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Couples Counseling in Reproductive Health: A Review of the Literature

Institute for Reproductive Health, Georgetown University



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LIST OF ACRONYMS AND KEY PHRASES

CVCT	Couples Voluntary Counseling and Testing
FA	Fertility Awareness
FACT Project	Fertility Awareness for Community Transformation
FAM	Fertility Awareness-based Methods
FP	Family Planning
ICDP	International Conference on Population and Development
IEC	Information, Education, and Communication
IPV	Intimate Partner Violence
IRH	Institute for Reproductive Health
LARCs	Long-Term Acting Reversible Methods
MCH	Maternal and Child Health
RCT	Randomized Control Trial
RH	Reproductive Health
SBC	Social and Behavior Change
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VCT	Voluntary Counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

Objective

To identify and synthesize couples counseling interventions with an emphasis on reproductive health (RH) outcomes, in order to facilitate future operationalization and guideline development in couples counseling for the family planning (FP) field.

Methods

This systematic review of peer-reviewed publications and grey literature from 1990 to 2016 utilized several search engines to identify 5,321 publications. A paper was deemed eligible for review if it met the following criteria: intervened with both members of the couple pair; described a systematic evaluation design (i.e.; experimental, quasi-experimental, or non-experimental), and; reported at least one effective RH primary or secondary outcome (FP, HIV/AIDS, maternal and child health [MCH] and/or; abortion and post-abortion care). Applying these criteria resulted in 41 couples counseling interventions being included in this review.

Results

The 41 interventions came from high, middle, to low-income countries and addressed a range of RH topics: 23 focused on HIV, 14 on FP, two on MCH, and two on post/abortion care. The majority of interventions were conducted in health facilities. Others involved community outreach activities, home-based counseling, or workplace engagement. The included interventions highlighted the diversity of couples counseling approaches, varying from couples-based (couples counseled together) to couples-focused (partners counseled separately) approaches. In general, improved FP outcomes as a result of couples counseling include:

1. **Improved contraceptive use.** Increased adoption and continuation of contraception (including post-partum), in addition to increased birth spacing. Reduced pregnancy incidence was also reported by one of the papers (Wall et al. 2013).
2. **Improved couple communication and partner support for FP.** Increased couple communication about FP, partner support for FP, improved decision-making about FP, and positive attitudes toward FP methods.
3. **Improved knowledge about fertility and FP.** Increased knowledge about fertility, FP, pregnancy, and condom use.
4. **Increased male outreach and participation in counseling services.** Increased uptake of couples counseling services and men accompanying women to post-partum and general health clinic visits.

Discussion

The literature review results highlight three programmatic implications:

1. A diversity of couples counseling definitions and approaches exists, and operationalizing a common definition and framework is needed.
2. Effective couples counseling approaches vary greatly in the intensity and depth in which they addressed gender and power dynamics, couple communication, and intimacy. Identifying most effective elements for addressing gender should be a next step.

3. Few studies describe outreach strategies to increase men's participation in counseling services. Much more evidence is needed, particularly for the FP context.

This report provides preliminary programmatic recommendations to address these three key findings, including the operationalization of couples counseling principles and guidelines. Next steps include convening a technical expert consultation meeting with key FP and couples counseling experts; producing a “Couples Counseling Principles and Guidance” brief; publishing a manuscript on the literature review findings, and; sharing findings through a public webinar to the community at large.

BACKGROUND

About this Literature Review

The Institute for Reproductive Health (IRH) at Georgetown University was awarded the Fertility Awareness for Community Transformation (FACT) Project by the U.S. Agency for International Development (USAID) in 2013 in order to help create an environment in which women and men can take part in protecting their RH through strategies to increase awareness and access to fertility awareness (FA), fertility awareness methods (FAM), and other FP methods available in their communities.

As part of the FACT Project, IRH is conducting a literature review of couples counseling interventions in RH to inform the potential development of a couples counseling product in FP. Building upon IRH's past experience with male involvement in FAM, this review synthesizes past and presents literature on effective couples counseling interventions across a variety of different RH settings with the objective of providing preliminary recommendations for future couples counseling interventions.

Why Engage Men in the First Place?

Over the last two decades, increased efforts have been directed toward engaging men in RH programs. Both the advent of the HIV/AIDS epidemic and the 1994 International Conference on Population and Development (ICDP) in Cairo shifted the RH discourse toward a more gender- and male-inclusive approach. First, the spread of the HIV/AIDS epidemic pushed policy-makers, researchers and service providers to shift their attention toward men, and specifically toward the role of gender norms vis-a-vis sexual behavior of both male and female sex partners (Amaro 1995; Campbell 1995). Second, the ICDP set in motion programming for action guidelines for increasing male responsibility and participation in RH - including FP - by mandating that “innovative” programs be developed to make information, counseling and services for RH available to men (Ndong, Becker, Haws and Wegner 1999; p. S53).

Since then, twenty years' worth of evidence reaffirms that gender norms – or social expectations of men and women's roles and behaviors - affect couples' reproductive intentions and FP decisions (Hawkes and Buse 2013; IRH 2013; Barker et al. 2007). Yet to date, the FP focus remains almost exclusively centered around women. Specifically, the FP2020 plan aims to expand access and use of contraceptives to 120 million **women** by 2020, but omits mention of men from these efforts. There are several reasons why the FP community should care about engaging both men and women into their programs:

- **Both women and men want male partners to be more involved in FP.** Evidence strongly supports that men want to be involved in FP decisions; and, women in turn frequently want their partner more involved (Stern 2015; Lavoie and Lungdren 2009; Harper et al. 2004;

Wilkinson and Tzani 1998). Yet some evidence suggests that providers may not always be aware of this interest. One US-based study of couples' FP services found that while 65% of women expressed interest in involving their male partner in FP visits, only 50% of service providers perceived that women would express the same desire to do (Zolna, Lindberg, and Frost 2011).

- **Men exert powerful influence on their partners' pregnancy and FP intentions.** Despite men's exclusion from FP services, studies show that men (in some countries/contexts) remain the primary decision-makers about FP (Nzioka 2002; Soldan 2004), and pregnancy decisions (Greene et al. 2006). In some contexts, women may not be able to make FP decisions or access FP services without their male partners' approval or financial support (Levtov et al. 2015).
- **Men themselves are active agents – in their role as both users and partners – of FP.** Male focused methods – such as condoms, withdrawal, and vasectomy – account for one-quarter of global contraceptive use (Hardee, Croce-Galis, and Gay 2016). In addition, methods such as FAM require active participation of male partners for correct method use.
- **Couple communication and gender equitable decision-making are key determinants of improved contraceptive use.** Evidence shows that when men are provided the opportunity to discuss FP, challenged about inequitable gender norms, and receive accurate information about FP methods, their female partners are more likely to use FP (Shattuck 2011; Rottach, Schuler, and Hardee 2009). As well, additional research shows that engaging both partners can improve couple communication in FP, increase shared decision-making and men's involvement in child care (Stanback and Shattuck 2015), while also improving FP method correct use and continuation (Lavoie and Lungdren 2009).

What is Couples Counseling?

In the 22 years since ICDP, a number of systematic reviews have shown that targeting and engaging couples in RH services may be an effective approach to both engage men and improve overall RH outcomes. In a systematic review of the couples counseling literature, Becker (1996) found that RH interventions engaging couples were more effective than those targeting only a single partner. Other systematic reviews of HIV-focused couples counseling found that couples counseling programs increased condom use and reduced unprotected intercourse (Burton, Darbes, and Operario 2010), in addition to reducing HIV incidence among HIV discordant partners (Jiwatram-Negron and El-Bassel 2014). A more recent review of HIV couples counseling concluded that effective results can come from both couple-only and group formats. The reviewed interventions resulted in reduced risky sexual behavior (LaCroix et al. 2013). Last, a systematic review of community-based interventions targeting young married couples showed that these interventions are associated with increased contraceptive use, delayed pregnancy, and increased antenatal and postnatal care visits (Sarkar et al. 2015).

Despite the growing evidence, definitions around couples counseling are rather fluid and lack consensus. To our knowledge, the first couples counseling terminology emerged from Becker and Robinson (1998) who called for expanding "services oriented to couples" in RH care, citing multiple benefits across sexually transmitted infections (STI), contraception and infant health outcomes. In their evaluation of couple engagement strategies in Title-X funded health clinics in the US, Hart, Ross and Silva (2006) differentiate between "couples-based" and "couples-focused" terminology. They describe "couples-based" as an approach that targets and intervenes with the couple together; and "couples-focused" as a flexible model that may initially target the couple together, but later involves individual-based activities and services separately to partners depending on the couples' expressed needs.

Table 1. Key Definitions and Terminologies

Reproductive Health: A state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes at all stages of life. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases. (United Nations Fourth World Conference on Women, Beijing 1995).

Heterosexual Couples: Any man-woman pair of reproductive age with an ongoing sexual relationship, where the definition of ongoing in terms of time may vary between contexts and a sexual relationship implies a risk of pregnancy. Most sexual, contraceptive, and child-bearing decisions are made or properly could be made with participation of both partners (Becker 1998).

Couple Counseling: A strategic approach to engage couples in shared decision-making to meet their overall RH goals (IRH 2016)

Couple-based Counseling: An approach that targets and intervenes with the couple together (Hart 2005; IRH 2016).

Couple-focused Counseling: A counseling model that targets and intervenes with the couple both together as a dyad, and with separate partners through separate couples, depending on the couples' expressed needs (Hart 2005; IRH 2016).

Male Outreach: Efforts to encourage men to participate in health services, including "in-reach" activities and structural efforts within the health service (clinic, provider based) and "out-reach" activities conducted outside at the community level (community campaigns, use of health workers) (Hart 2005; IRH 2016).

Absent from most of these definitions is what constitutes counseling. Instead, the definitions focus on the composition of the counseled while avoiding the word "counseling" all together. As a result, we reviewed two FP counseling definitions to help provide structure and goals to the counseling services. The first definition from EngenderHealth defines FP counseling as "a two-way interaction between a client and a provider, to assess and address the client's overall sexual and RH needs, knowledge, and concerns" (2003). The more widely used World Health Organization (WHO) defines the purpose of FP counseling as to "help a client achieve three things: self-exploration, self-understanding, and decision-making with consequent action" (2011). The EngenderHealth definition implies that a counselor is also an educator who assesses and addresses the client's needs, while the second guides a process of self-reflection. The WHO definition more explicitly supports the mandate of informed choice by stating a three-step process aimed at meeting the client's needs and concerns. These important distinctions bound the parameters of counseling, the expectations of the counselors themselves, their training, and associated programmatic activities.

In reviewing the different terminologies, we find no single, accepted definition of couples counseling in FP. As a result, we propose and apply an overarching umbrella definition to couples counseling as "an intentional approach to engage couples in shared understanding and joint decision-making to meet their overall RH goals," which we apply in the review methodology below.

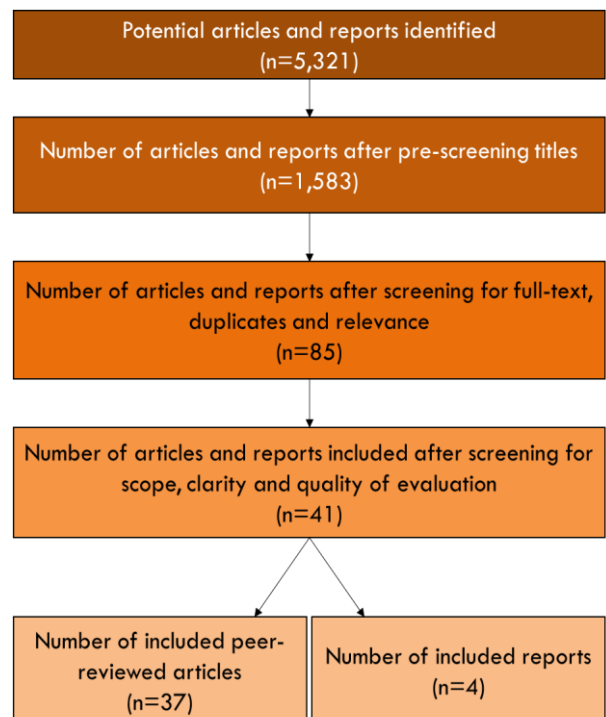
METHODOLOGY

In undertaking the literature review, interventions that met the above couples counseling definition and targeted couples across different areas of RH – including FP, HIV/AIDS, MCH and abortion and post-abortion care - were included in the review. As part of the scoping review, we included papers from other RH areas – outside of FP-specific counseling - due to the limited number of evidence-based couples counseling studies in FP. Interventions from other sectors were included if they reported one FP-related outcome and/or uptake of couples counseling services. For instance, effective MCH interventions were included if they reported post-partum counseling and FP use-related outcomes. Post-abortion care interventions were included if they reported FP-related outcomes during post-abortion counseling and recovery. Abortion counseling interventions were considered for inclusion if they were effective in improving uptake of couples counseling acceptance during counseling of abortion services (whether or not to seek an abortion). Finally, most of the couples counseling interventions, to-date, come from the HIV sector, and as such, effective couples counseling interventions were included to learn from the HIV sector’s effective approaches.

We also did not restrict inclusion based on couple targeting strategy, model approach, or level of intervention intensity. For example, some intervened separately with each member of the dyad, and others with both members at the same time (targeting strategy); few interventions conducted individual sessions, while others conducted group counseling sessions (model approach); some had one point of contact, while others had repeated points of contact (levels of intensity). We also did not restrict based on where couples counseling interventions were conducted (clinical versus non-clinical setting). For example, intervention settings ranged from health facilities, to within the community, at the couple's home or other settings (e.g. workplace).

To be considered for inclusion, a paper was required to report at least one statistically significant outcome, regardless of whether the outcome was behavioral (e.g. increased condom use or FP use) or relational (e.g. increased couple communication about FP). Papers with experimental and quasi-experimental designs comparing outcomes across intervention and control groups were included in the review. Non-experimental designs were included in the review if they used longitudinal data to report outcomes among participant cohorts (common in clinical HIV studies). With the exception of Becker et al. (2008), non-experimental study designs which only collected post-intervention data from the intervention group were excluded from the review.* In general, analysis

Figure 1. Flow Diagram of Search Results



* Becker et al. 2008 only collected data at one time point, but the study design used to assess its primary outcome – couples' uptake of abortion counseling services – was methodologically sound. The study was included in the

methods used multivariate analysis to control for other confounding factors, although this was not considered a criteria for inclusion. Given the cross-sectorial heterogeneity of the interventions, we did not calculate pooled effects as typically done in meta-analyses; rather we reviewed the literature as a scoping exercise to understand lessons learned and gaps in couples counseling across different RH intervention areas.

We conducted electronic searches for publications and peer-reviewed literature published between 1990 and 2016 through Google Scholar, Popline, PubMed and USAID Development Clearing House between January and March 2016. Search terms included “couple”, “couples”, “partner”, “men”, “married women”, or “partners,” in conjunction with “RH”, “sexual health”, “FP”, “contraceptive use”, “HIV”, as well as “intervention”, and “counseling”.

