PASSAGES PROJECT

Study of the Effects of the Husbands' School Intervention on Gender Dynamics to Improve Reproductive Health in Niger

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PREFACE

This study report represents one of several studies commissioned by the Passages Project to explore evidence gaps in understanding how community-based norms-shifting interventions lead to normative change.

Husbands Schools were designed to address the significant barrier of men not allowing their wives to access health services, in the context of a patriarchal society where women have minimal personal decision-making power and financial resources. The reasoning in the initial 2007 design of Husbands Schools was to engage men in understanding the importance of reproductive health for their couple and families and supporting wives' use of reproductive health services. The informal village-level schools focused on civic engagement, shared leadership between 'Model husbands' and oriented members to sensitize others on reproductive health issues and service use. The program design did not directly address gender equality's roots in power-sharing and social equity were in member orientations or community sensitizations. Instead, modeling of men as supportive partners invested in their wives' health was done using flipbook images in husbands' training and sensitization during community discussions. Images showed men accompanying their wives to health centers, consulting with providers, engaging in couple discussions, and showing men sharing domestic chores in their homes.

From the beginning of our collaboration, it was clear that UNFPA and SongES needed and wanted a better understanding of the gender effects of Husbands Schools. The anecdotal evidence was positive from field observations, and qualitative data from the 2014 outcome evaluation focused on services utilization. Such evidence indicated that gender shifts were occurring, including improved couple communication and male support of women's use of services. It also appeared that similar gender shifts were diffusing outward to members' wives and other men in the community and their wives.

This exploratory study was thus designed to understand how power-sharing was taking place between men, who were members of Husbands Schools, and their wives, and the broader community. We aimed to understand better the change pathways (of program theories of change) leading to the expected outcome of Husband School activities: increased use of antenatal, delivery, postnatal, and family planning services at a community level. From a norms perspective, what shifts did Husbands School activities lead to vis-a-vis member couples' gender attitudes and roles relating to reproductive health decision-making and use of services? Were similar changes observed at a community level, indicating gender-equitable expectations (i.e., norms) around reproductive health and services use? The qualitative study sample included three regions in Niger to assess sites in different phases of scale-up, allowing comparison of School effects on power-sharing and gender role shifting in different socio-economic and geographic regions.

The study finds that gender role shifting and power-sharing were prominent in visited sites, yet these effects were manifested differently at different levels of decision-making and power-sharing. At one level, patriarchy and the view of men's social position did not seem to be changing. Men retained an ultimate decision-making power on services use; still, men now understand the importance of reproductive health service use and male engagement, a marked departure from earlier times when men did not understand, trust, or allow their wives to use services. At another level, significant and widespread changes were seen in how women and men view each other and interact as couples. There is much more gender-equal access to reproductive health information. Couple communication, now initiated by women and by men, is occurring around family planning (most pronounced) and antenatal and delivery care and services use, a clear transition from earlier when men held power over spouses by deciding when and what to communicate to their wives on these issues. Women likewise expressed newfound freedoms and actions to seek and use services independently and to engage with their husbands in discussions on reproductive health. These shifts held true at a community level.

Although more work remains for gender-role shifting and power-sharing, a simple intervention based on outreach by a dozen 'Model husbands' in any one village catalyzed changes in reproductive health and services use and related gender attitudes, expectations, and behaviors of women and men and couples. This shift affirms theoretical pathways of change that norms are beginning to shift – the expectations of what is 'correct' and 'should be done' (i.e., reproductive health norms) - in those directly and indirectly reached by Schools.

EXECUTIVE SUMMARY

The strategy of the Husbands' Schools (HS or Écoles de Maris) intervention focuses on training and reinforcing the knowledge of a core group of husbands on the importance of promoting and using reproductive health services - antenatal, assisted delivery, and family planning services. These men called Model husbands (Maris modèles*)* serve as change agents in their homes and the community. They aim to generate a change in knowledge, behavior, and attitudes, and through their modeling and community outreach actions to plant the seeds of change in gender roles about reproductive health (RH) and antenatal, delivery and postpartum and family planning services. This qualitative, exploratory study was carried out in 3 regions (Dosso, Tahoua, and Zinder) to evaluate the effects of the HS intervention on gender dynamics to improve sexual and reproductive health in Niger. A total of 35 individual interviews and 25 focus groups were conducted with respondents directly and indirectly exposed to the HS intervention. Questions focused on present-day perceptions and often elicited before-after reflections on HS and their impact on couples and the larger community. Some questions aimed to understand how diffusion of new ideas occurred, which would contribute to norms-shifting at community level. Focus groups and individual interviews were recorded on dictaphones, then transcribed to serve as the study's database. Data collection occurred from June 09 to July 09, 2018.

Study results showed that *Husbands' Schools* is an intervention accepted and supported by the community. Model husbands, a name given to men who are members of schools, are listened to and are seen as credible resources for RH by their wives, peers, and community members, enhancing the value of women's reproductive health and use of services. They are considered specialists, and respondents often put on the same level of esteem as health workers. Model husbands have a positive perception of their role to sensitize their peers and feel they have a mission to bring about positive behavior change in their household and the community concerning reproductive health services. One of the elements that facilitated the acceptance of HS is their roots in the community. The Model husbands' actions go beyond RH to embrace other areas; many HS meet other community needs, including improving child health and community hygiene.

Husbands' Schools helped reinforce husbands' and their wives' knowledge of the importance of using RH services. By comparing the level of knowledge before and after the intervention, it appears that HS have filled a gap in information and knowledge about the benefits of RH. Prejudices that contributed to creating doubt and mistrust about RH, particularly family planning (FP), have gradually given way to trust and acceptance, especially on the part of the men and women involved in the HS. The intervention's immediate effect was a significant improvement in the communication between husbands and wives as couples. Reproductive health issues that were considered taboo in the couple are now discussed between husbands and wives for joint decision-making. This change was observed in both model and non-Model husbands and their spouses, indicating a diffusion effect leading to wider community acceptance of improved couple communication. Some observed changes also go beyond the communities that have HS: Participants indicated that the HS messages are reaching surrounding villages and health areas with no HS through exchanges between communities and there is now discussions on RH and men's involvement in RH.

