the Navrongo trial was completed and results disseminated, a validation of the model was conducted to ensure its relevance to the national program and its feasibility for scale-up. The model was validated and programmatic and policy guidelines were developed for its scale-up at the national level. National expansion of the program occurred in 2000 and is ongoing. However, while long-term observation of the project has shown that decreased child mortality was sustained, reduced fertility rates were not. A recently completed qualitative study, led by Columbia University, identified challenges in sustaining a programmatic focus on strategies for social mobilization (i.e. community mobilization with volunteers) when scale-up must depend upon a medicalized system of care. These results suggest that fidelity to the original Navrongo success story requires continued

attention and resources devoted to social engagement with male networks, community mobilization and household outreach that have been lacking in the Ghana Health Service system.

### Community Workshops/ C-Change Project

As part of the C-Change Project funded by USAID, FHI360 coordinated a short-duration intervention in rural Guatemala to influence inequitable gender norms that constrain the practice of FP. The intervention, which took place between March and April 2012, consisted of a series of six interactive workshop sessions for couples: two for men only, two for women only, and two that both sexes attended together. The sessions were led by trained community-based educators from a local NGO, APROFAM, using a manual developed by C-Change that incorporated games, role plays and other exercises. Workshop sessions focused on gender norms and FP, gender equality, and sexuality. Specifically, the workshops covered the following topics:

1. Exploring the concept of gender
2. Strengthening demand for FP and responsible fatherhood (men only) and initiating FP use and negotiating use with partners (women only)
3. Sexual and reproductive rights and effective communication between couples
4. Sexuality and communication about sex, sexual pleasure and FP

After the workshops, APROFAM held mobile FP clinics in or near all selected communities.

Evaluation of the intervention included baseline and endline assessments of randomly selected intervention and control communities. Assessments measured gender attitudes and contraceptive use among participants. Gender attitudes were measured using the Gender and FP (GAFP) Scale, developed for this study. Service statistics were also examined to assess change in contraceptive use. The evaluation found that the intervention had a significant effect in changing both men and women's inequitable gender attitudes. FP knowledge increased significantly, while changes in contraceptive use were suggestive but not significant, possibly because of the brief duration of the project.

These results suggest that this strategy could be taken to scale, and indicate that it is possible to develop scalable gender transformative programs, as this intervention model is short in duration and relatively inexpensive.

### Fertility Awareness-based Methods (FAM) Project

The introduction of the fertility awareness-based Standard Days Method® (SDM) in 2001 provided an opportunity to test and scale up innovative strategies to engage men in FP services and promote male participation in contraceptive use. SDM requires cooperation of the male partner, and strategies to incorporate the method into service delivery have included a variety of efforts to engage men, including training providers to address the needs of couples and men, explicitly addressing couple issues in counseling protocols, offering couple counseling and conducting

outreach activities for men. These strategies were successfully tested during operations research in six countries from 2001 to 2007. Under the FAM Project (2007-2013), IRH and local partners had the opportunity to scale up SDM, including strategies for engaging men, in five countries (India, Democratic Republic of Congo, Guatemala, Mali and Rwanda).

IRH and partners worked with Ministries of Health and private sector FP organizations to integrate SDM into provider capacity building efforts, health management information systems, health education and outreach activities and relevant policies and norms. Capacity building activities enabled providers to engage men directly and to discuss issues relevant to FP use such as management of the fertile days, condom use, HIV/STIs, intimate partner violence and alcohol use. Outreach activities were also conducted to reach men with accurate information on fertility awareness and FP methods and their benefits, while promoting equitable gender norms. Awareness-raising activities included simple efforts such as including male images and perspectives in communication initiatives such as radio and television spots, posters, brochures, billboards, wall paintings, puppet shows and street theatre; as well as more intensive activities such as training male radio disc jockeys and male community volunteers or providing satisfied male FP users "invitation cards" to distribute to friends to encourage them to seek FP information and services.

IRH conducted a six-year prospective, multi-site comparative case study of the processes and outcomes of scaling up SDM in five countries while using the ExpandNet/WHO model for scaling up health innovations to guide the scale-up process. The results of this study provide information on the extent to which the intrinsic values of the SDM innovation, such as promoting gender equity by engaging men, empowering women and expanding contraceptive choice, were maintained during expansion. Data sources include baseline and endline assessments and stakeholder interviews in each country, as well as reflections from users, providers and program managers using Most Significant Change methodology. IRH included DHS questions on couple communication, women's empowerment and intimate partner violence in endline and baseline surveys with both men and women; and the extent to which positive male engagement remained a core element of SDM services was assessed through simulated client visits, provider observation, and client follow up visits. These data were complemented by qualitative information from stakeholder interviews and Most Significant Change story collection.

Results suggest that success depended upon the extent to which core male engagement principles were included in the definition of the innovation in each country, and how effectively fidelity to these principles was tracked over time. Overall, results indicate that it is feasible to increase male involvement in FP services and use by offering methods that men can use individually or as a couple (condoms, SDM); and by carefully operationalizing male involvement within the innovation package and monitoring fidelity over time. The findings reveal that offering SDM, which requires male involvement, motivated providers to broaden the traditional female-centered paradigm for FP services. Additionally, male and female SDM users credited their experience using SDM with improved fertility awareness, couple communication and marital harmony. SDM service delivery strategies and scale-up are likely applicable to all FP methods and may inform future efforts to promote male involvement in the promotion of FP more generally.

### HealthBridge Program

The HealthBridge Foundation of Canada implemented the program *Promoting Male Responsibility towards Greater Gender Equality* in India, Vietnam and Bangladesh between 2004 and 2008. The program in India and Vietnam, partially funded by the Canadian International Development Agency, sought to increase positive male involvement in FP, and address violence against women and inequitable gender roles in the family. The program's guiding principle was to engage men while valuing women. HealthBridge's approach focused on promoting greater access to, and use of, male-centered methods of contraception, specifically condoms and vasectomy, while addressing the stigma and misconceptions related to contraceptive use in general. HealthBridge also worked with local organizations to demonstrate the value of domestic work traditionally performed by women in order to address root causes of gender inequality. The key components of the project's implementation phase included:

- *Information, Education and Communication*: Public awareness-raising on FP/SRH and services; working with journalists to address gender issues through gender-sensitive articles that discuss the need for men's engagement in SRH; and organizing men and women's groups to increase awareness of the benefits of positive male involvement in family life through group discussion, counseling, videos and poster shows.
- *Government engagement*: Support to government-run reproductive health programs.
- *Capacity building*: Capacity building activities with government staff, media workers, women's unions and health institutions using a gender equality and reproductive health curriculum, focusing on men's roles and responsibilities.
- *Networking*: Sharing and exchanging information with other non-government organizations (NGO) networks about approaching gender issues from a male perspective.

The program's evaluation consisted of baseline and endline data collection, including interviews, focus groups and structured observational of communication and task-sharing between couples, conducted by an independent evaluator. Attitudinal and behavioral changes were seen in the program's participating communities. Selected evaluation results include:

- Increase in men seeking information about modern contraceptive methods (at health centers) and purchasing condoms
- Decline in sex-selective abortion rates in participating communities compared to the national average
- Increase in condom use from 45% to 65% among male participants at endline
- Increase in gynecological visits by female participants at endline
- Decline in domestic violence reported by participants at endline

Since the program ended in 2008, HealthBridge has heard from several NGOs interested in incorporating the program's approaches into their own programs. While there was also discussion of scaling up the program in other communities, the program's donors have since shifted priorities. HealthBridge plans to integrate approaches from this work in their current and future programs.

### Male Motivator Program

The *Male Motivator Program*, developed by Save the Children, aims to increase FP use among couples through a male peer outreach worker, referred to as a male motivator. The program has been implemented in the Philippines, Malawi, Nigeria and India. This summary will focus on the approach, evaluation, and results from its implementation in Malawi by Save the Children and Family Health International (FHI360).

The intervention consists of identifying and training men who use modern contraception and who are enthusiastic about it as male motivators. These male motivators then provide information to men in the community who are married or living with women younger than 25 years old and are willing to be visited. Men in the community receive information on FP and skills to seek out and eventually adopt contraception. Over the course of eight months, trained male motivators visit participants an average of five times to discuss the following topics:

- An overview of FP, the socioeconomic benefits of birth spacing and information on local resources;
- FP experiences, attitudes and norms, based on the personal experiences of male motivators;
- Skills development, including correct condom use, and interpersonal communication to encourage couple communication.