Our search yielded 5,321 articles and reports (Figure 1). A total of 3,738 articles and reports were excluded after pre-screening titles, resulting in the inclusion of 1,583 abstracts for further screening as per the eligibility criteria (see Table 2). Once full-text articles and reports were reviewed and duplicate interventions removed, 85 articles and interventions were deemed relevant according to the inclusion criteria. Upon closer review, 44 papers were excluded, mostly due to the scope, rigor and quality of their evaluation methods.

Papers were excluded if they belonged to other RH areas not relevant to FP outcomes, including infertility, reproductive cancers, and infant/child health (e.g. Diczfalusy 1995; Hardee & Young 1995). Some community-based interventions were excluded since they did not directly intervene with couples as a specific target group. These included community-based campaigns such as Information, Education and Communication (IEC), and Social and Behavior Change (SBC) mass media campaigns.

Ultimately, 41 interventions were included in this review (See Appendix B for matrix of all 41 interventions). Thirty-seven were peer-reviewed journal publications, and four interventions came from project reports (AQUIRE Project 2008; Population Council 2008; ICRW 2006; Population Council 2001).

Table 2. Selection Criteria

POPULATION	Interventions that intervened with both members of heterosexual couple, either separately or conjunctively.
INTERVENTION TYPE	RH interventions in either: a.) FP, b.) HIV and STIs, c.) maternal and child health, or, d.) post-abortion care.
STUDY DESIGN	Interventions with completed evaluations, for which data was available, including evaluations using experimental, quasi-experimental, and non-experimental designs.
OUTCOME	(i) Evaluations that measured: a.) FP, HIV, MCH, and abortion care outcomes; b.) couple communication outcomes, and; c.) male participation in counseling services. (ii) Effective interventions, defined as having at least one statistically significant result as per the outcomes listed above.
LANGUAGE	Papers published in English.
DATE	Papers published between 1990 and 2016.

review given the importance of understanding male and couple counseling uptake, as a key intermediary indicator prior to intended behavioral outcomes (such as uptake of FP).

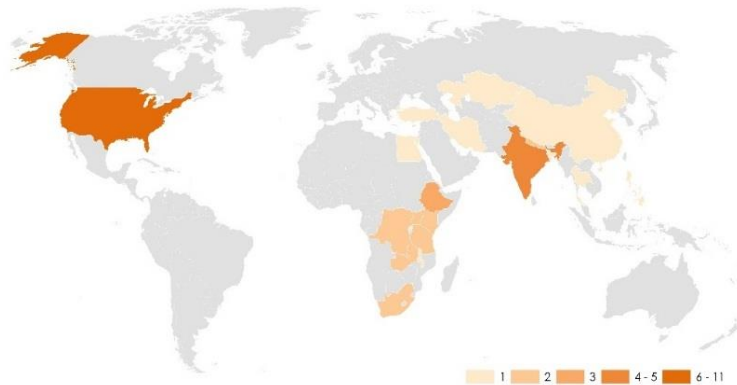
RESULTS

Description of Included Interventions

Regions and Target Population

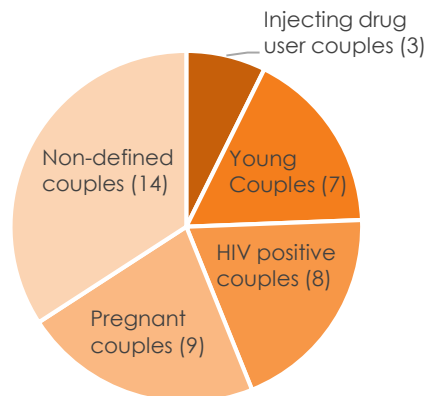
Fifteen of the 41 couples counseling interventions **were implemented in Africa** (Ethiopia [3], South Africa [2]; Zambia [2]; Democratic Republic of Congo [2]; Rwanda [1]; Tanzania [1]; Malawi [1]; Uganda [1]; Kenya [1]; Egypt [1]). Another **12 interventions in Asia** (India [4]; Nepal [2]; Bangladesh [1]; Philippines [1]; China [1]; Kazakhstan [1]; Turkey [1]; Iran [1]); **11 in North America** (all in United States), and **one in Latin America** (El Salvador). In addition, two HIV interventions (Coates et al. 2000 and McGrath et al. 2007) were multi-country studies (Kenya, Tanzania, and Trinidad, and India, Thailand and Uganda, respectively).

Figure 2. Continental regions of couples counseling interventions (n=41)



Almost all interventions targeted heterosexual couples, except for SMART Couples, an HIV medication adherence intervention, which intervened with both heterosexual and same-sex couples (Remien et al. 2006). Fourteen papers targeted couples of any reproductive age; followed by pregnant couples (9); either HIV positive concordant or discordant couples (8); young couples between the ages of 15 – 35 years of age (7), and; couples who are injecting drug users (3). Papers also defined “couples” in different ways – ranging from “married”, to “in union”, “co-parenting”, and “co-habiting.” In some papers (14), couples were not explicitly defined.

Figure 3. Intervention couples as defined in literature (n=41)



RH Intervention Areas

The 41 identified couples counseling interventions came from four RH areas: HIV/STI (23), FP (14), MCH (2), abortion (1), and post-abortion care (1). Of the 41 interventions, 15 overlapped into multiple RH areas (see table 3). As a result, we categorized interventions focused on multiple RH areas according to their reported primary outcome of interest. For example, Erulkar and Tamrat (2014) provided general RH education to married youth in Ethiopia, but reported FP as a key outcome. Byamugisha et al (2000) tested the provision of antenatal counseling to both women only and partners, but report voluntary counseling and testing (VCT) as a primary outcome. As a result, we include these two interventions in the FP and HIV/STIs areas, respectively.

Table 3. Types of couples counseling interventions, by single versus multiple RH areas (n=41)

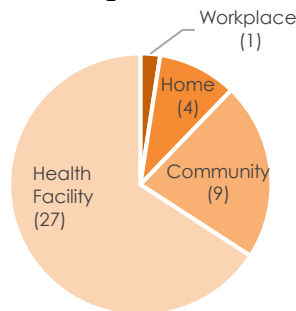
	HIV/STI (23)	FP (14)	MCH (2)	Post-Abortion (2)
Single RH area (26)	<ul style="list-style-type: none"> • 16 HIV • 1 STI / safe sex 	<ul style="list-style-type: none"> • 7 FP 	<ul style="list-style-type: none"> • 1 antenatal 	<ul style="list-style-type: none"> • 1 abortion counseling
Multiple RH areas (15)	<ul style="list-style-type: none"> • 5 HIV + Antenatal • 1 HIV + FP 	<ul style="list-style-type: none"> • 3 FP + RH youth • 2 FP + HIV • 1 FP + Abortion • 1 FP + IPV 	<ul style="list-style-type: none"> • 1 antenatal + fatherhood + FP 	<ul style="list-style-type: none"> • 1 post-abortion + FP

Note: For the “multiple RH areas” row, the primary intervention focus was included first. For instance, for the “1 HIV + FP” category, the intervention focused primarily on HIV, but also reported secondary FP-related outcomes; the “2 FP + HIV” category refers to two interventions primary focused on FP, but also reported on secondary HIV knowledge and VCT outcomes.

Intervention settings

The majority of couples counseling interventions were implemented in health facilities (27), followed by community spaces (10), participants’ homes (3; see figure 4). Only one intervention was implemented in a workplace setting (Wang et al. 1998). The type of RH intervention drove the location of the setting. For instance, HIV-based couples counseling were mostly implemented in clinic facilities (19), followed by two in a community-based setting and two via home-based counseling. In contrast, FP interventions were dispersed across different settings, including seven community-interventions, four facility interventions, two home-based counseling interventions, and one in the workplace. Both post/abortion interventions were implemented in a health facility setting, as were the MCH health counseling interventions, with one being replicated in a community-based setting in Turkey (Turan et al. 2001). One intervention from China (Wang et al. 1998) implemented same sex FP counseling groups in a workplace setting. Community-based intervention spaces varied from community meeting places to markets, churches, and bars.

Figure 4. Couple Counseling Intervention Settings (n=41)



Evaluation design and sample size

Evaluation designs varied in rigor. A total of 20 interventions used randomized experimental study designs, 14 used quasi-experimental designs and seven used non-experimental designs. Of the 20 randomized experimental designs, the majority were conducted in the HIV field (13), followed by FP (5)*, and MCH (2). Non-experimental study designs were included if they fell into one of the following design categories: 1. Longitudinal study design following the same sample of couples over time (Allen et al. 1992; Becker et al. 2014; Kamenga et al. 1991; McGrath et al. 2007; Padian et al. 1993); 2. Baseline and endline survey designs with intervention group only (ACQUIRE 2008). One non-experimental study, which only collected data at one time point was included in the review since its only objective was to assess abortion-counseling uptake at one point in time (Becker et al. 2008).

Table 4. Evaluation design, by type of intervention (n=41)

	HIV/STI (23)	FP (14)	MCH (2)	Post / Abortion (2)
Randomized experimental (20)	• 13 studies	• 5 studies	• 2 studies	
Quasi-experimental (14)	• 5 studies	• 8 studies		• 1 study
Non-experimental (7)	• 5 studies	• 1 studies		• 1 study

Sample sizes varied greatly, from 40 couples (Gilbert et al. 2010) to 1,060 couples (Wall et al. 2013). As mentioned in the inclusion criteria, evaluations that collected data from both members of the couple were prioritized. However, interventions were also included if either: their key objective was male outreach for RH services participation; or if they were unable to collect data from men they were attempting to reach.




Intervention Approaches

Interventions engaged couples through a range of different models, from “couples-focused” (El Bassel et al. 2010; Gilbert et al. 2010; Remien et al. 2006) to “couples-based” approaches (McMahon et al. 2013; Koniak-Griffin et al. 2011; El Bassel et al. 2011). For the majority of papers, couples counseling approaches were not explicitly defined: some interventions were framed as “health education sessions” (Mullany et al. 2007); or “group counseling” (Wall et al. 2012); or “husband-focused” (Raj et al. 2016). For those interventions that were not explicitly defined, we systematically categorized them according to whether they intervened with the couple together (couples-based), separately (couples-focused), or intervened with the couple both together and separately (couples-based + focused).

Of the 41 interventions, 18 used a **couple-based counseling** approach, intervening with both members of the couple at the same time, either through private counseling visits and/or group counseling with other couples. Table 5 highlights different types of counseling deliveries and resulting outcomes, undertaken under the different couples-based and couples-focused approaches:

* The five FP RCT studies include Amatya et al. 1994; Kraft et al. 2007; Raj et al. 2016; Wall et al. 2013; Wang et al. 1998



Table 5. Examples of couples-based approaches (18 interventions)

COUPLES-BASED COUNSELING	
<i>“Approach that targets and intervenes with the couple together”</i>	
<p>Counseling visit to couple together (6 interventions)</p> 	<ul style="list-style-type: none"> In Wall et al. (2013), HIV positive couples in Zambia received counseling via the “Methods” video on long-term acting reversible methods (LARCs). Couples then discussed the video with a facility-based counselor. Among baseline contraceptive users, viewing the Methods video was associated with a significantly lower pregnancy incidence (Hazard ratio [HR] = 0.38), relative to the control group.
<p>Group counseling to couples together (3 interventions)</p> 	<ul style="list-style-type: none"> In Koniak-Griffin et al. (2011), In the US, Latina adolescent mothers and their male partners participated in six group sessions that emphasized games, role-playing and discussion related to family protection, skills building, and issues related to gender, power, and healthy sexual decision-making. The intervention reduced the proportion of unprotected sex episodes (Odds ratio [OR] =0.87** per month), and increased intent to use condoms ($b=0.20^*$), relative to the control group.
<p>Visit + group counseling to couples together (2 interventions)</p> 	<ul style="list-style-type: none"> In El Bassel et al. (2010), African-American couples (in the US) received an HIV/STD risk-reduction intervention through eight weekly 2-hour sessions provided by male and female co-facilitators. The couple received four individual counseling sessions with a facilitator, followed by four group counseling sessions with other couples. The intervention increased condom use, with the proportion of condom-protected intercourse acts larger among couples in the intervention group (0.77**), relative to the control group (0.44).

(Statistical Significance: *** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$)

Fewer interventions used a **couples-focused approach**, with only six interventions intervening with partners separately, either through separate private counseling visits and/or group counseling with other members of the same sex. Table 6 highlights two examples of couples-focused approaches:

Table 6. Examples of couples-focused approaches (6 interventions)

COUPLES-FOCUSED COUNSELING	
<i>“Approach that provides individual-based services separately to partners dependent on the couples’ expressed needs.”</i>	
<p>Counseling visit to separate partners (2 interventions)</p> 	<ul style="list-style-type: none"> In Amatya et al (1994), Bengali husbands of Norplant female users were counseled in FP clinics on Norplant information and use, both at study admission and again at a one-month follow-up to promote Norplant continuation rates. During counseling, the husbands were given a brochure on Norplant and the supportive role husband’s play in decision-making and side effects management. Husbands were encouraged to share the information with their female partner. At the end of 36 months, Norplant discontinuation rates were less in the husband-counseled group (32 per 100** women) than the control group (42 per 100 women). The effect was stronger in clinics with higher discontinuation rates.
<p>Group counseling to separate partners (3 interventions)</p> 	<ul style="list-style-type: none"> In Erulkar and Tamrat (2014), female and male mentors from rural Ethiopian communities were trained to mobilize and lead same-sex girls and boys groups – some of them married young adolescent partners – three times a week on communication and self-esteem, STIs, HIV, FP, RH, menstruation management, gender and power dynamics, and financial literacy. The male curricula was adapted to also address issues related to domestic and sexual violence. Study respondents for whom both husband and wife participated in the groups were nearly twice as likely to have ever used FP (OR 1.9***), and were twice as likely to go to a health clinic together (OR 1.7**).

(Statistical Significance: *** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$)

The remaining interventions (16 out of 41), blended at least two or more of the above **couples-based and couples-focused** models, using a combination of couples-based (couples together) and couples-focused (partners separately) approaches, with individual visit and/or group counseling formats.

The diversity of couples counseling models suggest two points: 1. approaches are context- and environment-specific; and, 2. some are responsive to couples' specific needs. In regards to the first point on environment-tailored approaches, community-based FP interventions tended to take a broader ecological approach, with a theory-driven curricula and set of tools for group education and counseling activities. In most of these cases, couples counseling was implemented as a secondary activity, primarily through home visits. Specifically, the ACQUIRE Project in Nepal educated married adolescents as peer educators to provide RH information to the community at large through group sessions; and as part of this mandate, also provided counseling visits at home to married adolescent couples on RH topics (2008). A few couples counseling interventions - primarily done in the facility based setting - were able to tailor their intervention toward the couples' needs. One example is Kamenga et al. (1991), which informed couples of their HIV test results separately in private rooms by same sex counselors. The participants then received counseling together with both members of the counseling team. An optional follow-up home visit was then scheduled for those couples identified as "at risk for intimate partner violence" (IPV).