The study also showed a shift in power relations within couples that reflect the complexity of change processes. Indeed, it appears that even if the husband remains the ultimate decision-maker, that is the husband must necessarily agree, the wife has gained a certain independence in decision-making, especially on the use of FP. Wives also participate in decision-making when the couple decides when to have a child. In communities where HS operate, women have also described they gained new freedom of expression on reproductive health issues, e.g., to initiate RH-related discussions with their spouses and to advocate for services use.

The intervention focuses on shared decision-making in the couple on RH issues. However, the nature of the intervention strategy, which highlights husbands as catalysts for change, has led to respondents (generally men and women who are non-members of HS) noting effects that may be detrimental to gender transformation. The most visible being the perception that a husband's involvement in HS increases his responsibilities in the reproductive health of his wife and the couple. While on its own, increased responsibility within a couple implies shared responsibilities, this has led some men (noted by only a few respondents) imposing RH-related decisions on their wives.

The sustainability of the gains of the HS is demonstrated through: given the speed with which the messages are conveyed within couples in HS communities and beyond the HS' intervention areas, indicating community interest in the topic and subsequent idea diffusion; community acceptance of the intervention as worthy; and the willingness of the Model husbands and their wives to not abandon the new behaviors and acquired knowledge, above all, to not revert to how they were "before."

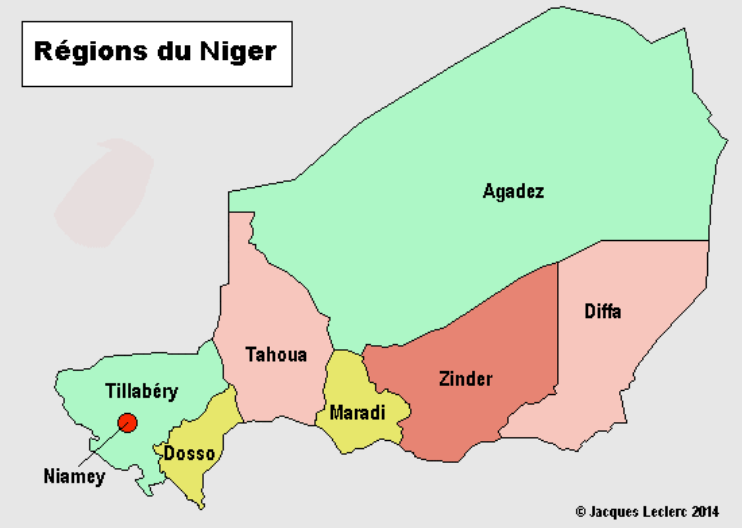
If these husbands succeed in changing their behavior and supporting a change in gender roles in their households as well as to other households in their communities, a profound social norms shift sought in communities is possible. That said, significant efforts are still needed for a greater change towards gender equity in RH decision-making across the different-level decisions relating to antenatal care, delivery, postpartum care, and FP services. Hence, the recommendation to intensify existing schools' training activities to deepen members' gender reflections vis-à-vis reproductive health, and to scale up HS activities in new areas to continue sowing seeds of gender norm shifting across communities in Niger.

THEORETICAL FRAMEWORK

THE CONTEXT OF THE IMPLEMENTATION OF HUSBANDS' SCHOOLS

In Niger, women give birth to around 7.6 children throughout their lives, making it the country with the highest fertility rate in the world (World Bank 2014). Five hundred fifty-three (553) women die in childbirth per 100,000 live births (World Bank 2015), and the modern contraceptive prevalence rate among women aged 15-49 is 14.4%, ranking Niger among the countries with the lowest rates of modern contraceptive use in the world (NIS 2013). Nearly half of the population is under 15 (Population Reference Bureau 2013), and in 2015, Niger was ranked 187th out of 188 on the Human Development Index and the Gender Development Index (UNDP 2016). Gender inequality affects all levels of society, and men dominate social, political, and cultural life. The majority of Nigerien women do not have the independence or ability to make decisions about their reproductive health. Societal expectations are that women (and men) should have many children. Niger has the highest rate of child marriage in the world, with three out of four girls married by the age of 18 (UNICEF 2016). Almost half – 48.2% - of girls give birth before 18 (UNFPA 2015). There is a close correlation between education and child marriage in Niger: The higher the level of education, the less likely a girl is to be married before 18 (UNFPA 2015, UNICEF 2016). This relationship is compromised by the fact that almost 85% of girls aged 15-19 and 57% of girls between 10 and 14 are not in school (UNFPA 2015).

Figure 1 | Map of Niger showing study locations in Dosso, Tahoua, and Zinder



Gender norms are the implicit rules and shared social expectations about how individuals should behave, based on their gender identity. In Niger, men are seen as the heads of households and make decisions on behalf of their wives and families. The use of reproductive health services, including antenatal care, delivery, and family planning, is considered 'women's matters,' and men are typically not involved. Yet, men hold power when it comes to the use of the family's limited resources. Since men are the decision-makers, it is considered normal for them to make decisions about whether or not a wife goes to the health center, and whether to use resources to pay for transportation and services. At the same time, the norm of having many children - to show a woman's worth and a man's virility – leads to men not approving family planning use. Because of these social and normative factors, women also lack power and decision-making ability. In the case of reproductive health, many women cannot access and use reproductive health services (Mayaki and Kouabenan 2015, Camber Initiative 2014, Mishra et al. 2014, Schuler et al. 2011, Nalwadda et al. 2010).

Politically, Niger is one of the African countries that have made firm commitments to improve sexual and reproductive health. Indeed, Niger was one of the countries that signed in 2004 and ratified in 2018 the Maputo protocol on the rights of women and girls. In Article 14, this protocol states that "States must ensure that women's rights to health, including sexual and reproductive health, are respected and promoted" (Maputo

protocol, 2003). Niger has a 2017 National Gender Policy (NGP) with two main objectives: 1) establish an institutional, socio-cultural, legal and economic environment that helps achieve equity and equality in chances and opportunities between men and women, girls and boys in Niger; and 2) ensure the effective integration of gender as a variable in the analysis, planning, implementation, monitoring and evaluation of development programs. The National Gender Policy is the result of a participatory approach. Formally adopted in August 2017, and its action plan was to be finalized in 2017, the Policy includes several social and behavior change strategies, including the Husbands' Schools/ Future Husbands' Clubs (*École des Maris / Club des futurs Maris)* (National Gender Policy, 2017).