The curriculum implements learning activities to challenge participants to reflect on their future and rethink traditional male roles regarding FP communication and decision-making.

The evaluation in Malawi used a randomized design which included baseline and endline assessments with an intervention and control group made up of men and their wives or co-habiting partners. It also included post-intervention in-depth interviews with male participants and female partners. Results revealed that contraceptive use increased significantly within and between groups, as did general communication and communication frequency. Within-group changes were also identified for FP knowledge, attitudes, self-efficacy and equitable gender norms.

While the program has been replicated in several countries, it has not been taken to scale in any one country or scaled up strategically across countries. It was noted that for scale-up of this type of program, additional funding to cover training costs would be required. A costing analysis of the program was initiated and may be interesting to explore in relation to its scalability. Results from implementation in other countries may also play a role in scalability.

### Male Reproductive Health Project

The US-based Male Reproductive Health Project (2008-2013), funded by the U.S. Department of Health and Human Services (DHHS), is implementing interventions to increase male FP clients and STI testing. Interventions documented at two of 12 clinics included:

- Outreach to men via female clients at FP clinics and through agencies serving men
- Assessments to determine the capacity of clinics to serve men

- Training for administrative, clinical and non-clinical staff on integrating and promoting services for men
- Clinic modifications to promote male-friendly environments

The evaluation included a comparison of two experimental clinics and four comparison clinics. Preliminary results show that male visits increased in the experimental sites, as did testing for chlamydia and gonorrhea. HIV testing increased comparably over time. Results also showed an increase in female clients, including female partners attending clinics with male partners. However, findings also suggested that providers lacked motivation to serve men, and that men were not always supportive clients.

One of the two clinics (experimental site) will continue implementing the program with their own funds and plan to expand to three additional locations with small grants and in-kind donations. DHHS hopes to obtain data on the income generated by linking men to FP services through these interventions to support efforts to secure funding for scale-up through future mini-grants.

### Tékponon Jikuagou Project

The *Tékponon Jikuagou Project (TJ)* in Benin, funded by USAID, is led by Georgetown University's Institute for Reproductive Health in collaboration with CARE International and Plan International (2012-2015). *TJ* aims to address unmet need for FP through interventions implemented through women's and men's social networks, specifically addressing social norms and barriers which influence non-use of FP despite access to services. The goal is to create a social environment that enables married couples to achieve their fertility desires by fostering reflective dialogue and catalyzing discussion about social norms related to FP, and diffusing information through formal and informal social groups, influential opinion leaders and well-connected individuals.

*TJ* uses social network analysis to identify the most influential and connected networks in a community and to assess the influence of these networks on fertility beliefs, attitudes, desires, intentions and behaviors related to FP. Interventions then work with key actors in social networks and the network structures themselves to promote reflection on existing social norms and attitudes that may negatively influence reproductive health and FP. While the project addresses information needs, it also uses participatory, communication-driven techniques that encourage reflection and dialogue on issues such as communication between husband and wife regarding fertility and the stigma associated with FP discussions and overt use of FP.

The core components of the project's intervention phase include:

- A participatory community social mapping approach to identify and prioritize significant women's, men's, and mixed sex groups (e.g. farmers' groups, folkloric groups, etc.) and influential individuals
- Group activities and stories, accompanied by discussion questions that aim to create reflective dialogues, led by identified leaders of existing groups, both formal and informal

- Advocacy and support activities with identified influential people, encouraging them to serve as advocates and role models to positively influence attitudes and norms around FP, fertility and gender norms and roles

The 18-month pilot intervention phase is currently underway and set to end in September 2014. The project's evaluation will include baseline and endline surveys in intervention and control communities and cohort interviews in intervention communities only. While *TJ* is not yet ready to expand, its design was developed with future scale-up in mind. The intervention package consists of simple materials and relies on limited training and support inputs. Relationships with potential scale-up partners, such as the Ministry of Health, have been nurtured throughout the project, beginning in the formative research phase, to lay a foundation for scale-up if interventions prove successful.

## B. FATHERHOOD AND MATERNAL AND CHILD HEALTH

### Husbands' Schools Initiative

UNFPA Niger developed a strategy known as the *Schools for Husbands* to involve men in health promotion and foster behavior change at the community level. The *Husbands' Schools* Initiative (2004-present) is implemented by the Reproductive Health Program at the MOH with funding from the European Union, UNFPA and the Spanish Agency for International Development Cooperation.

Capacity building activities and supervision of the schools is managed by the MOH, local NGOs, and UNFPA. Participation in the schools is voluntary; however, participants are selected based on a number of criteria, including only men married to women who use RH services, aged 25 or over, and who are accepting of women's participation in community life. Participants become guides and role models within their family and communities and each member assumes part of the school's responsibilities on a rotational basis.

The approach for the *Husbands' Schools* is to have husbands meet twice a month to analyze and discuss specific RH concerns, in particular MCH issues identified in their community. Participants explore topics ranging from communication with their wives to infrastructure of a local health facility. Men discuss possible solutions to health problems based on their knowledge and experiences and resources from local health centers. Participants then devise strategies and actions to implement their proposed solutions with local resources. Additionally, some schools collaborate with women's groups to facilitate communication with women on concerns that have been identified.

An evaluation of the initiative is scheduled for 2013. Preliminary data show promising results, including:

- Greater communication between participating husbands and their wives
- Increase in husbands attending births of their children
- Increase in births assisted by skilled personnel

- Increase in prenatal and postnatal consultations
- Increase in use of FP

The initiative, which began in 11 pilot schools, is now set up in more than 170 schools throughout Niger, and discussions are on-going with the MOH about further scale-up. UNFPA is planning to support partners and government entities to expand the initiative to other regions. At the regional level, UNFPA is also initiating replication of the initiative in other countries.

### MenCare Campaign

MenCare is a global fatherhood campaign coordinated by Promundo and Sonke Gender Justice in collaboration with the MenEngage Alliance. The campaign aims to promote men's involvement in equitable, responsive, and non-violent fatherhood and caregiving, including safe childbirth. The campaign provides:

- community and mass media messages and adaptable resource materials including posters, manuals, and activity guides
- technical assistance and training on strategies to engage men as fathers
- policy and program recommendations for promoting men's involvement in fatherhood
- evidence on engaging men and boys in caregiving

These resources and technical assistance are provided to governments, local NGOs, women's rights groups and international organizations. The campaign also conducts research on men's participation and their role as fathers and caregivers.

MenCare pretests its campaign messages on fatherhood across different contexts and in multiple languages for use around the world. Local organizations work with MenCare to adapt campaign messages and communication strategies to their local context and setting. Some of the messages promoted through the campaign are: engaging men in prenatal care through childbirth, encouraging men to show affection to and play with their children, and engaging men in preventing violence against women and children.

An evaluation and results of the campaign are forthcoming.

### One Man Can Fatherhood Project

*One Man Can (OMC)* is a rights-based gender equality and health program in South Africa implemented by Sonke Gender Justice Network, a local organization that works to support men and boys in taking action to promote gender equality and improve SRH outcomes. The program seeks to encourage less violent, more communicative and more affectionate relationships with their partners and children, reduce the spread and impact of HIV and AIDS, and reduce violence against women, men and children. As part of the OMC program, the *OMC Fatherhood Project*, also known as the *Fatherhood and Child Security Project*, was developed and implemented in 2007-2009 to increase men's involvement in meeting the needs of children affected by HIV and AIDS. The OMC

Fatherhood Project worked with black South African men ages 18 and over, recruited through Sonke community partner organizations, in communities with high AIDS mortality.

The objectives of the project were to:

- increase men's involvement in the lives of their children and of other vulnerable children in their communities by ensuring their access to essential social services;
- develop men's capacity in efforts to eliminate violence against women and children, to prevent HIV, and to promote the health, care and support of orphans; and
- give voice to vulnerable children, by training and engaging them in advocacy to reduce sexual abuse, address HIV/AIDS, and improve refugee rights.

The project used focus group discussions to elicit attitudes and assumptions about men's roles and works with local NGOs and government officials to devise grassroots strategies to help men and boys prevent violence and respond to HIV. Sonke also trained partner organizations in using the *One Man Can* methodology.