A total of nine interventions also described specific **male outreach activities** used to increase men's participation in couples counseling and/or other RH services. Of these, two interventions used invitation letters delivered to men by their female partner to increase men's participation in HIV testing and counseling and had mixed results (Becker et al. 2010; Byamugisha, et al. 2011). For instance, a sub-analysis by Becker et al. (2010) showed that HIV positive women in couples voluntary counseling and testing (CVCT) intervention group were more likely to use abstinence or condoms compared to control women (90% intervention versus 60% control), but intervention women were least likely to receive a CVCT test result (39% intervention versus 71% control). Other more effective male outreach strategies included community sensitization activities (ICRW 2006; Mohlala, et al 2011; Population Council 2008), the provision of community counseling venues such as bars and churches (Ditekema et al 2011), use of influential community "agents" and social networks as recruitment mechanisms (Wall et al 2012), and provision of home-based couples counseling (Becker et al, 2014).

Counseling content and materials

Consistent with the various counseling models, the counseling content and materials offered to couples varied by setting and RH intervention area. Some interventions (ACQUIRE 2008; Allen et al. 1992; Gilbert et al. 2010; Villar-Loubet et al. 2013; Wall et al. 2013) used more interactive tools, such as stories, poems, articles, activity cards, a photo-journal and videos; while others used more clinical tools such as risk assessments and risk reduction plans (Coates et al. 2000; Ditekema et al. 2011; McMahon et al. 2013). Generally, we categorized the materials into three groups:

1. **Provider and facilitator tools.** Manuals, curricula, flipcharts, discussion guides, facilitator guides;
2. **Participant materials.** Pamphlets/brochures, booklets, and;
3. **In-session activity materials.** Sexual activity calendar, homework assignments, games, and personalized risk reduction plans.

The content of the counseling sessions depended on the counseling method delivery – whether through individual counseling visits or group counseling sessions. Individual counseling visits with a couple (separately or together) typically consisted of needs assessments, role-playing on couple

communication, problem solving, and goal setting. Group counseling models – typically conducted in non-health facility settings – focused on providing couples with educational information on RH and services, referrals to services and group discussions on problem solving and couple communication (see Table 7).

Table 7. Counseling content, duration and frequency, by individual versus group counseling

	INDIVIDUAL COUNSELING VISITS	GROUP COUNSELING
Typical counseling content	<ul style="list-style-type: none"> • RH knowledge and needs assessment • Information and experience sharing, and interactive role playing on communication and problem-solving • Setting plans and goals to address RH needs 	<ul style="list-style-type: none"> • RH knowledge • Information and referrals to RH services • Group discussion and role playing on communication, and problem-solving
Duration of session	<ul style="list-style-type: none"> • 15 minutes to 2 hours 	<ul style="list-style-type: none"> • 30 minutes to 3 hours
Typical session frequency	<ul style="list-style-type: none"> • One time • Monthly • Every few months 	<ul style="list-style-type: none"> • Weekly

In contrast to group counseling approaches, individual counseling interventions included more in-depth explanations of misconceptions and barriers to using services and products. In particular, these interventions placed a stronger emphasis on the importance of couple communication, including assertive communication, listening, and problem solving. Group counseling often reflected an approach that primarily focused on “educational sessions”, rather than “counseling”.

Gender approaches

The majority of interventions addressed gender in either one or both of the following ways: 1. designing gender sensitive intervention components, and/or; 2. integrating gender relational content into their sessions.

Gender sensitive designs. The vast majority of interventions were delivered by either same sex counselors (when partners were counseled separately) or mixed sex counselor pairs (when couples were counseled together). Interventions – and in particular those that combined **couples-based and couples-focused** approaches – were purposefully designed to be responsive to couples’ and partners’ expressed needs and requests. For instance, a few interventions offered separate partner counseling sessions for the first point of contact, but then allowed participants to choose how they would be counseled thereafter, whether together or separately (Becker et al. 2014; Parsons et al. 2002). Some documents, albeit far from the majority, highlighted strategies to ensure informed choice, client autonomy and reduce likelihood of potential IPV. For example, in Becker et al. (2014) male and female counselors visited couples in their homes separately and used color-coded cards to discreetly inform the male counselor if the female client wanted to be counseled with her partner.

Few interventions engaged key reference groups and social networks such as peers or family members who could influence couples’ attitudes and behaviors. One exception came from India, where the KEM Hospital Research Centre informally engaged parents, in-laws, and other community members in group counseling sessions to reduce any potential normative barriers to accessing FP services (ICRW 2006). Another exception, Wall et al. (2012), identified influential network agents from different health, faith-based, community and private sectors to deliver VCT invitation letters to couples, using influential social networks to overcome stigma associated with VCT.

Gender relational content. Twenty-five of the 41 interventions included content that explicitly addressed gender. Generally, these topics were broken down by: 1. Gender norms; 2. Couple communication; 3. Couple intimacy and caring; 4. Male partner support in method use; 5. Sex and sexuality; 6. Violence prevention, and; 7. Empowerment.

Table 8. Gender-related content in couple counseling interventions

CONTENT CATEGORY	TYPE OF CONTENT
1. GENDER POWER DYNAMICS	<ul style="list-style-type: none"> Gender roles and expectations; power dynamics; role and influences of family members and peer groups; son preference; early marriage and dowry system
2. COUPLE COMMUNICATION	<ul style="list-style-type: none"> Couple communication and problem solving strategies; communication about sex
3. COUPLE INTIMACY AND CARING	<ul style="list-style-type: none"> Partner caring and emotional support, fatherhood and caregiving; relationship anxiety
4. MALE PARTNER SUPPORT IN METHOD USE	<ul style="list-style-type: none"> Gender equitable decision-making; negotiation about sex, condoms, FP; male partner participation in use of FP
5. SEX AND SEXUALITY	<ul style="list-style-type: none"> Safe sex practices; sexual enjoyment; sexuality; sexual monotony (or sexual boredom); sexual monogamy and trust; menstruation management
6. VIOLENCE	<ul style="list-style-type: none"> IPV; sexual violence; alcohol and drug use; conflict resolution
7. EMPOWERMENT	<ul style="list-style-type: none"> Self-esteem and confidence; social support and stigma (HIV); RH rights; financial literacy

Among these topics, interventions typically integrated content related to couple communication, negotiation, and decision-making around sex and FP use. Not surprisingly, community-based interventions emphasized the deconstruction of gender norms and power dynamics among couples, aiming to not only influence FP use, but also social and gender norms that affect RH outcomes and women's autonomy. In Ethiopia and Iran, two interventions effectively addressed these gender norms through sex-disaggregated discussion groups (Erukhar and Tamrat 2014; Farnam et al. 2008). Unfortunately, only two studies addressed violence as a primary outcome (Mohlala et al. 2001; Raj et al. 2016). Raj et al. (2016) developed and delivered a gender equity and FP curriculum – CHARM – through husband-only and joint partners counseling sessions, and showed improvement in both contraception and IPV outcomes.

Intervention Outcomes

The diverse nature of this literature highlights an assortment of target outcomes. We coded reported outcomes into behavioral, attitudinal/relational, knowledge, or male outreach categories. Health **behavior** outcomes included increased condom or FP method use or antiretroviral drug adherence; **attitudinal/relational** outcomes included improved perceptions of either joint decision-making, partner involvement, or partner communication related to RH matters; and **knowledge** outcomes were related to RH information (i.e.; ways to prevent HIV infection, knowledge and awareness of fertility and FP methods). **Male outreach** outcomes included increased male attendance in counseling sessions, HIV, VCT, or CVCT and/or RH health services as either a primary or secondary outcome rather than a descriptor (See Table 9 in annex for a description of outcomes by RH area).

Of the 41 interventions, 33 reported more than one of the outcomes listed above, resulting in a total of 108 identified outcomes. Figure 5 shows that of these 108 outcomes, over half were behavioral outcomes (58), followed by attitudinal/relational (21), and knowledge-related (16). In addition, 13 papers reported male outreach outcomes. Figure 6 presents the proportion of behavioral, attitudinal/relational, knowledge, and male outreach-related outcomes by intervention area. The figure highlights that HIV papers proportionally reported more behavioral outcomes rather than knowledge outcomes in comparison to FP, while FP papers reported more knowledge-based and attitudinal/relational-based outcomes.

Figure 5. Number of reported outcomes, by type (41 papers)

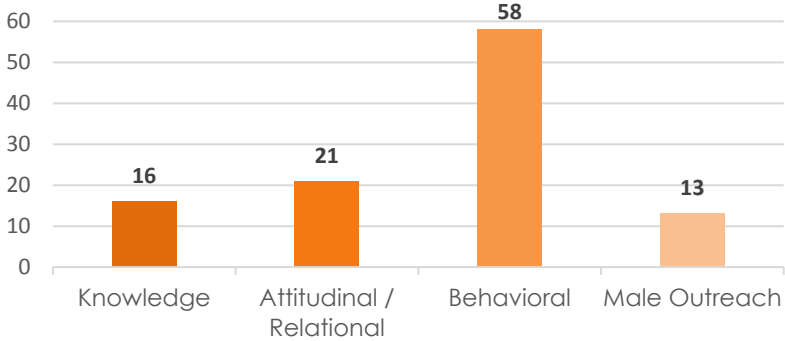
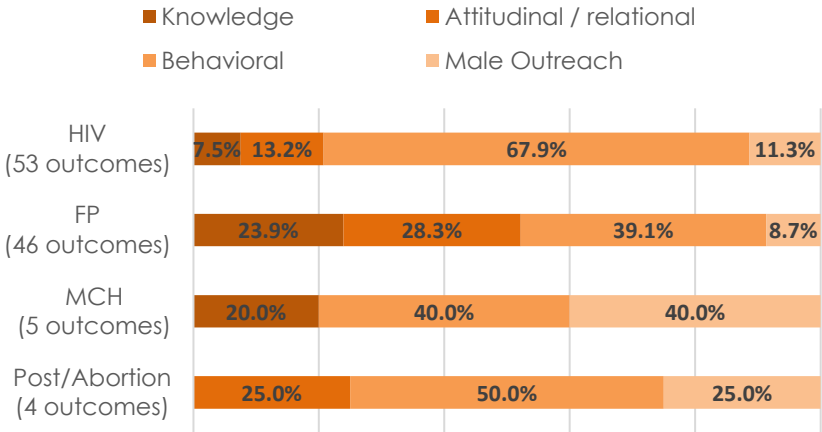


Figure 6. Reported outcomes by intervention areas (41 papers)



Sub-analysis of effective FP outcomes

To understand how couples counseling affects FP outcomes specifically, we conducted further outcomes analyses of the 14 FP papers, as well as the two MCH, and two post/abortion papers. We pooled the four latter MCH and post/abortion papers into the FP sub-analysis since these papers also reported FP outcomes. In general, couples counseling improved the following FP-related outcomes:

1. **Improved contraceptive use.** Increased adoption and continuation of contraception (including post-partum), in addition to increased birth spacing. Reduced pregnancy incidence was also reported by one of the papers (Wall et al. 2013).
2. **Improved couple communication and partner support about FP.** Increased partner support and couple communication about FP, improved decision-making about FP, and attitudes toward FP.
3. **Improved knowledge about fertility and FP.** Increased knowledge about fertility, FP, pregnancy, and condom use.
4. **Increased male outreach and participation in counseling services.** Increased uptake of couples counseling services and post-partum visits, and male accompaniment for general visits to the health clinic.

Figures 7-10 below highlight effective outcomes, disaggregated by behavioral; attitudinal/relational; knowledge; and male outreach outcome categories. Effective outcomes were defined as any statistically significant improvement from baseline to endline, and/or against a comparison arm.

Improved behavioral FP outcomes. Of the 18 FP interventions included in the analysis, eight were effective in improving FP behavioral outcomes (Figure 7). Specifically, six were found to be effective in increasing contraceptive use (Daniel et al. 2008; Erulkar and Tamrat 2014; Population Council 2008; Raj et al. 2016; Terefe and Larson 1993; Turan et al. 2001); decreased NORPLANT discontinuation rates (Amatya et al 1994), and reduced pregnancy incidence (Wall et al. 2013).

Figure 7. Effective FP behavioral outcomes (8 interventions)

- **Increased FP use** (Population Council 2008; Terefe and Larson 1993; Turan et al. 2001)
- **Increased FP use + decreased IPV** (Raj et al. 2016)
- **Increased FP use + increased birth spacing** (Daniel et al. 2008)
- **Increased FP use + husband support for housework** (Erulkar and Tamrat 2014)
- **Decreased NORPLANT discontinuation rates** (Amatya et al. 1994)
- **Reduced pregnancy incidence** (Wall et al. 2013)

The interventions that were effective in improving FP behavioral outcomes varied in location of delivery, from facility (4) community (3); to home (1). For the three effective community-based interventions (Daniel et al. 2008; Erulkar and Tamrat 2014; Population Council 2008), couples counseling activities were conducted as a secondary activity under a multiple component approach. As a result, attribution of individual couples counseling activities is not possible. For instance, the PRACHAR Project (Daniel et al. 2008) – which used a quasi-experimental pre and post intervention design – provided counseling visits to couples at home. However, as a comprehensive behavior change intervention, PRACHAR also engaged other influential community members in project activities, in addition to delivering group “infotainment parties” for

newlywed couples, and providing lunchboxes with pills and condoms to participants. The intervention more than tripled the use of contraceptives among newlyweds exposed to the intervention (from 5.3% to 19.3%), with the majority reporting the use of pills and condoms. This suggests that other intervention components such as the distribution of condoms and pills also contributed to contraceptive uptake. Among the effective facility-based interventions, one noteworthy example is the gender equitable CHARM intervention, which was evaluated as a randomized control trial (RCT; Raj et al. 2016) and integrated FP and IPV topics in facility-based counseling sessions. The intervention showed significant increases in contraceptive use (adjusted odds ratio [aOR] 1.58 at 18 month follow-up; p=.05), couple communication about FP (aOR 1.77; p=.04), and decreased sexual IPV (aOR 0.48; p=.01).

Three papers reported ineffective FP use outcomes (ACQUIRE 2008; Kraft et al. 2007; Population Council 2001). Another three interventions also reported mixed effect on contraceptive use (Lungdren et al. 2005; Tilahun et al. 2015; Abdel-Tawab et al. 1997). In the community-based “Planning Together” intervention in El Salvador – which used a quasi-experimental design - men's reported use of any contraceptive method increased significantly from baseline to endline (from 44% to 63%; $p=.0001$), but no significant increases in contraceptive use were reported among women.