Niger also has a 2012-2020 action plan to boost FP. The objective set by this plan is to increase use of modern contraception from 12% in 2012 to 50% by 2020, through three primary strategies, namely: improving availability and demand for FP services and modern contraceptive use, and promoting an enabling environment for demand and use of FP services. The Husbands' Schools intervention is perfectly aligned with the second and third strategies of the 2012-2020 Action Plan. The scaling up of HS is also one of the main strategic actions in this action plan, with an evaluation indicator being the number of Husband Schools created by 2020 (Family Planning in Niger, Action Plan 2012-2020).

In Niger, sexual and reproductive health indicators are among the lowest, especially in family planning, with only 12% of women aged 15 to 49 (all of those currently in union and those not in union and sexually active) using modern contraceptive methods, according to preliminary results from NDHS 2012. The use of modern contraceptive methods in Niger is very different depending on the place of residence. Indeed, only 8.5% of women in rural areas use a modern contraceptive method, compared to 23.5% in urban areas. The total demand for family planning services remains as low: 26% (NDHS, 2017, preliminary results).

The comparative table and graphs below show the RH indicators by national and regional levels for the period prior to operationalization of HS (2006) and when in full implementation (2012).

Table 1: Evolution of RH indicators for the country of Niger

Indicators	NDHS 2006	NDHS 2012
Total Fertility Rate (TFR)	7, 1	7,6
% who attended Antenatal Consultations, at least 4 visits (ANC)	15	32,8
% who gave birth with the assistance of Skilled personnel (ADS)	18	29,8
% who attended at least one postnatal consultations (PONC)	15	33
% who use a modern method of Family Planning (FP)	5	12

The following graphs are related to the evolution of these indicators in the regions where HS were established over the same period, especially the regions of Dosso, Tahoua, and Zinder where the study occurred.

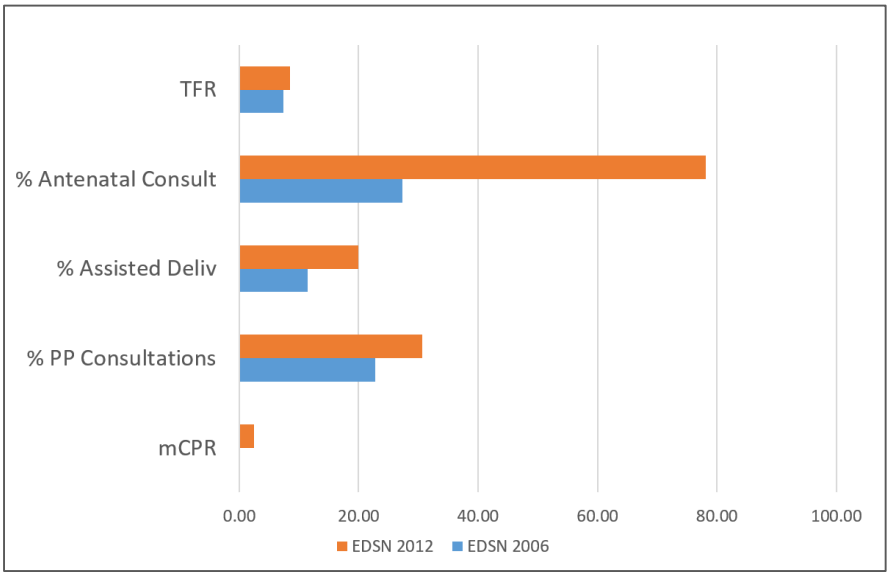


Figure 2 |Reproductive Health Service Indicators and Total Fertility Rate, Dosso

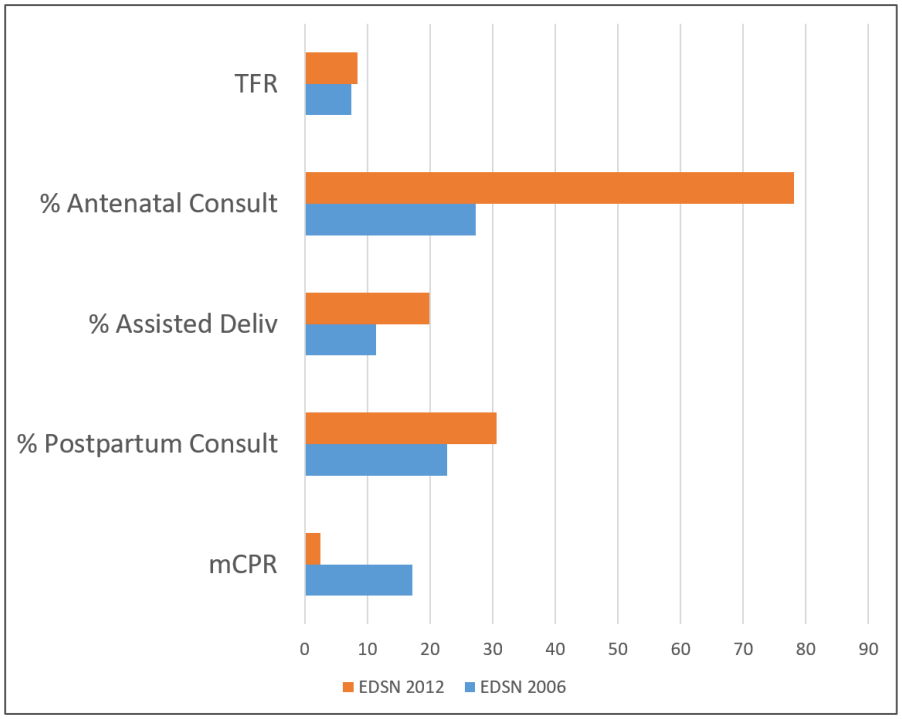


Figure 3 | Reproductive Health Services Indicators and Total Fertility Rate, Tahoua