The evaluation consisted of interviews with men six months after their participation in the program. Interviews focused on topics related to masculinities, gender roles and rights, violence, gender and HIV risk, alcohol, parenting, fatherhood and relationships. Results reported by adult participants include:

- being less violent and more caring and protective towards their children
- being a more present and positive role model in their children's lives
- improved communication with children
- using less corporal discipline with their children
- contributing more to household work
- encouraging their sons to share household tasks with their sisters and female partners

The OMC program is currently being implemented across South Africa, with funding from more than 20 organizations including the MacArthur Foundation, South Africa Development Fund, Oak Foundation, CARE, RFSU, UNFPA, UNHCR, and Save the Children.

## C. HIV/AIDS AND GENDER-BASED VIOLENCE PREVENTION

### CHAMPION

*Channeling Men's Positive Involvement in the National HIV/AIDS Response (CHAMPION)* is a five-year USAID-funded project implemented by EngenderHealth/Tanzania in collaboration with FHI360, local NGOs and the Government of Tanzania. *CHAMPION* seeks to promote men's participation in family healthcare and increase gender equity, in order to reduce vulnerability of men, women and children to HIV/AIDS and other adverse SRH outcomes. Specifically, the project aims to:

- Reduce men's high-risk behaviors
- Increase fidelity and reduce number of sexual partners
- Eliminate gender-based violence

- Increase men's participation in health services

*CHAMPION*'s strategy is based on an ecological model which involves working on the individual, community, healthcare system, workplace, and policy level in order to promote individual behavior change while transforming the environment that influences reproductive health demand, access and use. In the pilot sites of the project the innovation package includes the following:

- *Capacity building*: Training to promote male-friendly services, including clinical and non-clinical health workers, and community health workers, as well as supportive supervision
- *Advocacy*: Collaboration with national and district health management teams, including review of exiting MOH policies
- *Community engagement:* Community activities to promote services and address inequitable norms; service provision through outreach; and referrals
- *Facility improvements*: Billboards and other signs to direct and inform clients about the availability and timing of services; TVs and DVD players, condom dispensers; improved client flow
- *BCC materials and commodities*: Brochures and posters reach men with FP, condom use and PMTCT messages

Implementation of male-friendly health services is ongoing in the pilot sites. The evaluation will include qualitative and quantitative data from health facility observations, key informant interviews, client exit interviews, service statistics review and provider interviews. A baseline assessment was conducted in 2010 and an endline assessment is planned for 2013. However, preliminary results from pre-post intervention comparisons show an increase in men counseled, tested and receiving HIV test results and a decrease in the ratio of antenatal care (ANC) and prevention of mother-to-child transmission (PMTCT) clients to number of ANC/PMTCT male partners tested.

In relation to scale-up, the project has identified a variety of facilities that would assist in replicating the model, including dispensary-level and district hospitals in the public and private sector, as well as clinics managed by international NGOs. The project also has a strong advocacy component and MOH involvement. There are ongoing discussions with the MOH about national scale-up and policy implications.

### Men as Partners Program

The Men As Partners® (MAP) program (1996–ongoing), developed by EngenderHealth and implemented by country-based EngenderHealth programs, intends to transform inequitable gender norms and increase information and access related to SRH. It seeks to address men as *clients* (increasing their use of SRH services and their adoption of healthy behaviors for the benefit of themselves, their partners, and their communities); men as *supportive partners* (increasing men's positive engagement in the SRH of their partners) and men as *agents of change* (mobilizing men, women, and communities to take an active stand for gender equality and against GBV).

The program uses various approaches to address gender inequalities, including:

- Hosting interactive skills-building workshops with men to address inequitable gender norms and roles.
- Improving the capacity of health care facilities to provide men with quality care by training health professional to offer male-friendly services.
- Leading local and national public awareness campaigns using murals, street theater, rallies, and media.
- Advocating through national and international networks to create a global movement to promote a positive role for men in SRH and against violence.

For interactive workshops the program trains master trainers or facilitators to use *Engaging Boys and Men in Gender Transformation: the Group Education Manual*, a gender-transformative manual developed for the program. Activities include a variety of reflective and participatory sessions to improve knowledge, attitudes, and skills on topics such as gender and sexuality, male and female sexual health, HIV and other STIs, healthy relationships, and prevention of GBV. MAP also has manuals to train health care providers on *male-friendly health services* and to help men and women plan and carry out *community mobilization* activities to promote gender equality and health.

Evaluation results suggest that participation can lead to decreased violence over time and improved communication with partners about condom use and HIV risks. In Ethiopia, a quantitative evaluation of a MAP program showed that male participants reported decreased physical intimate partner violence, from 36% at pretest to 16% at posttest in Arm 1 (Group Education plus Community Engagement) and from 36% to 18% in Arm 2 (only Community Engagement) (Pulerwitz, J, et al., 2010). MAP activities have been adapted and used successfully by trainers around the world.

Recently, MAP has begun to work more frequently with men and women together in what is called "gender-synchronized" programming. This gender-synchronized programming builds on MAP methodologies and activities and seeks to promote gender equality and health among women and men. Examples include *Gender Matters* in Austin, Texas, *Couple Connect* in Tanzania, and *Together to End Domestic Violence* in Angola.

## D. Adolescent Programs

### Brief Curriculum to Promote Condom and Health Care Use among Out-of-School Young Adult Males

The John Hopkins School of Medicine, Bloomberg School of Public Health and the Baltimore City Health Department collaborated with a youth employment and training center, Youth Opportunities, to replicate a brief SRH intervention, previously offered in New York City, with young men in Baltimore. The intervention, funded by the U.S. DHHS, targeted predominantly African-American 16-24 year-olds, with the aim of improving knowledge of STIs, health care and health care use, attitudes towards safe-sex practices and promoting safer sexual behavior.

The intervention consisted of three-one hour sessions led by African-American male health educators and conducted immediately following classes the young men were participating in at the center. The sessions were offered consecutively over three days. The sessions, designed to be interactive, used a group discussion format along with audio-visual presentations on key concepts. The key topics covered by the sessions include:

1) STI prevention and transmission, links between STIs and HIV transmission, and STI symptoms
2) Correct use of condoms, ways to make condoms more pleasurable, pregnancy prevention and ways to assist partners in using emergency contraception
3) How men get examined in clinical visits, testing and treatment for chlamydia, and reinforcement of topics from previous sessions

The intervention evaluation used a quasi-experimental design which included structured questionnaires with men in control and intervention groups. Participants completed a self-administered questionnaire at baseline and at three months post-intervention they were interviewed in person or by phone. The evaluation measured knowledge about STIs and health care, and attitudes about condoms, sexual behavior, and health care use. Results show that the short intervention was successful in significantly increasing knowledge about STIs and health care and use of condoms, as well as improving use of health services (talking with providers and getting tested for STIs). However, no significant change was found in relation to attitudes about condoms (enjoying sex with a condom).

The evaluation of this intervention shows that a brief and affordable intervention such as this can be successfully replicated in similar settings. The intervention may also work in other settings where young men gather or may potentially be integrated into existing SRH curriculum for young men. The project's use of innovative low-cost approaches and brief intervention design may be feasible to take to scale.

### Gender Matters Project

EngenderHealth launched *Gender Matters (Gen.M)* in 2011 in Austin, Texas in a state with the third highest rate of teenage pregnancy in the country. *Gender Matters*, supported by the U.S. DHHS, is a five-year project testing a teen pregnancy prevention intervention focused on mostly African-American and Latino youth ages 14 to 16 with goals to delay age of first intercourse and increase contraceptive use, including correct condom use. The project is implemented through local organizations, including a summer youth employment program, and consists of three components:

1) A 20-hour gender-transformative educational workshop that provides comprehensive sexuality education over five days using pairs of male and female facilitators;
2) A social media strategy that includes a Facebook page and a four-month SMS text message campaign to reinforce messages about healthy behaviors and question harmful gender norms; messages;

3) A public screening of a twenty-minute documentary film using youth-generated video footage from *Gen.M* workshops to further underscore the key messages of the project.

*Gender Matters* aims to address social constructions of masculinity and femininity as key determinants for risky behavior that can lead to teenage pregnancy. The project works with both young men and women together in a 'synchronized' approach to help transform gender norms. Another innovation of the project is that it is designed and implemented with the combined expertise of a local GBV organization and an international SRH organization to provide a more holistic approach to prevention.

The project is being evaluated by Columbia University's Mailman School of Public Health and Mathematica Policy Research, Inc. The evaluation will assess behavioral outcomes related to sexual risk-taking and experiences of intimate partner violence and determine whether changes in gender-related attitudes are associated with behavioral change. Utilizing a randomized control study design, interviews will be conducted with youth in intervention and control groups six months and 18 months post-intervention. The evaluation will also include in-depth interviews with male and female participants and an assessment of participants' satisfaction with the program. Preliminary data from in-depth interviews shows positive results related to transforming gender norms.