Figure 8. Effective FP attitudinal and relational outcomes (8 interventions)

- **Increased couple communication about FP** (*Population Council 2008*)
- **Increased couple communication about FP + positive attitudes toward FP** (*Lungdren et al. 2005; Population Council 2001*)
- **Increased couple communication about FP + attitudes toward IPV** (*Raj et al. 2016*)
- **Increased couple communication about FP + willingness to be involved in FP** (*Tilahun et al. 2015*)
- **Improved attitudes toward FP** (*Daniel et al. 2008*)
- **Improved positive expectations for partner's support of FP** (*Kraft et al. 2007*)
- **Improved perceived decision-making around FP** (*ACQUIRE 2008*)

Improved attitudinal and relational outcomes. Of the eighteen interventions, eight improved attitudinal and relational outcomes related to FP (Figure 8). Five interventions increased couple communication about FP (Lungdren et al. 2005; Population Council 2001; Population Council 2008; Raj et al. 2016; Tilahun et al. 2015). Three interventions improved overall attitudes toward FP (Daniel et al. 2008; Lungdren et al. 2005; Population Council 2001), and one toward IPV (Raj et al. 2016). Two interventions improved partner support and involvement in FP (Kraft et al. 2007; Tilahun et al. 2015); and one intervention reported improved decision-making around FP (ACQUIRE Project 2008).

One attitudinal/relational outcome – specifically motivation/decision-making regarding FP – was found to be unchanged by couple counseling (Kraft et al. 2007). In the same study, Kraft et al. (2007) found that their US-based intervention was in fact associated with an increase in positive expectations pertaining to the partner's support for contraception ($F=4.83$; $p=.029$). But this did not necessarily translate into improved contraceptive outcomes: intervention participants were no more likely to use effective contraception at the six month follow-up than those in the control information group.

Abdel-Tawab et al. (1997) also reported mixed attitudinal/relational results, showing that post-abortion recovery improvements among Egyptian women were more likely to be affected by husband's characteristics - and particularly levels of emotional support - than participation in the counseling program. This is consistent with other studies in HIV and FP field, which show that husband support for FP, in addition to relationship characteristics – including higher levels of education, fewer children, and lengthier relationships – are predictors of improved behavioral outcomes. Interestingly, the study also showed that husbands and wives who are blood relatives are almost twice as likely to have an improved post-abortion recovery (aOR 1.9).

Improved FP-related knowledge outcomes. As per Figure 9, seven interventions showed improved knowledge outcomes (ACQUIRE Project 2008; Daniel et al. 2008; ICRW 2006; Lungdren et al. 2005;

Figure 9. Effective FP knowledge outcomes (7 interventions)

- **Increased awareness/knowledge about FP/methods** (ACQUIRE 2008; Population Council 2008; Turan et al. 2001)
- **Increased knowledge of fertility** (Daniel et al. 2008)
- **Increased knowledge of pregnancy, fertility, and condom use** (ICRW 2006)
- **Increased awareness/knowledge of FP and fertility** (Lungdren et al. 2005; (Population Council 2001)

Population Council 2001; Population Council 2008; Turan et al. 2001). In the Philippines (Population Council 2001), husbands and wives who attended couples-based group counseling sessions together were twice as likely to know that a woman can get pregnant during the middle of the menstrual cycle, in comparison to control participants (OR 2.3; $p=.01$). In addition, wives who participated in the group counseling sessions were more likely to know about condoms (OR 9.2; $p=.05$); tubal ligation (OR 15; $p=.01$), and vasectomy (7.4; $p=.01$), than control wives.

Increased use of services as a result of male outreach activities. Seven interventions reported increased use of couples counseling services and/or other health services as a result of male outreach and counseling activities (Amatya, et al. 1994; ACQUIRE 2008; Becker et al. 2008; Ditekemena et al. 2011; Erulkar and Tamrat 2014; Mohlala et al. 2011; Mullany et al. 2007.)

For example, Becker et al (2008) sought to increase uptake of couples counseling in a US-based abortion clinic, by spontaneously asking women if they were interested in having their partners - who were in the vicinity - participate in the counseling with them. In total, 42% of women accepted and received couple counseling, highlighting a simple and effective strategy to increase men's participation in couples counseling services.

Figure 10. Effective male outreach-related outcomes (7 interventions)

- **Increased uptake of follow-up counseling visit** (Amatya et al. 1994)
- **Increased use of services among young married adolescents** (ACQUIRE 2008)
- **Higher acceptance couples counseling services** (Becker et al. 2008; Ditekemena et al. 2011; Mohlala et al. 2011)
- **Increased male accompaniment to the health clinic** (Erulkar and Tamrat 2014)
- **Increased uptake of post-partum visits** (Mullany et al. 2007)

A few papers reported on non-effective male outreach strategies, in addition to other reported behavioral or attitudinal/relational outcomes. In Turkey, Turan et al. (2001) offered group counseling sessions to pregnant couples together and partners separately in a health facility. They reported higher post-partum contraceptive uptake in the intervention group (62%; OR=1.49), relative to the control group (47%). However, the intervention also experienced very low participation of expectant fathers in the group counseling sessions, with only 26.2% of men attending at least one session. Based on this experience, Turan et al. (2001) replicated the study in a community-based setting, resulting in increased men's participation in the groups, and effective outcomes in infant health and spousal communication and support. The follow-up study results are consistent with Becker et al. (2010; 2014) conclusions that community-based outreach may be needed to increase men's participation in counseling services.

DISCUSSION

Overall, the review findings reveal a wide spectrum of couples counseling interventions. The findings suggest that effective couples counseling interventions can take the form of different engagement models, from couples-based to couples-focused counseling interventions. In general, couples improved RH behaviors, attitudes/relational, and knowledge outcomes whether they were approached through individual couples sessions, single-sex groups, or in groups with other couples. The findings also show that couples counseling can take place in a number of settings, ranging from facilities to communities, home, and workplace settings. In many cases, interventions used more than one of the above approaches, suggesting that couples counseling interventions should be flexible models that can address contextual norms and client needs.

Consistent with the diversity of approaches, we elaborate below on three main findings and then provide recommendations for FP programming moving forward, as follows:

1. Effective couples counseling interventions are diverse in their approaches and terminologies, and as a result; operationalizing a common definition and framework is needed;
2. Effective couples counseling approaches vary in the intensity and depth with which they address gender power dynamics, couple communication and intimacy: identifying common elements, including standard principles for integrating gender should be a next step, and;
3. More evidence is needed to increase men's participation in counseling and other RH services.

Finding 1. *Effective couples counseling interventions are diverse in their approaches and terminologies, and as a result; operationalizing a common definition and framework is needed.*

In most cases, the couples counseling delivery appears to be driven by the context and needs of the specific couples. For the former, the location of the counseling services affects the delivery format: community-based interventions tend to deliver sessions in groups, while facility-based one conducted counseling sessions with couples or partners separately. In many contexts and cultures, providers need to be sensitive in the way that they approach couples (together or separately), and as a result approaches may shift dependent on that given context. To avoid reinforcing inequitable gender power dynamics between couples, one common strategy includes offering partners – and in particular women – a choice of counseling delivery, whether together as a couple (couples-based), or separate from their partner (couples-focused). While power dynamics between the couple were often integrated into the curricula or counseling sessions, no papers shared how they addressed structural power dynamics between the counselor and the couple.

Approaches varied in intensity, duration and points of contact, and in the topics that they could address. One upshot of the approach diversity is the lack of a consistent, clear definition for couples counseling. We encountered very few definitions or consistent terminologies related to couples counseling in the reviewed literature. As the field continues to evolve, program planners and evaluators should identify and apply appropriate definitions for what they consider as counseling within their interventions. This requirement provides parameters by which feasibility can be assessed, training developed and administered, and proper evaluations implemented.

Moreover, it is unclear from the literature how different interventions integrated their couples counseling models with existing best practices on conventional FP counseling guidelines (e.g. Balanced Counseling Strategy, WHO's Decision-Making Tool, etc.) These include key counseling principles such as ensuring informed choice, client autonomy, privacy, and confidentiality. As a result, one key gap moving forward includes finding ways to integrate existing FP clinical counseling principles with guidelines on couples counseling.

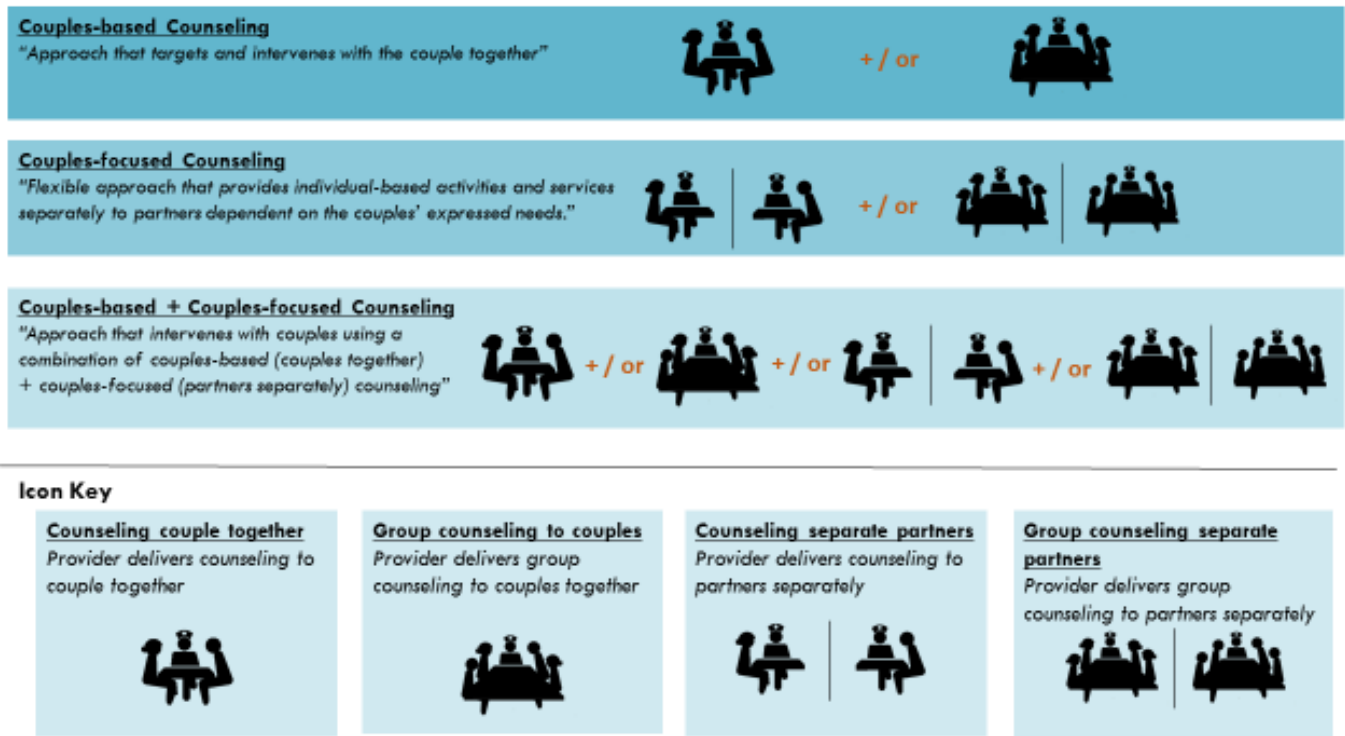
Second, not all interventions highlighted the training, profile or skillset needed by counselors to deliver couples counseling sessions. As seen in Appendix B, Training models ranged from a one-day orientation for physicians (Abdel-Tawab, et al. 1997), to 40 hours of experiential facilitator training (El Bassel, et al. 2010; Koniak-Griffin, et al. 2011), and a six day training, segmented into two different trainings to allow for community practice in between trainings (Population Council 2001). One intervention, SMART Couples, also allowed their counselors to practice and pilot test their curricula with a small number of pilot couples, prior to implementing the full intervention (Remien, et al. 2006).

Recommendations for programming. In the absence of terms and definitions in the literature, we sought to seek and redefine terms, such as “couples counseling,” “couples-based”, and “couples-focused” based on other literature (Hart 2006; Becker 1997) and IRH's own experience (Lavoie and Lungdren 2009). We use this report as a sounding board to test out our proposed terminologies. Specifically, we propose an overarching umbrella definition to “couples counseling”, as follows:

“An intentional approach to engage couples – whether couples-based and/or couples-focused – in shared understanding and joint decision-making to meet their overall RH goals.”

We use an “intentional approach” to emphasize the need to have a clear strategy or pathway to engage the couple. Consistent with the literature review, we argue that the overall aim of couples counseling interventions should be to meet the couples' “overall RH goals,” rather than FP uptake specifically. Under this overarching definition, we propose framing different couples counseling approaches as done earlier in this report, as per: 1. Couples-based (couple together); 2. Couples-focused (partners separate), or; 3. Couples-based and Couples-focused (couple together and separate) as per Figure 11:

Figure 11. Types of couples counseling approaches



In the absence of operationalized principles on couples counseling, we propose the below initial counseling framework guidelines:

- Couples counseling goes beyond providing information (e.g. brochures to men) or male outreach strategies (e.g. male friendly services);
- Couples counseling is a user/s centered approach that helps couples make informed decisions about their RH needs;
- Couples counseling should facilitate informed and gender equitable decision-making – primarily through communication, negotiation, and skills building – between two partners regarding their RH needs and expectations;
- Couples counseling should take on an intentional approach – whether couples-based and/or couples-focused – with the aim of working through their RH decisions either together during or after the counseling session;
- Couples counseling approaches should integrate existing FP counseling clinical guidelines, working to ensure both partner's informed choice and agency, while also providing the couple with the opportunity to engage in gender-equitable decision-making about their RH needs.

There are two above concepts – "RH goals" and "equitable decision-making" – that deserve further discussion. In general, papers did not report how couples counseling interventions addressed incongruences in RH goals and needs between partners. Specifically, papers reported information about their intervention approach, curricula and content, but very little on the process they undertook to enable couples to reach a congruence in mutual or joint decision-making during the counseling sessions. However in most cases, interventions went beyond joint decision-making about

just method use specifically, to also discuss joint decision-making around spacing of children and communication about when to have sex, among others.

In fleshing out the above definition, we also raised several constructs of reproductive empowerment (RE) theory, such as informed “choice” and “agency.” We use ICRW’s (2017) working definition to define Reproductive Empowerment as:

“A transformative process of change whereby individuals expand their capacity to make informed decisions about their reproductive lives, amplify their ability to meaningfully participate in public and private discussions related to reproduction, and act on their preferences and choices to achieve desired reproductive outcomes free of violence, retribution or fear.” (ICRW 2017)

Further considerations – to be explored at the technical expert consultation meeting – include further conceptualizations of agency and informed choice in the context of couples counseling interventions. Some key questions include: how should couples counseling interventions address issues related to an individual’s empowerment and agency? In relation to their partner’s empowerment and agency? And in relation to the power dynamic with their counselor? While the literature review could not answer these questions specifically, we aim to discuss these Reproductive Empowerment concepts and issues at the expert consultation meeting.