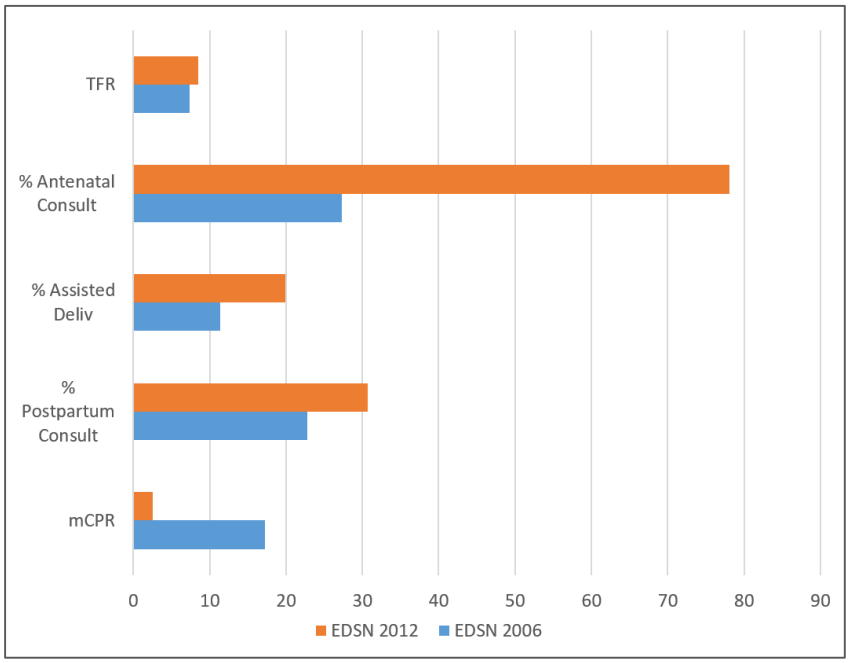


Figure 4 | Reproductive Health Service Indicators and Total Fertility Rate, Zinder

In Dosso, Tahoua, and Zinder, indicators have evolved with high variability, except for delivery assisted by a skilled attendant, which is linear and positive. Note the changes in services use in the timeframe when the activities of HS and other development agencies were fully funded and operational (2006-2012). Therefore, HS have their share of contribution to the positive development of RH indicators from 2007 to 2013. This evidence is affirmed in the report on an evaluation of the HS approach commissioned by UNFPA (Saley, 2014). The evaluation showed that in the sites where HS intervened, the use of RH services increased considerably over baseline, at the time of the evaluation. This was corroborated by comparing health center (CSI) reproductive health services statistics in areas with HS and those in areas without HS: similar improvements in the use of RH services in HS areas were noted. These data and other information collected during the evaluation led the author to conclude that the presence of HS was an important factor for increasing the use of RH services.

Gender, Social Norms and RH

Attitudes, beliefs, and gender and social norms can influence RH behavior. To be more effective, RH programs should systematically address gender and social norms that prevent men and women from accessing RH services. Interventions implemented at the community level targeting the husband, the wife, the family, and the community at large have contributed more to improving RH results than interventions targeting individuals only (Wegs et al. 2016). A systematic review of what works in family planning has shown that approaches focused on interpersonal communication and community dialogue are more effective in improving knowledge, attitudes, intentions, and behaviors related to family planning or the use of sexual and reproductive health services (Mwaikambo et al. 2011). Qualitative research conducted in Tanzania has shown that current gender norms in which men are heads of households and discussing family planning is taboo; such norms are a significant barrier to using modern contraceptives (Schuler et al. 2011). An additional study

in Nigeria using qualitative methods, including focus groups and vignettes, showed that pro-natalist gender and social norms also hindered sexual and reproductive health services (Ariansola et al. 2014). Data revealed that to improve RH outcomes, social and gender norms should be tackled. However, there are gaps in knowledge on the impact of men's involvement and gender dynamics changes. Although there are qualitative studies on male involvement and the importance of gender norms for the promotion of family planning in West Africa (Adeleye et al. 2011, Ariansiola et al. 2014) and in Sub-Saharan Africa (Farmer et al. 2015, Hartmann et al. 2012, Wegs et al. 2016), to our knowledge, such studies are rare in Niger.

In 2006, UNFPA-Niger requested an assessment of barriers women face in their efforts to access reproductive health services. Results showed that men, as power and resources holders and decision-makers, were a significant barrier to women's access to health services, especially sexual and reproductive health services (Lasdel 2007). In partnership with the government and with the non-governmental organization, SongES, UNFPA-Niger developed and implemented the HS intervention to remove the barriers to reproductive health and gender that contribute greatly to poor reproductive health outcomes. The HS were first established in the Zinder region in 2007. They have since been replicated in the regions of Tahoua, Maradi, and Dosso. Currently, HS are present in all regions of Niger, except for the urban community of Niamey. The strategy has also been replicated in several countries in the West Africa region, including Côte d'Ivoire, Burkina Faso, Mali, and Cameroon.

Description of the Husbands' Schools intervention

Husbands' Schools are a voluntary and non-hierarchical intervention. Men must meet specific criteria before being admitted as members and become "Maris modèles" (Model husbands), serving as role models in their communities. The criteria stipulate that men must be at least 25 years old, have a wife who uses reproductive health services (any service, including antenatal, delivery, postpartum, and family planning), accept the participation of women in the community, take good care of their families, and strive for peace in the family. Schools consist of 8-12 Model husbands, who meet twice a month to discuss health and other topics. Also, they regularly organize ad hoc community awareness sessions, home visits, and carry out activities aimed at improving the health center. Members receive basic training in leadership, group dynamics, teamwork and communication, advocacy, and negotiation skills. They also receive basic information on reproductive and child health. Schools are overseen by Coaches and Supervisors, NGO staff who are trained to guide husbands and support them with technical assistance. Schools prioritize problems (called cases) their community faces based on the urgency of these problems to good health, their importance to the community, and the likelihood that HS can solve them.