### Parivartan Program

*Parivartan* is a Mumbai-based program to engage cricket coaches, mentors in schools, and the community to teach boys about controlling aggression, preventing violence, and promoting respect. The program, funded by the Nike Foundation, was designed after the *Coaching Boys into Men* program in the U.S. *Parivartan* is managed by the International Center for Research on Women (ICRW) along with Futures without Violence, and local sports associations and NGOs in India.

The program aims to accomplish the following:

- Raise awareness about abusive and disrespectful behavior;
- Promote gender-equitable, non-violent attitudes; and
- Teach boys skills to speak up and intervene when witnessing harmful and disrespectful behaviors.

Using a trainer of trainers approach, the program trains coaches and community mentors using a toolkit made up of a card series, a reference handbook and a diary. Trained coaches and community mentors then lead interactive sessions with athletes. The intervention also involves building the capacity of partner organizations in gender, communication and facilitation skills to support the coaches implementing the program.

The evaluation utilized a quasi-experimental design in each setting, with two arms: an intervention and a control group. The evaluation set out to evaluate changes in perceptions, attitudes and behaviors related to gender equity and GBV. The schools and community athletes in each of the study arms completed a survey at baseline and at follow-up (one year later). The coaches and mentors were also interviewed at baseline and follow-up. In addition, researchers interviewed

female relatives of the coaches and mentors to document perceived changes in the coaches and mentors' gender-related attitudes and behavior. Selected findings from the evaluation are listed below.

- Participants demonstrated a greater positive shift in gender attitudes than non-participants.
- Community athletes became significantly less supportive of physical abuse of girls, but changes in school athletes were not significant.
- Participants showed greater intention to intervene in response to hypothetical scenarios of abuse against girls.
- Community athletes reported a decline in sexually abusive behavior.

School coaches and mentors demonstrated increased support for gender-equitable roles and relationships and decreased acceptance of wife beating. Female relatives of coaches and mentors reported improvement in the men's gender-related attitudes and behaviors. Building on these promising results, along with lessons from global programs that use sports to address HIV/AIDS, ICRW is currently developing the new curriculum for *Parivartan+. Parivartan+* will incorporate components of SRH and HIV into the existing *Parivartan* model and will reach boys and girls in rural Karnataka and urban Mumbai.

### Project Connect-Baltimore

In 2012 the Johns Hopkins Bloomberg School of Public Health launched Project Connect in Baltimore, Maryland. The project, originally implemented in Los Angeles and considered a 'Best Practice' by the Centers for Disease Control (CDC), involved using a short-term intervention with health staff in school settings to increase uptake of SRH services, including FP, and HIV and STI testing. The intervention involves training on the use of a clinic provider guide specifically designed for the target communities.

In Baltimore the three-year CDC-funded project aims at increasing the proportion of sexually active African-American and Latino males and females aged 15-24, including young men who have sex with men, who receive quality SRH services inclusive of HIV and STI testing. The intervention is being adapted so that it is male-friendly and culturally appropriate.

Formative research was conducted to inform Project Connect Baltimore components and collect data for and develop the youth guide for print and online applications, as well as test a guide for implementation among youth-serving organizations and schools.

The original evaluation in Los Angeles was recently completed and final results are pending. Preliminary results point to the intervention being more effective with young women than young men. If the replication in Baltimore is successful, the project's use of innovative low-cost approaches and easily transferable technology may be feasible to take to scale.

### Program H

*Program H* was developed in 1999 by a group of Latin American NGOs, including coordinator Instituto Promundo. The program, originally implemented in Brazil and Mexico, focuses on helping young men ages 15 to 24 question traditional norms related to manhood and promote their abilities to discuss and reflect the disadvantages of inequitable gender attitudes and the advantages of gender equitable behaviors. The program's key components include group education activities and a lifestyle social marketing campaign carried out over weekly sessions over several months. Educational activities are guided by the *Program H* manual, which consists of 70 activities, carried out with small groups, including role plays, brainstorming exercises, discussion groups and individual reflections, as well as use of a theoretical framework and cartoon video to facilitate discussions. The themes of the manual include:

- SRH
- Violence and violence prevention, including GBV
- Reasoning and the ability to identify and control emotions, including communication skills and substance abuse
- Fatherhood and caring
- HIV/AIDS, including prevention and treatment

The second component, a campaign, relies on participants to design and implement activities in their communities to raise awareness about program messages through various mediums including billboards, t-shirts, street plays and dances.

Program effectiveness was measured after two years, and included development and use of the GEM scale. The evaluation consisted of interviews and discussions with facilitators, male participants and their partners, public health staff and members of youth-serving organizations as well as a household survey to measure community-level change. Evaluation results suggest that *Program H* positively influenced attitudes related to gender equality, including greater sensitivity to GBV, increased intention to use condoms, improved partner-negotiation skills and a greater desire to be an involved father.

*Program H* activities have been incorporated into programs and training activities in over 25 countries around the world. The program has both been replicated and integrated into relevant programs, including health, workforce and schools. *Program H* approaches were designed to be replicated at reasonable cost, and youth-serving organizations have found the program to be adaptable to their needs. Several organizations have translated the program manual and adapted the program to their local context, integrating components into existing activities or adding stand-alone activities. However, securing funds for these efforts has been an obstacle for some countries wishing to implement or scale up Program H. Offering the program widely through public school systems may be an option to scale the program, but fidelity to the original model may be difficult to maintain. A report on scaling up Program H is forthcoming.

### Young Men Initiative

CARE Northwest Balkans' *Young Men Initiative* (2007-2013) is designed to build more equitable attitudes and behaviors in order to decrease gendered and peer violence. The program was implemented by youth-serving organizations in Bosnia and Herzegovina, Croatia, and Serbia and from 2011 in Kosovo with 15-19 year-old men in technical schools.

CARE organized intensive trainings on gender and masculinities with leaders from youth-serving organizations who were to implement the program with young men. The intervention comprised of educational workshops and a lifestyles campaign carried out over a year. The design of the intervention is grounded in "gender conscious practice," which focuses on critical reflections about the ways society influences attitudes and behaviors and ways to develop skills to overcome harmful expectations. The 20 educational and interactive workshops, drawn largely from Promundo's Program H manual, promote critical and personal reflections on multiple topics including: gender norms, masculinities and health, sexual health, drug and alcohol use, peer violence and violence against women. The campaign, titled 'Be a Man', uses posters, t-shirts, brochures and social media (Facebook, Twitter and YouTube) to reinforce the messages from the workshops including condom promotion, violence prevention and more gender-equitable norms.

A quasi-experimental study design, with data collection at baseline and endline among an intervention and control group, was used to evaluate the program. The evaluation included self-administered interviews, which included items from the Gender Equitable Men (GEM) Scale. These surveys gathered information on health and well-being, gender roles, pregnancy and STI prevention, violence, sexual activity and participation in the campaign and programs. The evaluation also included in-depth interviews with program coordinators, school principals, guidance counselors, teachers and young men participating in the program on violence, sexual activity, reproductive health and drugs and alcohol, as well as obtaining feedback on the program. Results showed an increase in gender equitable attitudes, decreased use of violence and a strengthened sense of civic engagement.

The educational program and campaign has been scaling up since 2011 and is now implemented in over 90 settings in four countries by different consortia managed by the local partners and a national resource center (located within partners) established to promote work with young people to improve SRH, increase gender equality and prevent violence. Through accreditation by the Ministry for Education in Croatia, all secondary schools have been approved to use the program and educators have been trained to implement the program. A similar process is underway in Serbia, with accreditation expected by June. In addition, the methodology has been expanded into many communities through youth offices and NGOs in Serbia, Bosnia and Herzegovina. Donors have committed support to expand the program to Albania in late 2013, and Austrian NGO's have inquired about using the program resources and tools with diaspora youth.

Local ownership has empowered youth-serving organizations to continue program implementation and advocacy efforts. Research and evaluation is ongoing to address structural barriers to scaling up and expanding efforts to engage with boys and men to address inequitable gender norms. Local

partners have been invited to participate in government panels focused on youth and their health and well-being. CARE International and its partners are active in alliances to engage boys and men, including the first European consultative meeting in 2009 establishing MenEngage Europe (part of the global alliance).