Finding 2. *Effective couples counseling approaches vary in their overall intensity and depth, and with which they address gender power dynamics, couple communication, and intimacy: identifying common elements overall and for integrating gender should be a next step.*

The findings show that couples counseling interventions were generally geared toward promoting couple communication, but the level of intensity in which they integrated gender topics and addressed gender power dynamics varied greatly. At one end of the RH spectrum, some of the effective interventions used one to two points of contacts with couples (e.g. one-two sessions on condom negotiation), to improve one behavioral outcome (e.g. condom use). Other effective interventions integrated a more gender-equitable approach, based on extensive formative research with local participants and gender and power theory, to explore issues related to sexual “politics” of males and females, gender roles, and maternal and paternal protectiveness (Koniak-Griffin, et al. 2008). While the vast majority of interventions also used same sex counselors to deliver the interventions; a few interventions also used married counselors to act as peer counselors and change agents (ACQUIRE 2008; Daniel et al. 2008). Three community-based FP interventions that improved overall RH outcomes, and incorporated couples counseling sessions as part of a broader ecological intervention model (Daniel et al. 2008; Erulkar and Tamrat 2014; Population Council 2008). As part of the ecological model, all three of these interventions involved key social support and/or influential groups (Daniel et al. 2008; Population Council 2008) to enable social support for the target couples.

Some evidence suggests that integrating gender into counseling curricula does not have to be an exhaustive effort. For instance, Raj et al. 2016’s effective CHARM intervention in India only offered three facility-based counseling sessions to couples, but integrated gender equity, FP, and IPV topics into these sessions. Specifically, CHARM’s couples counseling approach – which the authors framed as “husband-focused” - provided the first two counseling sessions to men alone; followed by a third counseling session together with their female partner.

Recommendations for programming. The findings suggest that whether or not a couples counseling intervention should be gender transformative – that is, the extent to which it should actively challenge and change gender norms and power dynamics – largely depends on the overarching context and goal of the intervention. Factors to consider include, the intervention setting (community, facility, home), the cultural context, and the availability and skills of the counseling providers. However, theory suggests that an “intentional approach” to couples counseling should, in fact, be explicit about how it aims to address gender dynamics and outcomes. We propose below common “gender” elements that could be integrated into couples counseling guidelines:

- **Define the overall goal of the intervention.** Keeping in mind that couples counseling interventions should improve RH outcomes more broadly, rather than one specific behavioral outcome (contraceptive uptake).
- **Consider the culture and context when designing the intervention.** The existing gender norms will decide the counseling approach, and specifically whether couples are counseled together, separately, individually with a counselor, or within a group.
- **Train same sex counselors.** Same sex counselors should be used for separate sessions with partners, and a pair of male and female counselors should be used for sessions with couples together.
- **According to the identified intervention goal and counseling design, programs can choose from the following gender outcomes and themes – identified through this review – to integrate into the counseling curricula:**
 - Gender power dynamics
 - Couple communication
 - Couple intimacy and caring
 - Male partner support in method use
 - Sex and sexuality
 - Violence
 - RE (as a couple and as individuals)

Finding 3. *More evidence is needed to increase men's participation in counseling and other RH services.*

The review findings show a gap of effective male outreach strategies to engage men in counseling and health services. Of the 41 included interventions, only four specifically focused on male outreach and increasing male participation in RH services as a key outcome. The majority of papers neglected to provide information on their male outreach and recruitment strategy, despite reporting challenges in recruitment and attrition of men. Global data on men's use of services is also lacking, but some evidence shows that men do show up at certain service delivery points. For instance, the International Men and Gender Equality Survey (IMAGES) found that the majority of interviewed men reported attending at least one prenatal visit with their partner, ranging from 78% of men in Brazil to 91% in India (Barker et al. 2011). In our review findings, we find only one intervention (Becker et al. 2008) which recruited and invited male partners already in the vicinity of the health facility to participate in couples counseling services.

Overall, we found that male outreach can be problematic, reflective of a reality that men do not regularly interact with the health sector. The use of invitation letters in the reviewed literature shows mixed results. Community-based interventions have the advantage of increasing access to male partners, by trying to reach them when and where they are available. For example, Ditekemena et

al. (2011) from the Democratic Republic of Congo offered VCT services to one of three venues, a neighborhood health center, bar, or church, and found that testing was higher in non-health service settings, in particular bars. In Zambia, Wall et al. (2012) also used influential community leaders and peers to invite couples to participate in group counseling and VCT at the health center and found that out of 29,119 invitations delivered by community agents, 1,727 couples came in for testing (6% success rate).

Recommendations for programming. Consistent with some evidence from male engagement literature, the review findings suggest three ways to increase male outreach:

1. **Utilize “In-reach” activities within health services**, such as male friendly services, and after work service hours. Training service providers to identify and recognize the presence of men within different health services is a key step in this process.
2. **Community outreach activities**, such as the use of same-sex community health agents and/or influential peers to reach out to male partners, and;
3. **Community-based counseling services**, such as providing counseling venues directly in the community, such as homes, churches, bars and community spaces.

This initial list of guidelines and recommendations are not at all exhaustive. For instance, one overarching gap includes identifying practical and resource-effective ways to train counselors on the value of engaging men, the deconstruction of their gender beliefs and behaviors as providers, all the while boosting their clinical skills in client centered services and guidelines.

Literature Review Limitations

There are a number of limitations to this review. Within this scoping exercise, we are able to generally classify intervention effectiveness based on reported outcomes, but unable to use more sophisticated meta-analytical methodologies. Additionally, the diversity of outcome variables and study contexts, lend themselves to a variety of research designs and methodologies. Not all papers labeled their intervention as a “couples counseling” intervention. The criteria we used included any intervention that intervened with both members of the couple, regardless of the format. As a result, a few community-based interventions were included in this review, which others might consider as primarily “group education” interventions. These interventions, however, were included if they had an additional component, typically vis-à-vis house visits, with the couple. Different interventions measure different outcomes, making model versus outcome comparisons difficult. For instance, most HIV studies are longitudinal, following the same couples over time, while FP studies utilize pre and post community household survey designs.

Our review also only includes papers with at least one effective outcome, excluding many lessons learned about what *not* to do in couples counseling. While we examined gender sensitive aspects of the different interventions, this review does not provide an assessment or comparison of different gender equitable designs and outcomes. As displayed by the variety of included interventions, couples counseling is not synonymous with gender transformative intervention design.

Not all papers explicitly reported their target groups. As a result, it is beyond the scope of this review to address how these interventions addressed couples' RH across the life course. A few of the interventions worked specifically with youth, but we did not report disaggregated results from these interventions here. As a result, we are unable to provide recommendations for couples counseling

interventions working with youth. However, the technical expert consultation meeting can be an optimal space to discuss such gaps and recommendations moving forward.

Our search is also limited to papers published in English; excluding lessons learned from other regions, in particular Latin America. Due to the selection criteria, our review excludes other promising but unpublished interventions, including Promundo's MenCare+ study in Rwanda and IRH's WALAN intervention, both of which provide group counseling to couples within the community (the latter providing direct counseling on FAM).

NEXT STEPS

In undertaking the literature review, we originally intended to scope existing evidence to inform the development of an imminent couples counseling tool. After screening 5,321 papers, and reviewing 41 of these, our overarching conclusion is that there is no one exclusive tool or approach that works best in couples counseling. Instead, we propose using these findings to set forth operational guidelines and principles in defining and conducting couples counseling in the FP field. Next steps include:

1. Convening an expert technical consultation to share the literature review findings, setting forth the operationalization of couples counseling definitions and approaches
2. Based on the expert technical consultation meeting, develop a "Couples Counseling Principles and Guidelines" brief for FP providers and practitioners
3. Publish a manuscript on the literature review findings in the *Global Health: Science and Practice* journal
4. Conduct a public webinar, informing the community at large of the review findings and proposed couples counseling guidelines

Overall, the literature diversity shows a clear need to operationalize couples counseling definitions and approaches. By framing our own terminologies and guidelines, we put forth preliminary guidelines, which we expect to discuss and revise as we share the review findings with the larger FP community.

REFERENCES

- Abdel-Tawab et al. 1997. Effects of Husband Involvement on Post Abortion Patients' Recovery and Use of Contraception in Egypt. In *Post Abortion Care: Lessons from Operations Research*. Population Council. 16-37.
- African Union. 2006. *The African Youth Charter*.
- ACQUIRE Project/Engender Health. 2008. *Mobilizing Married Youth in Nepal to Provide RH: The RH for Married Adolescent Couples Project, Nepal, 2005-2007*. E&R Report No 12. New York: ACQUIRE Project/Engender Health.
- Allen et al. 1992. Effect of Serotesting with Counseling on Condom use and Seroconversion among HIV Discordant Couples in Africa. *British Medical Journal*. 304 (6842) 1605-1609.
- Amaro, H. 1995. Love, Sex, and Power. Considering Women's Realities in HIV Prevention. *American Psychologist*. 50(6) 437-447.
- Amatya et al. 1994. The Effect of Husband Counseling on NORPLANT Contraceptive Acceptability in Bangladesh. *Contraception*. 50(3) 263-273.
- Becker and Robinson. 1998. Reproductive Health Care: Services Oriented to Couples. *International Journal of Gynecology & Obstetrics*. 61(3) 275-28.
- Becker et al. 2008. Couples Counseling at an Abortion Clinic: a Pilot Study. *Contraception*. 78, 424-431.
- Becker et al. 2010. Comparing Couples' and Individual VCT for HIV at Antenatal Clinics in Tanzania: A Randomized Trial. *AIDS and Behavior*. 14, 558-566.
- Becker et al. 2014. Pilot Study of Home-Based Delivery of HIV Testing and Counseling and Contraceptive Services to Couples in Malawi. *BMC Public Health*. 14, 1309.
- Byamugisha et al. 2011. Male Partner Antenatal Attendance and HIV Testing in Eastern Uganda: a Randomized Facility-Based Intervention Trial. *Journal of the International AIDS Society*. 14(43).
- Campbell, CA. 1995. Male Gender Roles and Sexuality: Implications for Women's AIDS Risk and Prevention. *Social Science and Medicine*. 41(2) 197-210.
- Coates et al. 2000. Efficacy of a Voluntary HIV-1 Counselling and Testing in Individuals and Couples in Kenya, Tanzania, and Trinidad: a Randomized Trial. *Lancet*. 356 (9224) 103-112.
- Cordova et al. 2014. The Marriage Checkup: A Randomized Controlled Trial of Annual Relationship Health Checkups. *Journal of Consulting and Clinical Psychology*. 82(4) 592-604.
- Daniel et al. 2008. The Effect of Community-Based RH Communication interventions on Contraceptive use among Young Married Couples in Bihar, India. *Int Fam Plan Perspect*. 34(4):189-97.

- Diczafalusy, E. 1995. RH: A Rendezvous with Human Dignity. *Contraception*. 52:1-12.
- Ditekemena et al. 2011. Male Partner Voluntary Counselling and Testing Associated with the Antenatal Services in Kinshasa, Democratic Republic of Congo: A Randomized Controlled Trial. *International Journal of STD and AIDS*. 22(3) 165-70.
- El-Bassel et al. 2003. The Efficacy of a Relationship-Based HIV/STD Prevention Program for Heterosexual Couples. *American Journal of Public Health*. 93(6) 963-969.
- El-Bassel et al. 2010. National Institute of Mental Health Multisite Eban HIV/STD Prevention Intervention for African American HIV Serodiscordant Couples: A Cluster Randomized Trial. *Arch Intern Med*. 170(17) 1594-1601.
- El-Bassel et al. 2011. Couple-Based HIV Prevention for Low-Income Drug Users from New York City: A Randomized Controlled Trial to Reduce Dual Risks. *J Acquir Immune Def Syndr*. 58(2) 198-206.
- Engender Health. 2003. *Comprehensive Counseling for RH – Participant's Handbook*. 9. New York: Engender Health.
- Erulkar, A and Tamrat, T. 2014. Evaluation of a RH Program to Support Married Adolescent Girls in Rural Ethiopia. *African Journal of RH*; 18(2) 68-76.
- Farnam et al. 2008. Effect of Sexual Education on Sexual Health in Iran. *Sex Education: Sexuality, Society and Learning*. 8 (2) 159-168.
- Farquhar et al. 2004. Antenatal Couple Counseling Increases Uptake of Interventions to Prevent HIV-1 Transmission. *J Acquir Immune Defic Syndr*. 37(5) 1620-1626.
- Gilbert et al. 2010. Couple-based HIV prevention for injecting drug users in Kazakhstan: A Pilot Intervention Study. *J Prev Interv Community*. 38(2) 162-172.
- Greene et al. 2006. *Involving Men in Reproductive Health: Contributions to Development*. Millennium Project.
- Hardee, K and Young, K. 1995. *From rhetoric to reality: delivering RH promises through integrated services*. Durham, NC: FHI 360.
- Hardee et al. 2016. *Men as Contraceptive Users: Programs, Outcomes, and Recommendations*. Working Paper. Washington, DC: Population Council, The Evidence Project.
- Hart et al. 2006. *A Collaborative Evaluation of Strategies to Encourage Couples-focused Health Service Delivery in a Sample of Title X-supported Family Planning Clinics*. U.S. Department of Health and Human Services.
- Institute for Reproductive Health (IRH), Georgetown University. 2007. *A Couple-Focused Approach to Improve Family Planning Services for Women and their Partners*. 1-4. Washington, DC: IRH.
- International Center for Research on Women (ICRW). 2006. *Improving the RH of Married and Unmarried Youth in India: Evidence of Effectiveness and Costs from Community-Based Interventions*. 15-17. Washington, DC: ICRW.

Kamenga et al. 1991. Evidence of Marked Sexual Behavior Change Associated with Low HIV-1 Seroconversion in 149 Married Couples with Discordant HIV-1 Serostatus: Experience at an HIV Counseling Center in Zaire. *AIDS*. 5, 61-67.

Koniak-Griffin et al. 2008. HIV Prevention for Latino Adolescent Mothers and their Partners. *West J Nurs Res*. 30(6) 724-742.

Koniak-Griffin et al. 2011. Couple-focused HIV Prevention for Young Latino Parents: Randomized Clinical Trial of Efficacy and Sustainability. *Arch Pediatr Adolesc Med*. 165(4) 306-312.

Kraft et al. 2007. Intervening with Couples: Assessing Contraceptive Outcomes in a Randomized Pregnancy and HIV/STD Risk Reduction Intervention Trial. *Women's Health Issues*. 17, 52-60.

LaCroix JM et al. 2013. Behavioural Interventions to Reduce Sexual Risk for HIV in Heterosexual Couples: A Meta-Analysis. *Sexually Transmitted Infections*. 89, 620-627.