Case examples include topics related to communication between spouses, access to family planning, and improvement of the health center's infrastructure. These group meetings help men to develop strategies that can resolve the cases referred to them. Social and gender norms/beliefs linked to poor RH outcomes are very implicit to the intervention, especially:

- The use of antenatal care, delivery, postnatal, and family planning services only concerns women, not men;
- Health centers are for sick people and not for healthy people;
- Men and women's worth is related to the number of children they have;
- Men should make all the decisions;
- Wives should never say "no" to their husbands;
- Men who approve or pay for the use of family planning lack authority.

Activities implemented as part of the HS initiative

The NGO, SongES, has led implementation and technical support of the HS intervention. The main activities are the establishment of HS, capacity building of the actors involved in the implementation, and hiring of and supporting technically NGO moderators to coach the Model husbands. (Of course, Model husbands exist outside of schools, but this is the name that communities give to men who are members of HS.)

Theoretically, the critical activities implemented by the HS fall into two categories: programmatic activities and non-programmatic activities. Box 1 gives more details on some programmatic activities implemented by HS with the support of NGO program staff, called Coaches, who support HS. The second category of activities called community outreach activities is implemented in consultation with the broader community. These include sensitization on themes close to RH as well as efforts to improve public cleanliness and restoration of social and health facilities. HS also do advocacy. They serve as an interface between CSIs and the community to communicate and support activities that promote and support the use of reproductive health services.

Some HS activities in detail

HS meetings: with the support of the coach from the implementing NGO, each husbands' group holds two meetings per month at the CSI or in the community. The primary purpose of the CSI meetings are to learn more about a specific RH topic in order to plan community outreach activities.

Outreach activities: *Model husbands* organize and conduct ad hoc *group sensitization activities,* much like peer educators. Each HS is expected to have at least two awareness activities per month. These are usually group chats and mass awareness sessions during baptisms, weddings, and other community gatherings. Model husbands also make *home visits*. They visit the homes of community members (most often men) who lack knowledge and trust of facilities, or who are not convinced by the public awareness sessions and who do not use health services. Home visits allow more personal discussions of the benefits of RH.

NGO coaches and community resource people known as moderators provide support from a distance; they are not the frontline actors in community outreach.

Theory of Change of the HS Initiative

The change theory clarifies the connection between the implemented activities and the desired results of increased services use. Intermediate effects highlight the conditions or prerequisites to the generation of the desired effect (individual and community-level changes in gender roles and gender norms regarding RH). The HS theory of change was developed by the program staff and stakeholders with the technical support of the Passages project in 2016, to identify change pathways and explore where existing evidence supports the theory of change and where it is missing (see the diagram of the theory of change below). An evaluation using mixed methods conducted in 2014 (only in intervention areas) revealed an increase in women using reproductive health services and an improvement in men's behavior regarding family planning in communities where HS are implemented. However, there was still a gap in data demonstrating how the HS intervention influenced the norms influencing behaviors such as spousal communication and decision-making and other role shifts, and how the change in gender dynamics affected the use of sexual and reproductive health services. There was also a gap in how HS have changed communication and decision-making between individuals and within the couple. Because norms shifting was implicit in the design (see earlier discussion), the study was both exploratory and explanatory in nature and designed to fill these gaps.