# IV. SUMMARY OVERVIEW OF STRATEGIES, APPROACHES AND EVALUATION METHODS

There is a rich body of program experience related to engaging men in SRH, and the 19 programs reviewed here span a wide range of strategies, from lifestyle campaigns to male-friendly clinics. These approaches were implemented in a range of diverse country contexts, including four programs in Latin America, nine in Africa, two in Eastern Europe, five in Asia, and four in the United States. Several of the programs were implemented in more than one country. The focus of this review is on programs which sought to increase male involvement in FP, but a number of initiatives with related objectives were chosen, including programs which addressed HIV/STIs, GBV, gender norms, couple communication, MCH and fatherhood. Table 1 presents the programs organized by thematic focus. It is interesting to note that most programs addressed multiple topics, for example, many simultaneously addressed gender, FP, HIV/STIs and GBV.

Table 1 **Male Involvement Programs by Thematic Focus**

| | Gender Norms | Couple Communication | Gender-based Violence | Family Planning | HIV/ STIs | MCH/ Father-hood |
|---|---|---|---|---|---|---|
| C-Change | X | X | | X | X | |
| CHAMPION | | | X | X | X | X |
| CHPS | | | | X | X | X |
| Clinic Café Timor | | | X | X | X | X |
| Curriculum on Condom/ Health Care | | | | X | X | |
| FAM Project | | X | | X | | |
| Gender Matters | X | | X | X | X | |
| HealthBridge | X | | X | X | X | |
| Husbands' Schools | | X | | X | X | X |
| Male Motivators | X | X | | X | | |
| Male RH Project | | | | X | X | |
| Men As Partners | X | | X | X | X | |

| | | | | | | |
|---|---|---|---|---|---|---|
| MenCare | | | X | | | X |
| One Man Can | X | X | X | | X | X |
| Parivartan | X | | X | | | |
| Program H | X | | X | X | X | X |
| Project Connect – Baltimore | | | | | X | |
| Tékponon Jikuagou | X | X | | X | | |
| Young Men's Initiative | X | | X | X | X | |

## PROGRAM STRATEGIES

Figure 1 presents the distribution of the programs by their primary strategy, although a number used a combination of approaches. While some programs explicitly sought to increase men's knowledge or improve their attitudes and behavior, others did not. Rather they implemented interventions to engage men in order to meet their broader goals. An example of this is the Fertility Awareness-based Methods (FAM) Project, which sought to expand FP choices, but identified the need to positively engage men in in order to reach their project objectives.

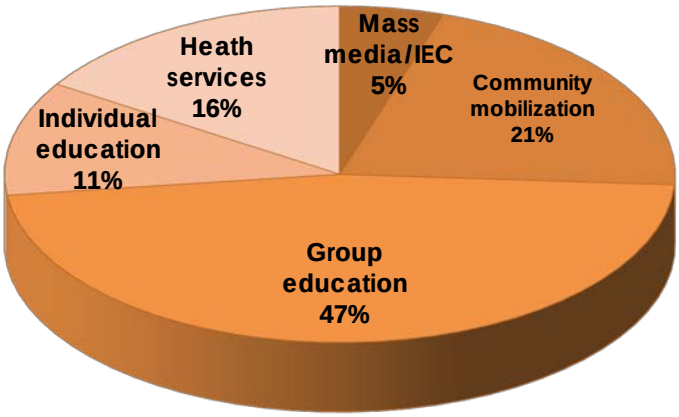


Figure 1 **Key Strategies of Male Involvement Interventions (n=19)**

The most common approach was group education sessions (13), including peer-or facilitator-led education and interactive workshops (*TJ, Male Motivator Program, Clinic Café Timor Initiative, C-Change Project, Husbands' Schools Initiative, One Man Can Fatherhood Project, CHAMPION, Men as Partners Program, Brief Curriculum to Promote Condom and Health Care Use, Young Men Initiative, Gender Matters Project, Program H, and Parivartan*). These sessions usually included not only educational content, but opportunities for critical reflection and discussion, as well as skills-building. Community mobilization was the second most common strategy, illustrated by CHPS and Men as Partners. A number of programs referenced social networks in their program description. *TJ,* for example, explicitly works through social networks to catalyze reflection on the influence of gender on family decisions and FP. Other organizations mobilized social networks through a combination of community group discussions, local government engagement and advocacy (*HealthBridge* and *CHAMPION*). Service delivery strategies were less common, and frequent in U.S. settings. These approaches sought to increase male utilization of services by outreach efforts,

promoting male- or couple- friendly clinic environments and building the capacity of staff to work with men and offering male/couple methods. About ten percent of the programs used individual education and interpersonal communication approaches such as the *Male Motivator Program* and *the Community-based Health Planning and Services (CHPS) Initiative*. Male motivators worked one-on-one with men in their communities providing information, motivating positive attitudes and encouraging healthy behaviors, while *CHPS* staff recruited male volunteers to support local nurses with education, counseling and distribution of FP methods. Communication campaigns were used by five percent of the programs reviewed and utilized a variety of media depending on the context, such as radio, billboards, social media and street theater.

Many of the experiences reviewed here applied an ecological approach, using multiple strategies to engage men and the social networks and structures that support them. In most cases implementing organizations used group education to educate, motivate and build skills along with a communication or mass media approach to reinforce these messages and create a supportive environment for change. However, some projects, such as *CHAMPION* and *HealthBridge*, took more comprehensive approaches utilizing ecological approaches to address the individual, social and environmental levels. For example, *CHAMPION* engaged men and women through community activities that promoted health services and addressed existing inequitable gender norms, while providers received training to build their capacity to work with men and communication and BCC activities reinforced key messages. In the case of *HealthBridge*, men and women were reached through community activities (women's and men's groups), members of government, NGOs and the media were oriented on gender equality and the importance of engaging men, and a public awareness campaign was implemented to promote key messages. Both projects advocated with local, state or national authorities to integrate or sustain components of their interventions.

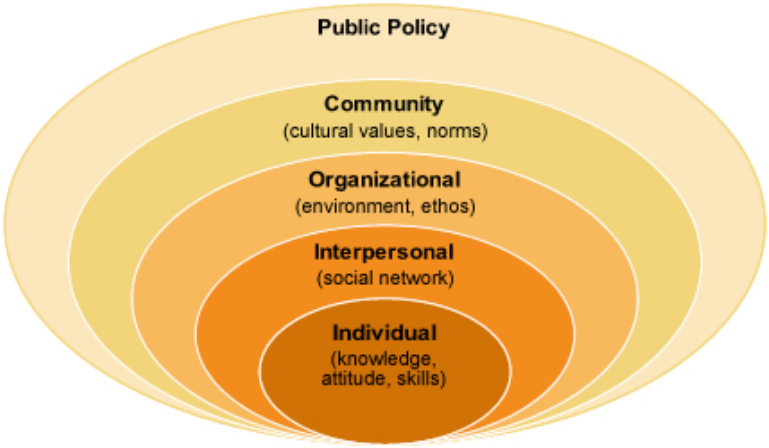


Figure 2 **Social Ecological Model**

There has been much discussion of the comparative benefits of targeting men, women or couples; in fact much existing evidence on the benefits of engaging men comes from couple-focused programs. About half of the programs reviewed focused on men (either youth or adults), while the remainder targeted both men and women separately or jointly. Only two projects, C-Change and FAM, targeted couples.

Table 2 **Interventions by Target Audience**

| Men-only | Men and women (separately and jointly) | Couples |
|---|---|---|
| Male Motivators | Tékponon Jikuagou | FAM Project |
| Clinic Café Timor | CHPS | C-Change |
| Male RH Project | | |
| Husbands' Schools | HealthBridge | |
| MenCare | CHAMPION | |
| One Man Can | Men As Partners | |
| Curriculum to Promote Condom/Health Care Use | Gender Matters | |
| Young Men's Initiative | Project Connect-Baltimore | |
| Program H | | |
| Parivartan | | |

Interventions which focused solely on men used the following approaches: 1) role models to encourage healthy behavior; 2) opportunities in a male-only setting for men to learn, reflect and build their skills; and 3) diffusion of positive messages and images of men. Programs that worked with both men and women are more difficult to categorize. Most worked with men and women separately, for example, holding men-only and women-only activities simultaneously. Two projects, however, C-Change and FAM, targeted couples with joint and separate activities. C-Change's *Interactive Workshops* included six sessions: two offered to men only, two to women only and the final two attended by couples. The FAM Project included capacity building for providers to improve their ability to counsel men and to address couple issues related to FP use while counseling women, and also conducted communication campaigns, such as radio programs and street theatre to reach men with FP information.