Lasee, A and Becker, S. 1997. Husband–wife Communication about FP and Contraceptive use in Kenya. *International FP Perspectives*. 23(1)15–20.

Lavoie, K and Lundgren, L. 2009. Improving Family Planning Services for Women and Their Partners: A Couple-Focused Approach. U.S. Department of Health and Human Services.

Levtov et al. 2015. State of the World's Fathers: A MenCare Advocacy Publication. Washington, DC: Promundo, Rutgers, Save the Children, Sonke Gender Justice, and the MenEngage Alliance.

Lundgren et al. 2005. Cultivating Men's Interest in FP in Rural El Salvador. *Studies in FP*. 36(3) 173-188.

Lundgren R et al. 2012. Engaging Men in FP Services Delivery: Experiences Introducing the Standard Days Method in Four Countries. *World Health and Population*. 14(1) 44-51.

McGrath et al. 2007. A Group-Based Intervention to Increase Condom use Among HIV Serodiscordant Couples in India, Thailand, and Uganda. *AIDS Care*. 19(3) 418-424.

McMahon et al. 2013. Effectiveness of Couple-Based HIV Counseling and Testing for Women Substance Users and Their Primary Male Partners: A Randomized Trial. *Advances in Preventive Medicine*. 2013, 1-15.

Mohlala et al. 2011. The Forgotten Half of the Equation: Randomized Controlled Trial of a Male Invitation to Attend Couple VCT. *AIDS*. 25(12) 1535-1541.

Mullany et al. 2007. The Impact of Including Husbands in Antenatal Health Education Services on Maternal Health Practices in Urban Nepal: Results from a Randomized Controlled Trial. *Health Education Research*. 22(2) 166-176.

Ndong et al. 1999. Men's Reproductive Health: Defining, Designing and Delivering Services. *Men's Reproductive Health*. 25, S53-S55.

Padian et al. 1993. Prevention of Heterosexual Transmission of HIV through Couple Counseling. *J of Acquired Immune Deficiency Syndromes*. 6, 1043-1048.

- Parsons et al. 2002. Maintenance of Safer Sexual Behaviors: Evaluation of a Theory-Based Intervention for HIV Seropositive Men with Hemophilia and their Female Partners. *Hemophilia*. 6(3) 181-190.
- Population Council. 2001. Enhancing NGO-LGU Collaboration in FP: Using Community Workers to Reach Men in Agrarian Setting. Final Report. FRONTIERS Program. Washington, DC: Population Council.
- Population Council. 2008. Promoting Healthy Timing and Spacing of Births in India through a Community-Based Approach. FRONTIERS Program. New Delhi: Population Council.
- Raj et al. 2016. Cluster Randomized Controlled Trial Evaluation of a Gender Equity and FP Intervention for Married Men and Couples in Rural India. *PLoS One*. 11(5)
- Remien et al. 2006. Moving from Theory to Research to Practice. Implementing an Effective Dyadic Intervention to Improve Antiretroviral Adherence for Clinic Patients. *J Acquir Immune Defic Syndr*. 43 (Suppl 1) S69-78.
- Renick, MJ et al. 1992. The Prevention and Relationship Enhancement Program (PREP): An Empirically-Based Preventive Intervention Program for Couples. *Family Relations*. 41(2) 141-147.
- Shattuck et al. 2011. Encouraging Contraceptive Uptake by Motivating Men to Communicate about FP: The Malawi Male Motivator Project. *American Journal of Public Health*. 101(6) 1089-1095.
- Sinai et al. 2006. Fertility Awareness-Based Methods of FP: Predictors of Correct Use. *International FP Perspectives*. 32(2) 94-100.
- Stanback, J and Shattuck D. 2015. Secondary Outcomes of Male Involvement in Family Planning Interventions. *Knowledge for Health Blog*.
- Stanley et al. Strengthening Marriages and Preventing Divorce: New Directions in Prevention Research. *Family Relations*. 44(4) 392-401.
- Stern et al. 2015. Engendering Men: A Collaborative Review of Evidence on Men and Boys in Social Change and Gender Equality. *Emerge*.
- Terefe, A and Larson, C. 1993. Modern Contraception Use in Ethiopia: Does Involving Husbands Make a Difference? *Am J Public Health*. 83, 1567-1571.
- Tilahun et al. 2015. Couple Based FP Education: Changes in Male Involvement and Contraceptive use Among Married Couples in Jimma Zone, Ethiopia. *BioMed Central* 15, 682.
- Tuloro et al. 2006. The Role of Men in Contraceptive Use and Fertility Preference in Hossana Town, Southern Ethiopia. *Ethiopian Journal of Health Development* 20 (3) 152-159.
- Turan et al. 2001. Including Expectant Fathers in Antenatal Education Programs in Istanbul, Turkey. *RH Matters*. 9 (18) 114-125.
- Villar-Loubet et al. 2013. HIV Knowledge and Sexual Risk Behavior among Pregnant Couples in South Africa: The PartnerPlus Project.

United Nations (UN). 1981. Secretary-General's Report to the General Assembly. A/36/215.

Wall et al. 2012. Promotion of Couples' Voluntary HIV Counselling and Testing in Lusaka, Zambia by Influence Network Leaders and Agents. *BMJ Open*. 2:e001171.

Wall et al. 2013. Impact of Long-Term Contraceptive Promotion on Incident Pregnancy: A Randomized Controlled Trial among HIV Positive Couples in Lusaka, Zambia. *AIDS Journal*. 63(1) 86-95.

Wang et al. 1998. Reducing Pregnancy and Induced Abortion Rates in China: FP with Husband Participation. *Am J Public Health*. 88, 646-648.

World Health Organization (WHO). 2001. Counselling Skills Training in Adolescent Sexuality and RH: A Facilitator's Guide. Geneva: WHO.

Zolna et al. 2011. Couple-Focused Services in Publicly Funded Family Planning Clinics: Identifying the Need, 2009. Guttmacher Institute.

APPENDIX

Appendix A: Tables 9 and 10

Table 9. Types of reported outcomes, by RH intervention area

HIV	FP	MCH	ABORTION
<ul style="list-style-type: none"> Increased condom use and; un/protected sex acts Reduced risky behavior (<i>composite</i>) Improved safe sex communication Increased acceptance of VCT services 	<ul style="list-style-type: none"> Increased contraceptive uptake, and; continuation rate Reduced pregnancy incidence Increased partner support for FP Improved couple communication about FP Increased attendance in FP counseling visits 	<ul style="list-style-type: none"> Improved couple communication skills Increased attendance in antenatal and post-partum visits 	<ul style="list-style-type: none"> Increased post-abortion contraceptive use Increased acceptance of post-abortion of counseling services

Table 10. HIV reported outcomes, by level of effectiveness

	BEHAVIORAL (36)	ATTITUDINAL / RELATIONAL (7)	KNOWLEDGE (4)	COUNSELING UPTAKE (6)
EFFECTIVE	<ul style="list-style-type: none"> Increased condom use (8) Decreased unprotected sex acts (6) Lower seroconversion rate (3) High acceptance / adherence of ARVs (3) Increased intent to use condoms (2) Increased use of abstinence (2) Increased protected sex acts (1) Decreased injection acts and sharing (2) Increased safe sex behaviors (2); and sexual satisfaction (1) Reduction in HIV risk (1) 	<ul style="list-style-type: none"> Increased couple communication about HIV/AIDS and safe sex (3) Increased condom negotiation self-efficacy (2) Improved relationship reconciliation (1) Improved sexual relationship (1) 	<ul style="list-style-type: none"> Increased HIV/AIDS knowledge (2) 	<ul style="list-style-type: none"> High uptake of VCT and/or couple counseling (4)
MIXED EFFECT	<ul style="list-style-type: none"> Mixed effect on unprotected sex/acts (2) Mixed effect on protected sex acts (1) 		<ul style="list-style-type: none"> Mixed effect on HIV/AIDS knowledge (2) 	<ul style="list-style-type: none"> Mixed acceptance of couple counseling and testing (1)
INEFFECTIVE	<ul style="list-style-type: none"> Decreased condom use (1) No effect on IPV (1) 			<ul style="list-style-type: none"> Low couple uptake of testing among CVCT (1)

(*Note: Numbers in parentheses reflect the number of reported outcomes*)

Appendix B: Intervention Outcomes Matrices

Counselor training and Gender Considerations, by Couples Counseling intervention

ARTICLE	COUNSELOR PROFILE	TRAINING	GENDER ELEMENTS
FP (14)			
<p>ACQUIRE Project/Engender Health. (2008). Mobilizing married youth in Nepal to provide RH: The RH for Married Adolescent Couples Project, Nepal, 2005-2007. E&R Report No 12. New York: ACQUIRE Project/Engender Health.</p>	<ul style="list-style-type: none"> Peer educators Peer educators were married adolescents who were from each ward of the 69 project VDCs. The recruitment process sought to ensure representation for all ethnic groups, including marginalized groups. 	<ul style="list-style-type: none"> Basic training on reproductive health and dissemination skills (3 days). Workshops were conducted at the VDC level with 18 participants per event. A total of 1,241 married youth participated. Facilitation and communication skills training (2 days). Workshops were again held at the VDC level, and 1,153 youth attended. Village health workers (VHWs) and maternal and child health workers (MCHWs) also participated, which increased the workers' individual capacity as well as their understanding of peer educators' roles and responsibilities. Leadership development training (5 days). One peer educator from each of the 69 project VDCs was trained in leadership skills. Major topics included coordination and networking skills, problem solving, social inclusion, community mobilization, good governance and transparency, women's rights, and volunteerism. Street drama performance arts training (7 days). Twenty-five peer educators were trained to develop and perform street theater that incorporated messages on the reproductive health needs and rights of adolescents, on HIV and AIDS and STIs, on child marriage, and on dowry practices. The workshop was conducted with technical assistance from Mithila Natyakala Parishad, a celebrated drama collective that has performed in the <i>terai</i> for more than two 	<ul style="list-style-type: none"> Two married youth from each ward of the 69 project VDCs—one male and one female—were trained and mobilized voluntarily to serve as community role models and “change agents.” The peer educators' central responsibilities were to disseminate reproductive health information to married adolescents, especially young women with restricted social mobility, and to act as key actors and advocates within their communities to promote services for married adolescents.

		<p>decades. Following the training, participants established theater groups in both districts.</p> <p><u>In tool (Training manual)</u></p> <ul style="list-style-type: none"> • Training manual covers sessions including: getting to know our clients (supporting clients informed and voluntary decision making, etc.) building communication and counseling skills (addressing misconceptions, managing side effects and other problems, etc.), and FP counseling in practice (counseling role plays, action plans to apply new learning, etc.) • The curriculum relies on a number of methods, materials, and tools to ensure transfer of training. • The rapport building, exploration, decision making, and implementing (REDI) framework encourages open communication and less rigid counseling. REDI lends itself well to counseling clients from different categories (e.g., new vs. return). Unlike other counseling frameworks, REDI also addresses whether and how the client will be able to carry out the decision he or she has made. • Because of the range of sensitive issues related to SRH in different countries, this curriculum uses the training participants' input to create "client profiles" that reflect the unique SRH situation in a given country. The client profiles are used for case studies and role-playing throughout the training and provide the basis for a "daily reflection" from the client's perspective. 	
<p>Amatya, et al. (1994). The effect of husband counseling on NORPLANT contraceptive acceptability in Bangladesh. <i>Contraception</i>. 50(3) 263-273.</p>	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • Husbands participated in counseling sessions with their wives. In the session they were given a brochure discussed the supportive role husbands can play in decision-making

<p>Daniel et al. (2008). The effect of community-based RH communication interventions on contraceptive use among young married couples in Bihar, India. Int Fam Plan Perspect. 34(4):189-97.</p>	<ul style="list-style-type: none"> • The personnel involved in the project were female change agents, male change agents, cluster supervisors, block-level project managers, training officers, district project officers, and the directors of the implementing partners. Their roles and responsibilities were as follows. <ul style="list-style-type: none"> ○ Change agents and training officers provided information to young men and women; their work was monitored and supervised by cluster supervisors. ○ Project managers, in turn, supervised all of the work in a block, and they organized (with help from cluster supervisors) activities related to social environment building and to improving access to reproductive health services. <p>At the district level, the work was jointly supervised by the director of the implementing partner organization and the district officer.</p>	<ul style="list-style-type: none"> • Project training officers were responsible for training change agents and cluster supervisors. In addition, they trained village youth on street theater performance; educated chemists and village shopkeepers on the sale of oral contraceptives and condoms; trained rural practitioners, village reproductive health teams, and traditional birth attendants; and conducted educational workshops for unmarried young men and women and infotainment parties. Project trainers were themselves trained by a local training organization using materials and methodologies developed by Pathfinder International 	<p>before acceptance of the method and in better tolerating side effects</p> <ul style="list-style-type: none"> • Group meetings were held for young married women and, separately, young married men; and young married women and men were counseled, separately, at home. • To reach young married women, a female change agent visited each young woman at her home every month to provide information and education. • A male change agent, also a local resident, conducted periodic group meetings for men (separately for young married men, fathers-in-law and influential male community members), and encouraged unmarried young men to attend educational programs. He also counseled young married men at their homes.
<p>Erulkar, A. and Tamrat, T. (2014) Evaluation of a Reproductive Health Program to Support Married Adolescent Girls in Rural Ethiopia. African Journal of Reproductive Health; 18(2): 68-76.</p>	<ul style="list-style-type: none"> • Mentors are all female and all from rural communities 	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • ‘Meseret Hiwott’ program (meaning ‘Base of Life’ in Amharic) was established with the aim of supporting girls who were married at an early age in rural areas of Amhara region, Ethiopia. • Project objectives were to provide girls with increased social networks, and knowledge and skills to improve their reproductive health and prevent HIV. Through the project, female mentors are recruited from rural communities and trained to mobilize and lead girls’

groups. Once trained, mentors go house-to-house to identify married adolescent girls aged 10 to 24, describe the program and invite girls' participation. Recruitment visits at the household level allow mentors to negotiate for the girl's participation with other gatekeepers, such as husbands or parents-in-law.

- Participating girls are organized into girls' groups which meet roughly three times per week, depending on the availability of participants. Groups meet in locally available meeting spaces, such as community halls, in participants' houses, or under a tree. Once in groups, girls are taken through a 32-hour curriculum that covers topics such as communication and self-esteem, sexually transmitted infections (STIs) and HIV/AIDS, voluntary counseling and testing (VCT), antiretroviral therapy (ART), reproductive health, menstruation management, family planning, safe motherhood, gender and power dynamics, and financial literacy.
- Shortly after 'Meseret Hiwot' groups for girls began at the end of 2008, men in the project communities requested a program of their own. 'Addis Birhan' (Amharic for 'New Light') was designed to contribute to achieving the objectives of the 'Meseret Hiwot' project by equipping rural husbands with communication and support skills to improve the health and well-being of their wives and families. Similar to the design of the program for married girls, male mentors are recruited from communities and trained. They make house-to-house visits to recruit husbands into the program, with groups meeting in community spaces. Unlike 'Meseret Hiwot', husbands of any age are eligible for the program, and not only men who are married to girls of adolescent age.