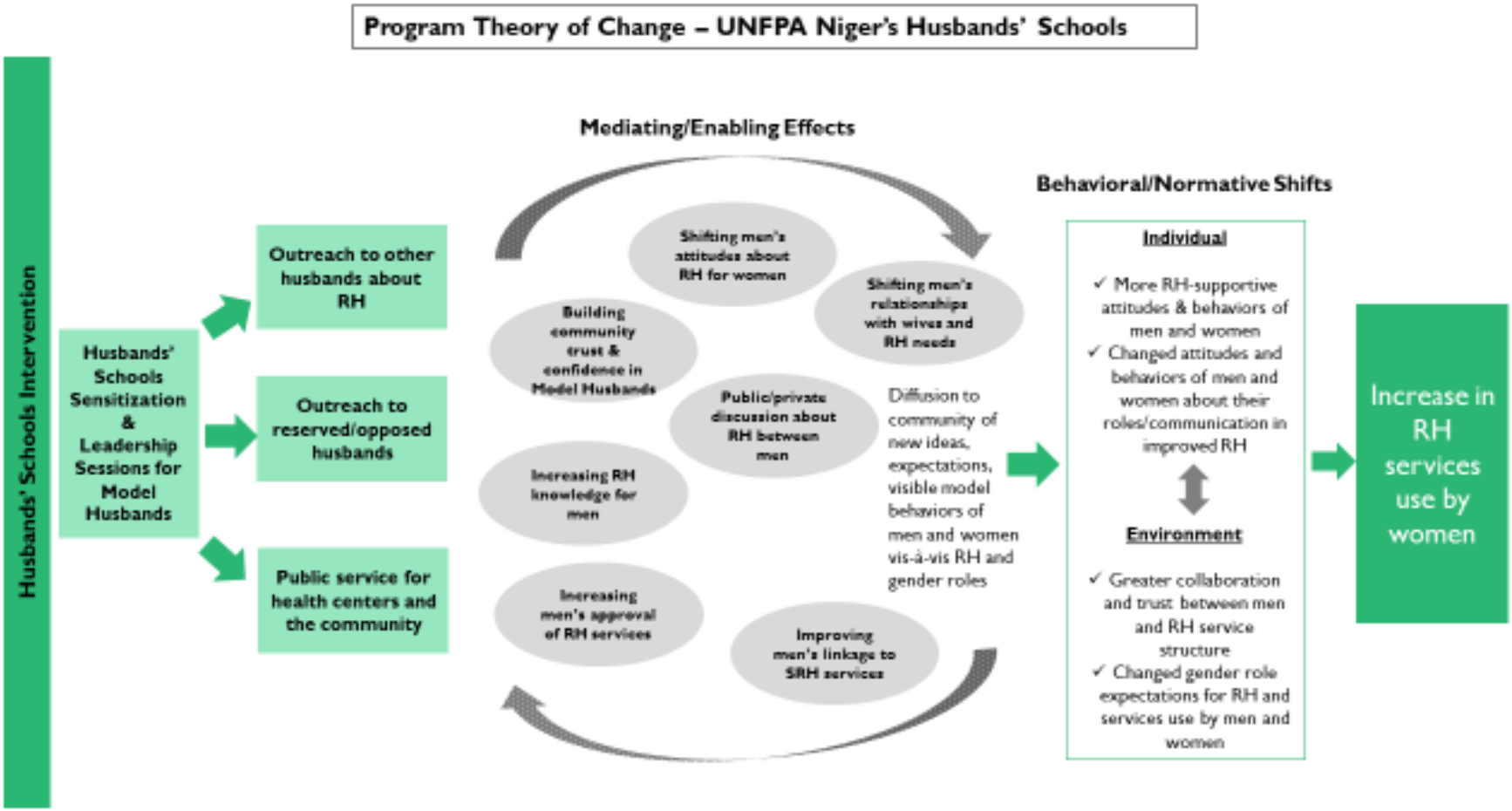


Figure 5 | Husbands School Program Theory of Change, 2016

OBJECTIVES OF THE STUDY

The main objective of the study was to assess gender-related changes resulting from the implementation of the HS intervention in Niger. The current study would address an information gap by providing systematically collected data to test the hypothesis that actions of actors and decision-makers of the HS program lead to intermediate changes, leading to the individual and environmental outcomes expected in the program theory of change. Specifically, this assessment explored the individual and environmental or socio-normative shifts as laid out in the objectives below:

Objective 1: Explore the attitudes, beliefs and behaviors of married men and women related to the use of reproductive health services in the communities in which the Husbands' Schools have been implemented.

Objective 2: Explore perceptions of community shifts in gender roles, couples' communication and decision-making as they relate to reproductive health services in the communities in which the Husbands' Schools have been implemented.

METHODOLOGY

Per the research protocol, data collection occurred through individual interviews and focus group discussions with people in visited communities having direct and less direct connection with HS. In addition, individual interviews and focus groups of several external stakeholder groups (e.g., NGO staff, CSI providers) enabled the comparison of different populations as well as opportunities for the triangulation of the results.

The study sought to answer the following questions:

1. What are the dominant attitudes, knowledge, and behaviors for married men and women in HS communities?

2. How do married men's and women's attitudes, knowledge, and behaviors differ based on their direct involvement in HS and past use of RH services?

3. What are the prevalent perceptions of changes in gender roles, couple communication, and decision-making in HS communities?

4. How do perceptions of changes in gender roles, couple communication, and decision-making for married men and women change with direct engagement in HS and past use of RH services?

The study's target groups and the sample

The sample was composed as follows: regions (3) and localities with a correspondent CSI (6): Dosso (Matankari and Malgorou), Tahoua (Kalfou and Mogheur) and Zinder (Baban Tapki and Mirriah). The purposive sample takes into account the age and existence of active HS and CSIs. The table below recaps the targets, the research technique used, as well as the number of sites and the number of interviews and focus groups per target. In total: 153 people participated in this study, including 36 respondents for individual interviews and 117 respondents for focus group discussions.

Table 2: Summary of sample and sample size			
Research technique	**Target population**	**Number per site**	**Total number in the 6 sites**
Focus groups (13)	Model husbands	1	6
	Wives of Model husbands	1	6
	HS Coaches/supervisors	1 (for all sites)	1
Individual interviews (36)	Model husbands	1	6
	Wives of Model husbands	1	6
	Husbands who are not members of HS, whose wives have used CSI services	1	6
	Wives of husbands who are non-members of HS and who have already used CSI services	1	6
	Health providers	1	6
	HS facilitator	1	6

Selection of the respondents

Inclusion criteria:

The husbands and wives eligible for this study are those who:

- Reside in a Husbands School intervention area;
- Reside in one of the sites selected for the study
- Are in union (married or living in union with a partner);
- Are 18 or older

Additional stakeholders (intervention coach, supervisors, facilitators, CSI staff, community leaders) are eligible if they:

- Reside/work in an area where *Husbands Schools* have been implemented;
- Work or reside in one of the sites selected for this study;
- Are 18 or older;

Exclusion criteria:

Individuals who did not meet the age, partnership, or residence criteria or were not intervention staff were not selected for this study.

The sample having already been predefined in the protocol (regions, sites, and target categories), the respondents were selected in a two-step process based on the criteria. Respondents were randomly selected from a large number of people who were informed of the study and invited to participate on the day researchers visited their village. Thus, 9 people were selected for each focus group (women-only, men-only groups). Also, respondents for individual interviews were selected from those not selected for the focus groups. Each respondent only participated in one activity, either the focus group or the individual interview. The individual interviews were conducted after the focus groups. Focus groups and individual interviews

with women were conducted by two trained female collection agents, and male interviewers similarly interviewed men. For health providers, the health worker who collaborated most with HS was selected (the head of the health center/CSI, the head nurse, or the midwife if the CSI head was just starting his job or is not present or available at the time of the visit). As for the moderator, the head of CSI and the HS invited them to come for a meeting. Finally, SongES invited a group of coaches for a meeting in their Niamey office, since many of the coaches were in town awaiting the start of a new project funding cycle to continue HS activities.

Categorization of respondents

Direct beneficiaries: These are husbands who have been selected based on HS criteria and who have actively participated in the programmatic activities described above. Thus, all those who took part in the programmatic activities (whatever the number of activities they participated in) are identified here as direct beneficiaries.

Indirect beneficiaries are people not directly engaged as Model husbands but who have heard HS messaging either directly from Model husbands or indirectly from others in their communities. This category also covers the wives of husbands who are members of HS.

Stakeholders who support/collaborate in HS activities: stakeholders are, among others, health providers, coaches, and supervisors who supervise HS, facilitators of HS, and community leaders.