## EVALUATION APPROACHES

While a systematic examination of the effectiveness and level of evidence of the programs reviewed here is beyond the scope of this briefing paper, it is useful to consider the evaluation designs and indicators used to assess their effects. Several of the programs described here are ongoing and have yet to be evaluated; for others, data is unavailable at this time. Not all of the programs reviewed were conducted as research projects, and most had limited funds for evaluation, thus evaluation rigor varied widely. The most common design was a pre and posttest assessment with a comparison group, used/planned by seven of the 19 interventions reviewed.

Table 3 **Planned/Completed Evaluation Designs of MI Interventions**

| | Post-test only | Pre/ Post-test | Comparison group | Follow-up | Qualitative |
|---|---|---|---|---|---|
| C-Change | | X | X | X | |
| CHAMPION | | X | | X | X |
| CHPS | | | X | | |
| Clinic Café Timor | X | | | | X |
| Curriculum on Condom/Health Care | | X | X | X | |
| FAM Project | | X | | | X |
| Gender Matters | | X | X | X | X |
| HealthBridge | | X | | | |
| Husbands' Schools | | | - Not available - | | |
| Male Motivators | | X | X | | X |
| Male RH Project | | | X | | |
| Men As Partners | | X | | X | X |
| MenCare | | | - Not available - | | |
| One Man Can | X | | | | |
| Parivartan | | X | X | X | X |
| Program H | | X | X | | |
| Project Connect – Baltimore | | | - Not available - | | |
| Tékponon Jikuagou | | X | X | | X |
| Young Men's Initiative | | X | X | | X |

Standard questions measuring couple communication and decision-making, violence and women's empowerment, such as those used in the DHS, were incorporated in surveys in several evaluations, for example the baseline and endline household surveys for FAM. A number of programs also relied on health service statistics to assess change in utilization of services such as FP, HIV/STI testing and pre/postnatal visits, among others.

Scales were used in several of the evaluations to assess changes in gender norms as a result of the intervention. The *Young Men Initiative*, *Parivartan* and *Program H* used the Gender Equitable Men (GEM) Scale, developed by Instituto Promundo. The GEM scale was designed to provide information about prevailing gender norms in a community as well as the effectiveness of a program that aimed at influencing them. The scale, which includes 24 items, is grounded in formative, qualitative research on gender norms with young men in low-income settings in Rio de Janeiro (Pulerwitz & Barker, 2008). Additionally, FHI 360 developed the Gender and Family Planning (GAFP) Scale, which contains 20 items (three of them from the GEM Scale) to measure gender attitudes and contraceptive use during their research in Guatemala and Tanzania (Schuler and Ramirez, 2001).

Best practice in evaluation of male involvement interventions is to conduct interviews with female partners to triangulate changes reported by men. For example, as part of the evaluation of Parivartan, the wives of coaches who worked with youth were interviewed about their partners and any changes they may have noticed since their participation in the program. This was the case in several programs, such as Male Motivators and Program H.

Many of the programs incorporated qualitative methods to understand the process and results of their interventions and to obtain feedback from participants on the program. A number also interviewed key informants in schools, health systems or the communities where the interventions took place. A handful conducted interviews with program facilitators to gauge their thoughts on the implementation process and ideas for its improvement.

A wide variety of indicators were used ranging from knowledge, individual attitudes and social norms, to service utilization and behaviors and ultimately, health outcomes. Appendix B presents a list of the indicators identified during the review.

Commonly used evaluation indicators included:

- Improved knowledge of FP, STIs, HIV/AIDs;
- More equitable gender norms, decreased acceptance of violence, greater acceptance of FP;
- Decreased self-reported use of physical, sexual and psychological violence in intimate relationships and corporal punishment;
- Increased communication with spouse or partner about child health, contraception and reproductive decision-making;
- Increased utilization of SRH services, including FP, HIV/STI testing, male clinic visits or accompanying wife/child to antenatal care;
- Increased contraceptive use, including condoms;
- Decreased rates of STIs; and
- Increased participation in the care and support of children, including seeking care for maternal, newborn and child health services.

# V. FRAMING THE CONSULTATION: SCALING UP PROMISING PRACTICES

This upcoming technical consultation will provide a valuable opportunity for male involvement and gender transformation experts to take stock of work being done in the field, discuss openly the successes and challenges of their work in a supportive environment, and work collectively to advance efforts to engage men in FP. As one interview participant stated, “I want to feel solidarity, a part of something bigger. It helps to make you feel that you are making an important contribution.” During the in-depth interviews conducted in preparation for the consultation, respondents identified a list of priority topics for a learning agenda in male involvement programming, Topics included identification of what has and has not worked, challenges experienced, and results from

going to scale. Issues related to program design were also flagged, including effective pedagogies, addressing psychosocial determinants, elements of gender transformative male involvement programs, and how to maintain fidelity when scaling up. A complete list of the topics and research questions identified by respondents is included in Appendix C. Interview participants proposed a range of products which would inform the field, from advocacy briefs to webinars and journal supplements. The results of this meeting have the potential to contribute to their development.

The focus of this consultation is squarely on scale-up, an issue mentioned frequently during the interviews, and participants will consider topics such as definition of key components of the intervention package, feasibility of scaling up male involvement programs, and whether sufficient evidence exists to demonstrate impact. When considering the topic of scale-up, a frequent question is "How do we define scale?" or "What does 'scaled up' imply?" Scale-up can be described as,

> "Deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and program development on a lasting basis." (ExpandNet, 2009).

### THE PROPOSED CONSULTATION OUTCOMES

- Practical, how-to guide for program and scale-up approaches
- Advocacy brief articulating the case for investment in developing better practices and scaling up initiatives
- A survey of groups working with men and FP
- Promoting successful initiatives and consultation findings through webinars, Father's Day events or auxiliary meetings at conferences
- Comparative case study of 3-5 male involvement initiatives to gain understanding of key factors making initiatives successful at scale
- Supplement in a journal such as "State of the Field," or a short "Review of the Evidence" answering the questions: Which male involvement programs have been scaled up? Where? To what effect?

Note the key elements of this definition: planned efforts and successfully tested innovations, which benefit more people and are sustained over time. Keeping in mind this definition, could we consider any of the programs described here as "brought to scale"? A good number of the programs reviewed have been replicated or expanded, from efforts to provide an intervention nationally through the MOH to country-based replication of programs across continents. For example:

- *Program H* has been replicated in more than 25 countries, while the *Male Motivators* program was replicated in four countries at small scale.
- *CHAMPION* was implemented at the national level in Tanzania, has identified facilities interested in replicating the model and is engaging in conversations with the MOH about national scale-up.
- FAM male involvement approaches were scaled up nationally in Rwanda, Democratic Republic of Congo, and at the state/regional level in India and Guatemala.
- The *Men as Partners Program (MAP*) has been implemented by country-based programs around the world since 1996.

- A U.S. clinic testing strategies to increase male utilization of services has continued the intervention with its own funding.
- Some projects, such as *HealthBridge*, arrived at the moment of discussing scale-up when shifting donor priorities derailed momentum.

The ExpandNet (2009) framework for scaling up provides a systematic, evidence-based and rights-oriented approach to frame discussion on the expansion of male involvement interventions. It lays out five systems elements to take into consideration when planning to implement an innovation on a large scale: the environment, the innovation, the resource team, the user organization and the scaling up strategy. The environment refers to conditions and institutions which will affect prospects for scaling up but are external to organizations seeking to expand the innovation (user organization). The resource team refers to individuals and organizations that wish to promote an innovation. Finally, the scaling-up strategy refers to the plans and actions needed to fully establish the innovation in policies, programs and service delivery.

DETERMINING
**INNOVATION**
SCALABILITY

1. What are key elements of the male involvement interventions?
2. What are costs/resource requirements?
3. Is there sufficient evidence suggesting the practice is effective and feasible?
4. Is the innovation scalable?

We can begin by discussing the male involvement innovation. The innovation refers to service components, practices or products that are new or perceived as new. Typically the innovation consists of a set of interventions which include not only the new practice (e.g. interactive workshops), but also the managerial processes necessary for successful implementation. Interventions poised for expansion must be supported by evidence of their effectiveness and feasibility obtained either through pilot, demonstration or experimental projects or through initial introduction in a limited number of local sites. A clear understanding of the innovation is a prerequisite for scale-up. Without this understanding, it will be impossible to advocate for, implement with fidelity or measure the impact of large-scale implementation. While a number of common approaches emerged from the interventions discussed here – such as gender transformation, gender synchronization/harmonization, a holistic approach addressing individual and social structures and men as protagonists rather than simply partners – we have yet to establish a specific definition of the practice of male involvement in FP/SRH programs.