			<ul style="list-style-type: none"> In the groups, men are taken through a participatory curriculum that includes partner communication, non-violent and respectful relationships, caring for wives and children, alcohol and drugs, STIs, HIV/AIDS, VCT, ART, family planning, safe motherhood, domestic violence and sexual violence, among others. Sessions in both programs are interactive and include group discussions, role plays and storytelling. As a considerable proportion of participants had never been to school, illustrations were used to spark discussion on topics such as assistance with domestic duties and childcare, couples going to clinics and domestic violence.
<p>International Center for Research on Women (ICRW). (2006). <i>Improving the reproductive health of married and unmarried youth in India: Evidence of effectiveness and costs from community-based interventions</i>. 15-17. Washington, DC: ICRW.</p>	<ul style="list-style-type: none"> Health providers, school teachers, and married couple field workers were trained 	<ul style="list-style-type: none"> KEM staff selected and trained interested local school teachers as reproductive health educators and lay counselors. They also trained various levels of health providers in reproductive health education and to recognize and refer people for counseling or health services. 	<ul style="list-style-type: none"> <i>None mentioned</i>
<p>Kraft, et al. (2007). <i>Intervening with couples: Assessing Contraceptive Outcomes in a Randomized Pregnancy and HIV/STD Risk Reduction Intervention Trial</i>. <i>Women's Health Issues</i>. 17, 52-60.</p>	<ul style="list-style-type: none"> Male and female facilitators with experience in social work, counseling, or a related field facilitated the intervention and comparison sessions. 	<ul style="list-style-type: none"> <i>None mentioned</i> <u>In tools (Facilitator training)</u> The facilitator training is two days long. Training includes lessons on group facilitation skills, co-facilitation skills, and reviewing and practicing sessions. Skills needed – communication skills including probing questions, and non-verbal communication, knowledge on how to avoid co-facilitation issues, ways to manage resistance, ways to handle difficult situations. In the training, the facilitators review ethical guidelines, the consent forms, materials for each session, FP methods, and pre and post-test for participants. 	<ul style="list-style-type: none"> Participants and interviewers were matched by gender.

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- Male and female PCI staff and existing water and sanitation volunteers
- Staff and volunteers were trained to incorporate family planning information into their educational activities. Water and sanitation volunteers referred couples interested in obtaining a family planning method to volunteers who had been trained by PCI to provide family planning counseling or to Ministry of Health services.
- Instructors explaining the Standard Days Method were trained to use a pictorial job aid to screen couples interested in using the SDM to determine whether the method was appropriate for them. For example, the job aid would help providers to identify couples with risk of sexually transmitted infections, domestic violence, or alcohol problems and other couple-related issues that could influence use of a contraceptive method. Instructors were also trained to address these couple related issues while teaching couples to use a method and while conducting follow-up visits.
- Training of PCI staff and community volunteers was accomplished in several stages. At the beginning of the project, the MOH provided PCI facilitators with two days of family planning training (including role-playing and case studies) and an additional day of training in the Standard Days Method. PCI facilitators trained 110 water and sanitation volunteers to incorporate family planning topics into their activities, using the manual *Planning Together*. Once the educational activities were underway, staff from PCI and the Institute for Reproductive Health trained a smaller group of 24 community volunteers to serve as "instructors," providing condoms and the Standard Days Method and referring potential users of other methods to ADS and the MOH. Bimonthly supervisory
- The effort to reach men required institutional flexibility and innovation. PCI provided compensatory time and per diem compensation for staff to conduct meetings during evenings and weekends with men in rural areas. Volunteers went out into the fields to talk with men while they were working and also conducted home visits. For monitoring purposes, sex-specific indicators (such as the percentage of home visits conducted with men present) were incorporated into supervisory tools and activities.

		<p>visits and a group refresher training three months later reinforced the initial training.</p> <ul style="list-style-type: none"> • Training of staff and volunteers covered basic counseling principles, informed choice, contraceptive technology, criteria for method eligibility, and how to refer couples for family planning services. Instructors were also trained to screen and counsel couples interested in using the Standard Days Method or condoms. Both groups were given information on how to reach men. 	
<p>Population Council. (2001). Enhancing NGO-LGU Collaboration in Family Planning: Using Community Workers to Reach Men in Agrarian Setting. Final Report. FRONTIERS Program. Washington, DC: Population Council.</p>	<ul style="list-style-type: none"> • Couple educators were identified by the People's Organizations in each of the study communities. They were selected for their leadership and communication skills and their willingness to commit their time to conducting educational events in the community. Some had been leaders in other KANIB programs, and all were farmers, like other residents in the communities. They had no special health training and no previous experience in health education or communication. 	<ul style="list-style-type: none"> • The training had two purposes: to increase the couples' knowledge of reproductive health and give them the skills to carry out the reproductive health awareness sessions in the communities. Since the couples had no previous health experience, it was necessary to give them a basic grounding in the reproductive health subjects they were to teach. In addition, they needed to learn how to impart this information to couples in their communities. The training was both didactic and experiential. • The training on the four RHA modules was undertaken in two stages, allowing the educators to gain mastery of material in a more gradual manner. During each three-day training session, the couple educators were trained in two modules. The training was experiential. Trainers modeled the instruction and couples held demonstrations in the classroom, before conducting practice sessions in the community. After one week of practice in the community, they returned for a three-day training that consisted of repeat demonstrations, feedback, and reinforcement. Couple educators used teaching scripts, which were developed in response to their request to help them more comfortably and competently conduct the sessions. The scripts included key content areas to be covered during the sessions, 	<ul style="list-style-type: none"> • The RHA model encourages couples to actively participate in their own reproductive health care with emphasis on four thematic areas: body/self awareness, family planning and awareness of gender issues, RTI/STIs and HIV/AIDS awareness and prevention, and couple communication. • Although a couple-approach was used, emphasis was placed on husbands' needs and their involvement in reproductive health, stressing the importance of the husband's presence and participation as educators. Male methods of family planning were highlighted and use of condoms was presented not only as a way to prevent STI transmission but also as a family planning method.

		<p>activities, and questions for reflection. The couple educators acquired the skills and confidence they needed to teach the sessions, as they were encouraged to practice at home. In addition to the topics included in the educational sessions, couples were trained in public speaking, facilitation, and in the elements of counseling. Fourteen couples completed the training and served as educators during the community sessions scheduled in the program areas</p>	
<p>Population Council. (2008). Promoting healthy timing and spacing of births in India through a community-based approach. FRONTIERS Program. New Delhi: Population Council.</p>	<ul style="list-style-type: none"> • Paramedics and community health workers (CHW) 	<ul style="list-style-type: none"> • The intervention included a TOT, who then trained the paramedics and other CHWs. • The educational campaign was implemented by 267 CHWs who were first reoriented in pre- and postnatal care, LAM, and postpartum contraception and trained in counseling skills to manage young couples' reproductive health needs and use job aids to make their counseling more effective. • Training of community workers: A three-tier training model was developed, to implement the training program. First, a one-day orientation meeting was organized on September 28, 2006, for the medical officers, ICDS officers, and district health and ICDS officers at the medical college, to orient them about the study, its research objectives, and proposed interventions. They were also oriented on how the intervention could help achieve their own program objectives. The orientation meeting was inaugurated by the District Magistrate (DM), who is the chief administrator of the district and all developmental programs, including health programs. His presence in the orientation and support for the intervention gave a clear indication of the commitment of the top program managers to the proposed program. At the end of the meeting, the participants worked out the training plan for the CHWs. The medical officers from the two 	<ul style="list-style-type: none"> • To raise the awareness among husbands, group meetings were organized. In these meetings, in addition to husbands, other community elders and the Pradhan (village leader) were also invited to attend. This approach was to raise the community's awareness about the risks associated with closely spaced pregnancies and why postpartum contraception is important. During the first male group meeting in each of the study villages, the HTSP booklet was made available and they were encouraged to take one. However, availability of MHWs for conducting group meetings remained limited because they had to cover a much larger area than an ANM. This fact, coupled with a lack of enthusiasm in organizing the meetings, led to only three male group meetings being held, out of which only one was managed by an MHW. The remaining two were organized by community-level workers and addressed by an ANM.

		<p>experimental PHCs and the Child Development Project Officers (CDPOs) from the study areas agreed to train the CHWs.</p> <ul style="list-style-type: none"> • Training of the CHWs was conducted in groups of 25 trainees over a two-day period. A second one-day training was given during the monthly meeting of AWs and ASHAs, one month after the first training. The training consisted of both classroom and role-play sessions. 	
<p>Raj, Ghule, Ritter, Battala, Gajanan, Nair, et al. (2016). Cluster Randomized Controlled Trial Evaluation of a Gender Equity and Family Planning Intervention for Married Men and Couples in Rural India. PLoS One 11(5): e0153190. doi:10.1371/journal.pone.0153190</p>	<ul style="list-style-type: none"> • Trained male village health care providers 	<ul style="list-style-type: none"> • The FP counseling training was the standard public health FP training for the state, provided by the partnering medical college. Two half-day booster sessions were delivered within 3 months of the initial training, primarily focused on GE elements, based on observations suggesting the need for more training in this area. All trainings were conducted by a combination of academic physicians and researchers in India with expertise on FP, GE, and marital violence. <p><u>In tool (Training manual)</u></p> <ul style="list-style-type: none"> • Training manual includes CHARM intervention overview, flip chart, in the intervention manual (which includes information on the three sessions) and the CHARM supplemental resources for providers • Includes information on the CHARM theoretical framework (detailed in the following column) 	<ul style="list-style-type: none"> • World Health Organization guidelines for research on domestic violence were followed to help ensure that women participating in our study, which did include domestic violence assessments, were not at increased risk for violence due to their participation. Hence, in addition to separately and privately surveying husbands and wives, we only surveyed women on experiences of spousal violence. We also did not inform husbands of the pregnancy test or test results obtained through this study • The intervention involved three gender, culture and contextually-tailored family planning and gender equity (FP+GE) counseling sessions delivered by trained male village health care providers to married men (sessions 1 and 2) and couples (session 3) in a clinical setting, or if required, near or in the participant's home • CHARM Theoretical Framework. The CHARM intervention was developed based on a theoretical framework inclusive of Social Cognitive Theory (SCT) and Theory of Gender and Power (TGP). TGP is a social-structural theory that posits that gender-based power dynamics inherent to many heterosexual dyadic relationships due to societally reinforced social norms can facilitate male control over sexual and reproductive decision-making, including contraceptive use, and some men may even

			use violence to control their female partners. Hence, counseling that can affect gender-equity and FP normative beliefs among men, particularly if the counseling was delivered by a respected male, could be useful in improving contraceptive use in the context of safer and healthier relationships.
Terefe, A. & Larson, C. (1993). Modern Contraception Use in Ethiopia: Does Involving Husbands Make a Difference? Am J Public Health. 83, 1567-1571.	<ul style="list-style-type: none"> Local, trained traditional birth attendants who were currently working in the district and had, on average, more than 10 years experience in the community were paired with a female interviewer having a 12th-grade education. Health assistants were also trained. 	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> None mentioned
Tilahun, et al. (2015) Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. BioMed Central (15): 682.	<ul style="list-style-type: none"> Three male and three female community agents who were hired for this study's purpose and undertook the intervention activity. These community agents had completed high school, whereas the health officer held a degree; they all spoke the local language fluently. 	<ul style="list-style-type: none"> Interviewers participated in a three day training 	<ul style="list-style-type: none"> None mentioned
Wall, et al. (2013) Impact of long-term contraceptive promotion on incident pregnancy: a randomized controlled trial among HIV positive couples in Lusaka, Zambia. AIDS Journal. 63(1):86-95.	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> None mentioned
Wang, et al. (1998). Reducing Pregnancy and Induced Abortion Rates in China: Family Planning with Husband Participation. Am J Public Health. 88: 646-648.	<ul style="list-style-type: none"> Health workers 	<ul style="list-style-type: none"> Each woman received 3-5 hours of on-site training. 	<ul style="list-style-type: none"> None mentioned
MCH (2)			
Mullany, et al. (2007) The impact of including husbands in antenatal health education services on	<ul style="list-style-type: none"> Providers included female study nurses and male auxiliary health workers 	<ul style="list-style-type: none"> All health educators received a standardized training course including education and counseling techniques and 	<ul style="list-style-type: none"> For delivery of the intervention, individual couples received a face-to-face education

maternal health practices in urban Nepal: results from a randomized controlled trial. Health Education Research; 22(2): 166-176.		role-playing, and structured intervention protocols were followed.	session administered jointly by one male and one female worker.
Turan et al. (2001). Including expectant fathers in antenatal education programs in Istanbul, Turkey. Reproductive Health Matters. 9 (18) 114-125.	<ul style="list-style-type: none"> Groups were led by two trained male physicians. 	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> Formative research was conducted and found that men did not participate in group sessions, so they used different strategies to reach the male participants. They also learned that in a program for couples, men's participation should not be made mandatory as it may be a barrier to participation for some wives.