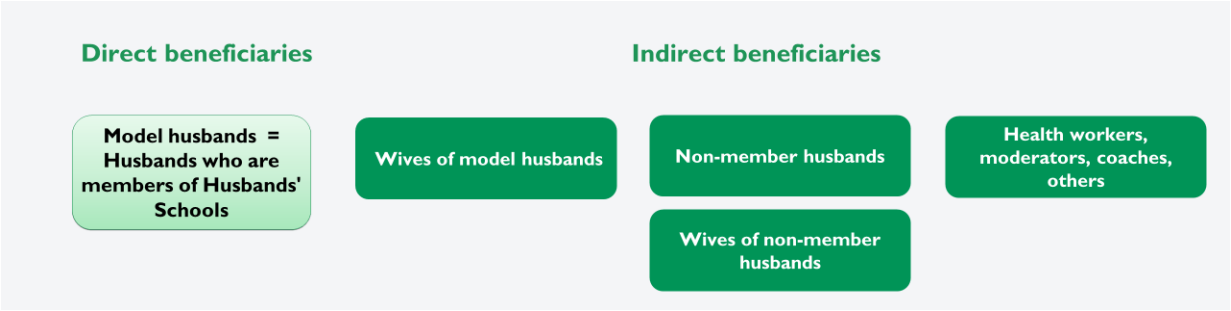


Figure 6|Direct and Indirect Beneficiaries of the Husbands' School Intervention

Data collection and analysis

Data collection was carried out between May and June 2018. With the support of IRH, the investigators received two days of theoretical training on RH, HS, realist evaluation, qualitative techniques of data collection, research ethics, and practiced tools by doing role plays. Tool pre-testing occurred over two days in Kargui-Bangou and Matankari (Dosso region).

Data were collected by four (4) interviewers, including two women and two men with the required technical and linguistic skills, under the Consultant's supervision. All data were recorded (using Dictaphones).

Transcripts were translated into French and uploaded to the NVivo 12 program. We organized transcripts according to HS status, e.g., member, non-member, gender, site, and coded with pre-established and emergent codes using AtlasTi 7. Pre-established codes followed research questions and reproductive health services themes, and emergent coding was added as new themes were identified. After coding all transcripts, code reports were generated to allow additional analysis and make more accessible data to illustrate findings.

The study aimed to examine the nature and direction of changes in gender attitudes and roles regarding RH resulting from HS activities. It focused on two levels, changes in the relationship between husbands who are members of an HS and their wives, and changes that occur in the whole community following HS sensitization activities and the dissemination of new ideas.

The logic which guided the analysis of the results show the gender elements explored in this study (see diagram below).

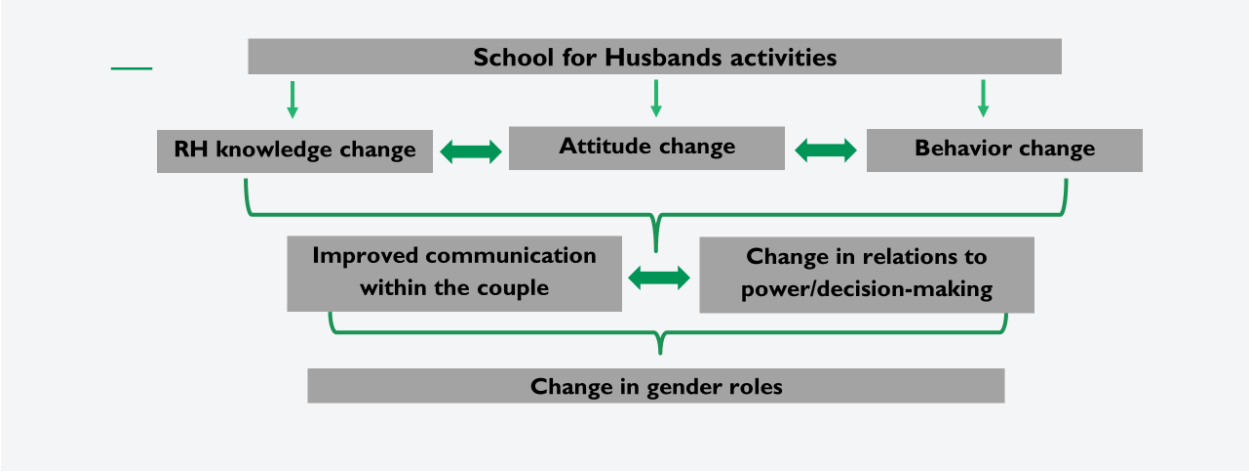


Figure 7 | Logic and Schema that Guided Analysis

ETHICAL CONSIDERATIONS

Data collection and management followed the terms of the research protocol, which emphasized confidentiality and informed consent, developed in consultation with Niger and Georgetown's Ethics Committees. The research protocol was submitted and validated by the National Ethics Committee of Niger and Georgetown University, Washington, D.C.

STUDY RESULTS

To reflect gender issues (and not just male engagement) in a comprehensive manner, the Results section is organized in segments to determine the intervention's added value of Model husbands' behavior as social change/social influencers; identify the level of direct exposure of Model husbands and indirect exposure of other members of the community to understand how gender attitudes and behaviors diffused and reflect normative shifts; and then explore how gender dynamics affect decision-making processes for RH care within direct and indirect beneficiary couples, again with the idea of diffusion and normative shifts. The results show the nature of changes experienced by couples in terms of communication about access and use of RH services; power-sharing between women and men in different areas of access to RH information and use of RH services by women; and husbands' attitudes towards this newly-acquired decision-making power of women, among others.

DESCRIPTION OF THE RESPONDENTS

In this section, we compare findings of husbands who are members of HS (Model husbands) who act as change agents and disseminate pro-RH messages in the community to husbands who are non-members of HS (not directly engaged as Model husbands but who have heard HS messaging either directly from Model husbands or indirectly from others in their communities).

Direct beneficiaries: Husbands who are members of HS

Direct beneficiaries are husbands who are members of a HS and who received training from the project, then began community sensitization and other activities to discuss messages promoting and supporting the use of reproductive health services. In this study we explore whether there have been changes or an evolution in the Model husbands' knowledge, attitudes, and practices regarding the use of RH services by women, and whether Model husbands' participation in HS led to changes in the couple as a result of their evolution in knowledge.