Decades of research on the diffusion of innovations and implementation research has shown that innovations with certain attributes are most likely to be successfully expanded (ExpandNet 2009). Scalable innovations are based on sound evidence and/or advocated by respected persons or institutions. In addition, potential users can see the results in practice, and find the innovation relevant for addressing their problems. Scalable innovations have a relative advantage over existing practices, are easy to install and understand, and are compatible with potential user's values, norms, and facilities. Finally, they can be tested at small scale so that potential users can see its benefits prior to large-scale adoption.

In working towards identification of scalable male involvement strategies, consultation participants must carefully reflect on experiences to date. Which programs were expanded or replicated? Why have some been expanded while others have not? Why haven't a greater number of successful pilot male involvement programs been scaled up? Discussion during the consultation will seek to identify effective, acceptable and feasible program elements for expansion, and reflect on their scalability vis-à-vis cost and resource requirements, and the possibility of integrating them into existing structures.

Once developed, evidence of the effectiveness and scalability of male involvement initiatives becomes imperative: how effective is this intervention in achieving our desired outcomes? Can this intervention be implemented at scale with the resources likely to be available? The 19 programs reviewed here discuss a variety of approaches and objectives, and there are varying levels of evidence available on each. Evidence is needed to guide both programs and advocacy toward for greatest impact. A conversation on what is needed – more research? different types of research? better sharing and synthesizing of results? – will prioritize efforts to fill knowledge gaps.

Finally, while the consultation will focus primarily on lessons learned from pilot programs, it is also worthwhile considering the scale-up strategy. Once we are confident that we have well-defined, scalable innovations with evidence of success, we must consider how we will take them to scale. Scale-up requires support and strong partnerships beyond the technical skills and understandings discussed here, and such partnerships are more likely if there is cohesion among the key players in the field.

### EXAMINING THE EVIDENCE BASE

1. The pilot-to-scale process: have male involvement initiatives been conducted with the "end in mind", meaning with the resources that can be expected when implemented at scale?
2. Are current indicators adequate? Are evaluation designs sufficiently rigorous?
3. What else is needed to develop a strong and persuasive evidence base? (e.g. longitudinal studies, measurement of health outputs, triangulation of change, robust measurement of gender norms and gender-based violence.

### DEFINING THE SCALE UP STRATEGY

1. What is the 'end point" or goal of scale up? Over what time period?
2. Who will roll out the interventions?
3. Who will serve as the resource team to support scale up?
4. How will this effort be resourced?
5. How well have we done so far to get donors and other stakeholders on board? What more can we do to engage them?

*A concluding reflection*. By the end of the consultation, we expect there will be clearer thinking on the kinds of male involvement innovations that are feasible to take to scale and should lead to desired impacts, as well as a proposed agenda of next steps to widely expand male involvement in SRH.

# REFERENCES


Awoonor-Williams, J.K., Vaughan-Smith, M., Phillips, J. (2010). Scaling up health system innovations at the community level: A case-study of the Ghana experience. *Social determinants of sexual and reproductive health: informing future research and programme implementation*. Geneva, Switzerland, World Health Organization [WHO]. 51-69.

Barker, G., et al. (2007). Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. World Health Organization [WHO]. http://www.who.int/gender/documents/Engaging_men_boys.pdf

Becker, S. (1996). Couples and Reproductive Health: A Review of Couple Studies. *Studies in FP* 27(6), 291-306.

California HIV/AIDS Research Program. (2007). Intervention Details: Project Connect. Retrieved from http://choicehiv.org/interventions/interventions

CARE International. (2012). *The Young Men Initiative: Engaging young men in the Western Balkans in gender equality and violence prevention: A Case Study.* Banja Luka, BiH: CARE International.

Das M., Ghosh S., Miller E., O'Conner B., Verma R. (2012) *Engaging Coaches and Athletes in Fostering Gender Equity: Findings from the Parivartan Program in Mumbai, India.* New Delhi: ICRW & Futures Without Violence.

El-Bassel, N., Witte, S.S., Gilbert, L., Wu, E., Chang, M., Hill, J., & Stinglass, P. The Efficacy of a Relationship-Based HIV/STD Prevention Program for Heterosexual Couples. *American Journal of Public Health*, 93(6), 963-969.

EngenderHealth. (2005). CHAMPION Project. Retrieved from http://www.engenderhealth.org/our-work/major-projects/champion.php

EngenderHealth. (2005). Men as Partners. Retrieved from http://www.engenderhealth.org/our-work/gender/men-as-partners.php.

EngenderHealth. (2011). Gender Matters. Retrieved from http://www.engenderhealth.org/our-work/major-projects/gender-matters.php.

ExpandNet. (2009). *Practical guidance for scaling up health service innovations.* Retrieved from http://www.expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf.

Fine, D., Rink, E., Johnson, D., Goldenkranz, S., Carlon, A., Aravelo, A. (2012). *Male Reproductive Health Project: The impact of clinic and staff interventions on male client volume and STI testing.* Cardea: Seattle, WA.

Glaser, B., Strauss, A. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine.

Greene, M., and Barker, G. (2010). *Masculinity and Its Public Health Implications for SRH and HIV Prevention.* In R. Parker and M. Sommer (Eds.), *Routledge Handbook of Global Public Health* (199-207). New York: Routledge.

Greene, M., and Levack, A. (2010). *A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations.* Population Reference Bureau, Washington, DC: Interagency Gender Working Group.

Hartmann, M., Gilles, K., Shattuck, D., Kerner, B., Guest, G. (2012). Changes in Couples' Communication as a Result of Male-Involvement Family Planning Intervention. *Journal of Health Communication: International Perspectives,* 17(7), 802-819.

Institute for Reproductive Health, Georgetown University. (2012). *Project Toto Jan: Addressing Unmet Need for Family Planning, Annual Progress Report.* IRH: Washington, DC.

Institute for Reproductive Health, Georgetown University. (2012). Tékponon Jikuagou, Benin. Retrieved from http://www.irh.org/?q=content/terikunda-jekulu-project.

Instituto Promundo. (2012). *Program H|M|D 10th Anniversary Reflection Report.* Rio de Janeiro: Floss, A.

Jacobsen, R and Jose, H. (2012). Working with men to improve reproductive health in Timor-Leste: Report on the evaluation of Clinic Café Timor and FP NSW's men's health project in Ermera.

Jacobsen, R., and Jose, H. (2012). *Working with men to improve reproductive health in Timor L'este: Report on the evaluation of Clinic Café Timor and Family Planning NSW's men's health project in Ermera.* Cooperative Café Timor: Timor L'este.

Kraft, J.M., S.M. Harvey, S. Thorburn, J.T. Henerson, S.F. Posner and C. Galavotti. 2007. Intervening with Couples: Assessing Contraceptive Outcomes in a Randomized Pregnancy and HIV/STD Risk Reduction Intervention Trial. *Women's Health Issues* 17(1), 52-60.

Levack, A. *Gen.M: Gender Matters* [PowerPoint slides]. Retrieved from personal correspondance.

Lundgren, R., J. Cachan, and V. Jennings. 2012. Engaging Men in FP Services Delivery: Experiences Introducing the Standard Days Method. *World Health & Population* 14(1), 44-51.

MacDonald, L., Jones, L., Thomas, P., Thu, L.T., FitzGerald, S., Efoymson, D. (2013). Promoting male involvement in family planning in Vietnam and India: HealthBridge experience, *Gender & Development,* 21(1), 31-45.

Marcell, A. V. (2012). Project Connect Baltimore Summary. Retrieved from http://www.jhsph.edu/faculty/research/search/results/project/8391.

Marcell, A. V., Allan, E., Clay, E. A., Watson, C., & Sonenstein, F. L. 2013. Effectiveness of a Brief Curriculum to Promote Condom and Health Care Use Among Out-of-School Young Adult Males. *Perspectives on Sexual and Reproductive Health,* 45(1), 33-40.

Massawe, S.N. and Kakoko, D.C.V. *Channeling Men's Positive Involvement in the National HIV/AIDS Response (CHAMPION) Project: Health Facility Needs Assessment for Male-Friendly Services in Tanzania.* Retrieved from personal correspondence. EngenderHealth.