ABORTION (2)

Abdel-Tawab et al. (1997). Effects of Husband Involvement on Post abortion Patients' Recovery and Use of Contraception in Egypt. In Post abortion Care: Lessons from Operations Research. Population Council. 16-37.	<ul style="list-style-type: none"> 40 midwives and 35 physician supervisors 	<ul style="list-style-type: none"> 35 physicians from five hospitals participated in one day of orientation for the intervention (counseling husbands of post-abortion patients). These physicians would then act as supervisors who would train their colleagues and provide on-site supervision and follow-up for three months. 	<ul style="list-style-type: none"> The intervention itself is counseling that emphasized the important role husbands play in their wives' recovery and in the adoption of a family planning method during the post abortion period.
Becker, et al. (2008) Couples counseling at an abortion clinic: a pilot study. Contraception, 78, 424-431.	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> Husband was present for the interview and the counselling session

HIV/STI (23)

Allen, et al. (1992) Effect of serotesting with counseling on condom use and seroconversion among HIV discordant couples in Africa. British Medical Journal; 304(6842): 1605-1609.	<ul style="list-style-type: none"> Local social worker 	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> None mentioned
Becker, et al. (2010). Comparing Couples' and Individual VCT for HIV at Antenatal Clinics in	<ul style="list-style-type: none"> Counselors at antenatal clinics 	<ul style="list-style-type: none"> Counselors at each antenatal clinic were trained in couple counseling techniques. UNAIDS and the U.S. Centers for Disease Control both had detailed training guidelines for HIV VCT counselors generally, 	<ul style="list-style-type: none"> Before study recruitment began, formative research was conducted to determine the best modalities for the study. In-depth interviews and focus group discussions with women, men, and counselors in a nearby, similar antenatal

<p>Tanzania: A Randomized Trial. <i>AIDS Behav.</i> 14, 558-566.</p>		<p>and these were adapted to the Temeke antenatal setting. The training also drew on the formative research results.</p>	<p>clinic were carried out to determine the acceptability of CVCT, how to make the clinics couple-friendly, provide test results and counseling for serodiscordant couples, and resolve conflict within couples.</p>
<p>Becker, et al. (2014) Pilot study of home-based delivery of HIV testing and counseling and contraceptive services to couples in Malawi. <i>BMC Public Health.</i> 14:1309.</p>	<ul style="list-style-type: none"> Male and female counselors and a qualified phlebotomist 	<ul style="list-style-type: none"> All counselors received intensive training in CHCT and CFP for five days, and each team had a qualified phlebotomist. 	<ul style="list-style-type: none"> After the baseline questionnaire, the woman's counselor sought a private location and asked her consent to CHCT + CFP, CHCT-only or CFP-only. That counselor then used color-coded cards to discreetly relay the woman's accepted intervention(s) to the male partner's counselor in a second private location (often outside the back of the house). The man was offered whichever service(s) the woman had accepted. If the woman accepted neither, the man was not offered any of the services and the session ended.
<p>Byamugisha, R. et al. (2011) Male partner antenatal attendance and HIV testing in eastern Uganda: a randomized facility-based intervention trial. <i>Journal of the International AIDS Society.</i> 14(43):</p>	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> <i>None mentioned</i>
<p>Coates, et al. (2000). Efficacy of a voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomized trial. <i>Lancet.</i> 356(9224) 103-112.</p>	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> <i>None mentioned</i>
<p>Ditekemena, J. et al. (2011) Male partner voluntary counselling and testing associated with the antenatal services in Kinshasa, Democratic Republic of Congo: a randomized controlled trial. <i>International Journal of STD and AIDS.</i> 22(3): 165-70.</p>	<ul style="list-style-type: none"> Counselors 	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> In the present study male partner VCT was conducted in three types of venues: bars, churches and neighborhood health centers. Neighborhood, availability of space for VCT, frequentation by men and willingness of the site's owner were the main criteria for venue selection.

<p>El-Bassel, et al, (2010). National Institute of Mental Health Multisite Eban HIV/STD Prevention Intervention for African American HIV Serodiscordant Couples: A Cluster Randomized Trial. Arch Intern Med. 170(17) 1594-1601.</p>	<ul style="list-style-type: none"> • Male and female African American cofacilitators who had at least a bachelor's degree and 2 years of clinical experience in HIV prevention or related fields. 	<ul style="list-style-type: none"> • Co-facilitators received 40 hours of centralized facilitator training. 	<ul style="list-style-type: none"> • <i>None mentioned</i>
<p>El-Bassel, et al. (2003). The Efficacy of a Relationship-Based HIV/STD Prevention Program for Heterosexual Couples. American Journal of Public Health. 93(6) 963-969.</p>	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • At baseline, simultaneous but separate interviews with gender-matched interviewers took place with each partner. Couples were then randomly assigned to 1 of 3 study conditions: (1) the couple condition, 6 weekly relationship-based sessions in which both a woman and her partner received the intervention; (2) the woman-alone condition, in which only the woman received the same intervention; or (3) the education control condition, in which a woman alone took part in 1 HIV/STD information session. All women and men were asked to return for follow-up assessment 3 months after the final intervention or control session.
<p>El-Bassel, et al. (2011). Couple-Based HIV Prevention for Low-Income Drug Users From New York City: A Randomized Controlled Trial to Reduce Dual Risks. J Acquir Immune Def Syndr. 58(2) 198-206.</p>	<ul style="list-style-type: none"> • All 3 intervention conditions consisted of 7 structured 2-hour sessions delivered weekly by a single female or male facilitator—matched to the gender of the index participant— who had at least a bachelor's degree and 2 years of HIV prevention experience. 	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • All 3 intervention conditions consisted of 7 structured 2-hour sessions delivered weekly by a single female or male facilitator— matched to the gender of the index participant—who had at least a bachelor's degree and 2 years of HIV prevention experience.
<p>Farnam, et al. (2008). Effect of Sexual Education on Sexual Health in Iran. Sex Education: Sexuality, Society and Learning. Vol. 8, No. 2. 159-168.</p>	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • <i>None mentioned</i> 	<ul style="list-style-type: none"> • In our study, the sex education we provided consisted of three hours of segregated classes for men and women with a same-sex counselor and consisted of brief lectures and discussions. It had been divided into two main topics: safe sex and sexual enjoyment. The safe sex lectures covered male and female genital anatomy and physiology, the reproductive cycle (menstruation, ovulation and conception), reproductive health,

			reproductive screening tests (pap smear, breast and testis examinations), contraception and prevention of STIs. The treatment of sexual enjoyment and sexuality covered the sexual response cycle, factors influencing in this cycle (fantasy, sexual stimulation, intimacy, fatigue, anxiety, monotony), physical and emotional differences between men and women in this cycle, sexual communication, sexual techniques and behaviors. Given the limitation of our time, we prepared pamphlets for every couple and in class our focus was more on sexuality and sexual enjoyment.
Farquhar, et al. (2004). Antenatal Couple Counseling Increases Uptake of Interventions to Prevent HIV-1 Transmission. <i>J Acquir Immune Defic Syndr.</i> 37(5) 1620-1626.	<ul style="list-style-type: none"> Women and men were counseled by a female or male HIV infected peer counselor, respectively. 	<ul style="list-style-type: none"> None mentioned <p><u>In tool:</u></p> <ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> None mentioned
Gilbert, et al. (2010). Couple-based HIV prevention for injecting drug users in Kazakhstan: a pilot intervention study. <i>J Prev Interv Community.</i> 38(2) 162-172.	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> Conducted in-depth interviews for formative research. The data suggested that female participants were uncomfortable talking about sex with their partners and felt that it would be helpful to learn about sexual risk-reduction skills in groups with other same-gender participants before addressing these issues with their intimate partners. Both male and female participants felt that it would be very helpful to meet with a facilitator as a couple to help them identify and talk about outside risks and to develop a working plan to protect themselves from HIV/STIs. The intervention included 3 single gender group sessions followed by individual couple session.
Kamenga, et al. 1991. Evidence of marked sexual behavior change associated with low HIV-1 seroconversion in 149 married	<ul style="list-style-type: none"> Trained Zairian health worker of the same sex as the participant and speaking the tribal language most familiar to the interviewees. 	<ul style="list-style-type: none"> None mentioned 	<ul style="list-style-type: none"> Patients met with same sex counselor.

<p>couples with discordant HIV-1 serostatus: experience at an HIV counseling center in Zaire. <i>AIDS</i>. 5:61-67.</p>			
<p>Koniak-Griffin, et al. (2008). HIV prevention for Latino adolescent mothers and their partners. <i>West J Nurs Res</i>. 30(6) 724-742.</p>	<ul style="list-style-type: none"> The intervention program was co- led by female and male facilitators who were health professionals (e.g., nurses, health educators, social workers, psychologists). 	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> The theoretical framework for this study was based on principles from Healing the Wounded Spirit (Tello, 1998), the theory of gender and power (Amaro, 1995; Connell, 1987; Wingood & DiClemente, 1998), social cognitive theory (Bandura, 1986), and the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). The curriculum drew on the theory of gender and power in a number of ways. At times the young mothers and the young fathers met in separate groups to explore issues such as sexuality, gender roles, and relationship violence and then came together for a full- group discussion. Sexual politics of males and females were discussed in both gender- segregated and combined groups to facilitate understanding of individual behavior and behavior in relations with a partner. Maternal and paternal protectiveness was viewed as an element of the emotional attachment in parent-child social relations that may motivate behavior change. To promote safer sex behaviors, the program included the positive aspects of sexual norms and values, such as protecting family. A number of activities, such as identification and delineation of goals and dreams, life-planning exercises, and letter- writing to children, addressed these issues.
<p>Koniak-Griffin, et al. (2011). Couple-focused HIV Prevention for Young Latino Parents: Randomized Clinical Trial of Efficacy and Sustainability. <i>Arch Pediatr Adolesc Med</i>. 165(4) 306-312.</p>	<ul style="list-style-type: none"> The facilitators of the couple- focused HIV prevention program were 4 men and 3 women, all Latino except 1 bilingual African American facilitator, with backgrounds in community health 	<ul style="list-style-type: none"> About 40 hours of didactic and experiential training prepared facilitators to act as role models, nurturers, and teachers/guides, using their own experience whenever possible. The facilitation was based on a process known as espejo (mirror) teaching, 	<ul style="list-style-type: none"> Pairs of male and female facilitators involved participants in small-group discussions about HIV prevention (e.g., transmission modes and vulnerability) and attitudes and beliefs about HIV and “safer” sex. Unique features included facilitated discussions (“talking circles”) in which issues of gender norms and

	and social services involving high-risk Latino youth.	using strategies such as storytelling, reflection, and guidance.	power were discussed in terms of effect on partner relationships and healthy sexual decision making.
McGrath, et al. (2007). A group-based intervention to increase condom use among HIV serodiscordant couples in India, Thailand, and Uganda. <i>AIDS Care</i> . 19(3) 418-424.	<ul style="list-style-type: none"> Male and female facilitators 	<ul style="list-style-type: none"> Groups of 4-6 couples were convened by experienced, trained male and female facilitators <p><u>In tool (Facilitator manual for implementing the intervention)</u></p> <ul style="list-style-type: none"> Includes scripted language, and other directions for facilitators 	<ul style="list-style-type: none"> <i>None mentioned</i>
McMahon, et al. (2013). Effectiveness of Couple-Based HIV Counseling and Testing for Women Substance Users and Their Primary Male Partners: A Randomized Trial. <i>Advances in Preventive Medicine</i> . 2013, 1-15.	<ul style="list-style-type: none"> One male bilingual (English and Spanish) interventionist performed 95% of the 330 HIV counseling and testing interventions administered across the three conditions. The remainder was performed by one female bilingual back-up interventionist. The principal male interventionist had over twenty years experience in community outreach, case management, education, drug treatment, and HIV counseling. He was also a trained phlebotomist and performed all biological specimen collection for HIV and hepatitis B and C antibody screening. The back-up interventionist had similar education and experience, including phlebotomy training. 	<ul style="list-style-type: none"> Both interventionists received extensive training on the two experimental interventions and standard-of-care control using an interactive skills building approach. <p><u>In tool (Intervention manual):</u></p> <ul style="list-style-type: none"> Intervention manual includes supply list, all sessions and objectives of those sessions, and facilitator scripts. 	<ul style="list-style-type: none"> <i>None mentioned</i>
Mohlala, et al. (2011). The forgotten half of the equation: randomized controlled trial of a male invitation to attend couple VCT. <i>AIDS</i> . 25(12) 1535-1541.	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> <i>None mentioned</i>
Padian, et al. (1993). Prevention of heterosexual transmission of HIV through couple counseling. <i>J of</i>	<ul style="list-style-type: none"> Counselor 	<ul style="list-style-type: none"> <i>None mentioned</i> 	<ul style="list-style-type: none"> <i>None mentioned</i>

<p>Acquired Immune Deficiency Syndromes. 6: 1043-1048.</p>			
<p>Parsons, et al. (2002) Maintenance of safer sexual behaviors: evaluation of a theory-based intervention for HIV seropositive men with hemophilia and their female partners. <i>Hemophilia</i>, 6:3. 181-190.</p>	<ul style="list-style-type: none"> Providers implementing this intervention were from a variety of disciplines, including nurses, social workers, health educators and psychologists. All providers had significant counselling experience in providing HIV risk-reduction services. 	<ul style="list-style-type: none"> The training consisted of an orientation to the TM and its specific application to HIV prevention. Ample opportunity was provided for skill-building activities and role-play practice with the stage-based intervention activities. 	<ul style="list-style-type: none"> <i>None mentioned</i>
<p>Remien, et al. (2006). Moving from theory to research to practice. Implementing an effective dyadic intervention to improve antiretroviral adherence for clinic patients. <i>J Acquir Immune Defic Syndr</i>. 43 (Suppl 1) S69-78.</p>	<ul style="list-style-type: none"> Two nurse practitioners 	<ul style="list-style-type: none"> Nurses were trained to provide referrals as needed for the couple or for either individual for mental health treatment, substance abuse treatment, sexual risk reduction counseling, and public assistance. Nurses received training from the Principal Investigator and Project Director regarding the theoretic basis for the intervention, the intervention curriculum, and the use of the MEMS. Both facilitators satisfactorily completed the full intervention curriculum with a pilot couple before meeting with trial participants. <p><u>In tool</u></p> <ul style="list-style-type: none"> Intervention manual including sessions, worksheets, and suggested scripts 	<ul style="list-style-type: none"> To help translate SAT constructs into specific activities within our couple-focused intervention curriculum, we drew on the literature on couple distress and satisfaction, which reveals the following critical components of an effective dyadic intervention: (1) clarify attributions and encourage positive ones, (2) increase expressiveness and foster effective communication, (3) create positive experiences, (4) develop strategies to protect the couple's investment in the relationship, (5) improve problem-solving skills, and (6) increase conflict management skills. Relationship-focused coping struggles with a primary dilemma: "How does one contribute to the partner's well-being, avoid unnecessary conflict, and yet look after oneself, balancing concern for the partner with one's own needs?" Coyne and his colleagues identified 2 broad classes of relationship-focused coping: active engagement, which involves open discussion and joint decision-making, inquiries into the partner's feelings, and problem solving, and protective buffering, in which concerns are hidden, worries are denied, and accommodation is employed to avoid disagreements. Intervention administered by a trained nurse practitioner in an outpatient treatment setting,

			<p>delivering 4 sessions, about 45 to 60 minutes each. Sessions include:</p> <ul style="list-style-type: none"> ○ What are my partner and I to do? ○ How can we improve? ○ How do we work together? ○ How well are we doing?
<p>Villar-Loubet, et al. 2013. HIV Knowledge and Sexual Risk Behavior Among Pregnant Couples in South Africa: The PartnerPlus Project.</p>	<ul style="list-style-type: none"> ● Intervention was led by two trained lay counselors 	<ul style="list-style-type: none"> ● <i>None mentioned</i> 	<ul style="list-style-type: none"> ● <i>None mentioned</i>
<p>Wall, et al. (2012). Promotion of couples' voluntary HIV counselling and testing in Lusaka, Zambia by influence network leaders and agents. <i>BMJ Open</i>. 2:e001171.</p>	<ul style="list-style-type: none"> ● Influential network agents 	<ul style="list-style-type: none"> ● Enrolled influential network agents received 4-day training in HIV/AIDS health advocacy/outreach, social networking, CVCT promotions and observation of successful door-to-door ZEHHP promotional strategies. During training, INLs and INAs were offered CVCT or VCT. 	<ul style="list-style-type: none"> ● <i>None mentioned</i>