Mtui, R.K. *Male-Friendly Health Facilities Can Attract Men! Experiences from the CHAMPION Project* [PowerPoint slides]. Retreived from personal correspondence.

Promundo, Sonke Gender Justice Network. (2012). *MenCare: A Global Fatherhood Campaign.* MenEngage Alliance. http://www.men-care.org/

Pulerwitz, J., and Barker, G. 2008. Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM Scale. *Men and Masculinities* 10, 322–338.

Pulerwitz, J., Martin, S., Mehta, M., et al. (2010). *Promoting Gender Equity for HIV and Violence Prevention: Results from the Male Norms Initiative Evaluation in Ethiopia.* Washington, DC: PATH. http://www.path.org/publications/files/GVR_gen_eq_eth_rpt.pdf

Schuler, S.R., and Ramirez, L.F. (2012). *Interactive Workshops to Promote Gender Equity and Family Planning in Rural Guatemalan Communities: Results of a Field Test.* Washington, DC: C-Change/FHI 360.

UNFPA. (2011). *Niger – Husbands' schools seek to get men actively involved in reproductive health.* Retrieved from http://niger.unfpa.org/docs/SiteRep/Ecole%20des%20maris.pdf.

UNFPA. (2011). *'School for Husbands' Encourages Nigerien Men to Improve the Health of Their Families.* Retrieved from http://www.unfpa.org/public/home/news/pid/7542.

van den Berg, W., Hendricks, L., Hatcher, A., Peacock, D., Godana, P., Dworkin, S. (2013). 'One Man Can': shifts in fatherhood beliefs and parenting practices following a gender-transformative programme in Eastern Cape, South Africa. *Gender & Development*, 21(1), 111-125.

Varga CA. How gender roles influence sexual and reproductive health among South African adolescents. (2013) *Studies in Family Planning*, 34(3): 160-172.

# APPENDIX A: Key Informants

John Crownover
Programme Advisor, CARE International in NW Balkans
Young Men's Initiative

Laurette Cucuzza,
Senior Reproductive Health Advisor, Plan International
Terikunda Jékulu Project

Charlotte Feldman Jacobs
Program Director, Gender, Population Reference Bureau
C-Change

David Johnson
Public Health Advisor, Office of Population Affairs/Department of Health and Human Services
Male Reproductive Health Project

Bradley Kerner
Adolescent Reproductive Health Advisor, Save the Children
Male Motivators

Andrew Levack
Director of U.S. Programs, EngenderHealth
Gender Matters

Manjula Lusti-Narasimhan
Scientist, HIV and Sexual and Reproductive Health Department of Reproductive Health and Research, WHO

Eric Ramirez Ferrero
Secretary General, Norwegian Afghanistan Committee

Lisa MacDonald
Project Manager, HealthBridge
HealthBridge

Arik Marcell
Assistant Professor, Johns Hopkins University
Project Connect Baltimore, Effectiveness of a Brief Curriculum to Promote Condom and Health Care Use Among Out-of-School Young Adult Males

James Philips
Professor, Columbia University's Heilbrunn Department of Population and Family Health
Community Health and Family Planning Project

Lori Rolleri
Independent Public Health Consultant
Men as Partners

Jane Schueller
Chief of Party: CHAMPION Project, EngenderHealth
CHAMPION Project

Tim Shand, Sonke Gender Justice
International Programmes Coordinator, Sonke Gender Justice Network
One Man Can

Leyla Sharafi
Technical Specialist for Gender Equality Issues, UNFPA
Husbands' Schools Initiative

Fabio Verani
Technical Advisor Gender/MAP, EngenderHealth
Men as Partners

Joseph Vess
Senior Program Officer, Promundo
MenCare, Program H

Ann Warner
Senior Gender and Youth Specialist, ICRW
Parivartan

Ross Brandon
Head of Project, Clinic Café Timor
Clinic Café Timor

Sidney Schuler
Senior Advisor for Research and Gender, FHI360
C-Change

# APPENDIX B: Evaluation Indicators from Projects Reviewed by SRH Theme

| | KNOWLEDGE | INDIVIDUAL ATTITUDES | SOCIAL NORMS | SERVICE UTILIZATION | BEHAVIORS | HEALTH OUTCOMES |
|---|---|---|---|---|---|---|
| Family Planning | • Increased knowledge of FP and methods | • Increase self-use efficacy in FP<br>• Decrease male opposition to FP<br>• Increase couple concordance re: FP use<br>• Decrease desired fertility | • Decrease FP stigma | • Increase HIV/STI testing<br>• Increase purchase of condoms<br>• Increase CHW training and capacity<br>• Increase men seeking information about FP | • Increase couple communication about FP<br>• Increase uptake and continued use of FP<br>• Increase male involvement in FP | • Decrease abortion<br>• Decrease unmet need for FP<br>• Decrease teen pregnancy<br>• Delay first sex |
| STIs/HIV | • Increased knowledge of STIs, HIV/AIDS, and avoidance | | • Increase community mobilization to prevent STIs/HIV | • Increase CHW training and capacity<br>• Increase gynecological visits by women<br>• Increase male clinic visits<br>• Increase HIV/STI testing | Increase male involvement in PMTCT | • Decrease chlamydia, STI positive results<br>• Decrease HIV test positive results |
| Gender and Couple Issues | • Increase awareness of gender norms and stereotypes<br>• Increase sharing and exchange of gender issues knowledge between organizations | • Increase support for more gender equitable relationships<br>• Increase empathy | • Increase reflection on gender norms<br>• Increase gender equitable attitudes | • Increase CHW training and capacity to work with men | • Increase shared decision-making | |
| Gender-based Violence | • Increase awareness of GBV health services and outcomes | • Decrease belief in defending one's honor/ disciplining through violence | • Increase community mobilization to stop GBV | • Increase uptake of GBV health services | • Decrease GBV<br>• Increase nonviolent conflict resolution | • Decrease GBV |
| Maternal and Child Health | | • Increase demand for MCH services | | • Increase access and use of MCH services | • Increase male involvement in antenatal care | • Decrease maternal and child mortality |
| Fatherhood | • Increase knowledge of nonviolent discipline techniques | • Increase positive fatherhood attitudes | | | • Decrease corporal punishment<br>• Increase positive communication between fathers and children<br>• Increase men's involvement in lives of their children | |

# APPENDIX C: Learning Agenda for Male Involvement in Family Planning Proposed during Key Informant Interviews

| | |
|---|---|
| GENDER-BASED VIOLENCE | • Identify the key determinants of intimate partner violence among men, such as witnessing gender-based violence as a child, alcohol abuse, rigid traditional gender norms, and desire for control, inability to empathize or lack of conflict resolution skills. How can programs address these determinants within the context of health services? How can they be addressed with younger men through gender transformative approaches?<br>• How can we advance better measures to assess changes in gender-based violence over time to inform the development of interventions for specific groups? |
| GENDER TRANSFORMATIVE APPROACHES | • Gain a better understanding of the broader gender norms at play in different contexts, and how those norms combine with other social and cultural factors to influence the effectiveness of male involvement initiatives.<br>• Can programs integrate gender transformative approaches that lead to joint decision-making within couples, better overall communication within couples and marital harmony? |
| APPROACHES WHICH INVOLVE MEN AND EMPOWER WOMEN | • Which approaches are most effective for involving men in SRH, and while also empowering women?<br>• What are the advantages/disadvantages of gender transformative approaches versus gender synchronization or gender harmonization strategies?<br>• Which have greater potential to go to scale? Can working with men and women be more effective and make more sense to scale-up? |
| SUPPORTIVE POLICY AND FRAMEWORKS | • What is the role of supportive national policies and frameworks to promote gender equity? How can policies be improved and resources mobilized for this work? |
| MARKETING SRH SERVICES TO MEN | • Better evidence and practices are needed for providing male-friendly services. How can systems be adapted for men (e.g. billing, HMIS) in services designed for women's needs?<br>• What are effective ways to market preventative care to men? |
| IMPROVING COUPLE COMMUNICATION AND RELATIONSHIPS | • What is the effect of women-only or men-only programs on the couple relationship?<br>• Does economic empowerment of women, for example involvement in a savings and loan groups, have an impact on their spousal relationships, intimate partner violence, communication, and household decision-making? |
| LEVERAGING FATHERHOOD | • How can programs leverage the father-child relationship to model positive gender norms, gain men's support for their children's education, and influence reproductive health outcomes? |