Given a key aim of HS is to increase the decision-making power of women to access and use RH services, women's decision-making power should, in principle, manifest as a greater ability for women to decide and take action for the use of RH services. Since men have greater decision-making power in Niger, the decision-making power dynamic between men and women can only be sustainable when men are involved in this process of changing social norms, that is when men allow or through their actions create spaces for women's greater decision-making. The wives of HS members confirmed this greater involvement over time of their husbands (Model husbands) and the opening of the couple decision-making space during a focus group in Kalfou:

> *"The men take us to the CSI [health center] on a motorcycle, and at the CSI we receive all the care. When we return home, if we realize that our condition has not improved, they take us back to the CSI for a consultation, before taking you home once you are in good condition " –Focus Group* wives of Model husbands, Kalfou, Tahoua

Indirect beneficiaries: Wives whose husbands are members of HS; husbands who are non-members; and their wives

Indirect beneficiaries are husbands who are non-members of HS and their wives, the wives of husbands who are members of HS, and the members of the community at large. Responses of indirect beneficiaries provide data on how the sensitization messages conveyed by HS have been diffused throughout the community to the point of 'routinizing' or 'normalizing' member and non-member husbands' behaviors and attitudes towards RH. The HS intervention envisions a change in social and gender norms at the level of the community, catalyzed by a small group of Model husbands as change agents. Seeing new behavior models by direct Model husbands (direct beneficiaries) seems to have paid off to the point that many of the respondents in this study claim to see no difference between Model husbands and non-model husbands regarding understanding the importance of RH in family health and community well-being.

> *"There is no difference between them (husbands who are members and husbands who are non-members of HS). For me, they are similar, because nowadays they are all awakened (éveillé) and it is difficult to see a non-member husband who is not involved in the health of his family and the community." –Focus Groups* Wives of husbands who are members of HS Mogheur, Tahoua

While we cannot say with certainty that this observation is due solely to HS, other male engagement-and-RH activities in the area have been minimal as far as we know, and we presume the diffusion effect that normalized men's appreciation of RH and health is related to HS activities. In any event, the discussion participants are linking HS to the observation.

Model Husbands versus husbands who are non-members of HS: attitudes and behaviors towards RH that distinguish Model Husbands as change agents

The respondents shared their understanding of the concept of a husband who is a member of an HS. While many expressed the concept of "husband who is a member of HS," it is through comparisons between Model husbands and other husbands, who could be called non-model husbands, that deeper understandings become apparent. The most cited difference is the Model husbands' communication skills and knowledge on health issues.

> *"We can easily identify a husband who is a non-member of HS. We often recognize them when it comes to debating health or social relationships. As soon as you hear him speak, you will understand that he is not a member of HS. If he attended HS, you will hear him advising women, children on childbirth, cleanliness; he only talks about these things "* –Focus Group husbands who are members of HS Baban Tapki. Zinder

However, this difference between the Model and other husbands is much nuanced in some localities and may be due to the intervention's level of intensity.

> *"My answer differs a little. They cannot be compared because they are not members of the School, and not everyone can be a member of the School so they cannot behave like members of the School. Despite this, there are others who are non-members who care about the health and well-being of their family and the community ... "* -Focus group husbands who are members of HS Matankari. Dosso

Model husbands are viewed as resources for supporting and promoting the use of RH services. According to these Model husbands, HS members have gained a certain notoriety in the community; their role is often compared to a health worker. (Note to interpreting the quotation below: Model Husbands' reflection on being comparable to health workers is not to be taken literally; these men do not want to be health workers with technical roles. Instead, such comments reflect community esteem for Model husbands as an available community resource.)

> *"We have had a big change because we are now comparable to health workers … They (the population) only show us respect and consideration. During ceremonies, they ask our wives to give them advice"* -Focus group husbands who are members of HS Malgorou, Dosso

It also appears that, through their association with Model husbands, their wives are also gaining more and more public trust in the promotion of the use of reproductive health services.

EXPOSURE TO THE INTERVENTION

Exposure to HS messages can be direct or indirect. In the community, HS participants represent a set of men who are selected based on personal integrity and who model pro-RH attitudes and practices. Beyond Model husbands, other community members may not be directly involved in HS, but receive messages through their peers.

In the HS intervention zone, there are two categories of men/husbands. The first category represents Model husbands directly involved in HS, who participate in meetings and other activities (direct exposure). The second category is composed of men and women who do not participate directly in HS meetings and facilitate outreach activities but who receive messages through sensitization either directly from Model husbands or from peers who have heard HS messaging (indirect exposure).

Direct exposure to interventions

The husbands directly exposed to the intervention are those who participate in HS meetings and activities. In this category, the majority of respondents had participated in all HS meetings held and received all messages disseminated in the group during the various meetings. The engagement of these husbands in RH issues, as we will see later, shows their degree of exposure to the messages.

During the interviews, these men could clearly explain both the objectives of the HS and the desired effects and results. While most interviewed members could not precisely say when they started participating in HS [the start or duration of their exposure], they often mentioned that it has been a long time and that they do not even remember the starting date. On the other hand, some respondents say they started participating in HS activities 5 or 6 years ago. All were directly exposed over time.

> *"I can't tell you when exactly HS arrived here, but what I can tell you is that it's been here for a long time, and we were the first people to be called and sensitized on the work and goals of HS. They made us understand the importance of convincing women to go to doctors when they are pregnant and to go to health centers for deliveries. And to that end, we go from "fada" to "fada" (informal groups where men regularly meet) to explain to husbands to take their wives to the health center for deliveries."* -Focus group, husbands who are members of EDM Malgorou. Dosso

The exposure of husbands directly involved can be measured not only by the duration of their participation in HS but also their knowledge and understanding of the content of the messages conveyed by HS. The high level

of exposure of men directly involved in HS is revealed in their responses to open-ended stories told during focus group discussions. Model husbands identified 'good' and 'bad' behaviors in the stories, indicating exposure to HS messaging was quite strong; Model husbands understand very well what is at stake regarding RH.

> *"Personally, I would say that Abdoul Karim [one of the actors in a story told during the FG and who did not behave like a husband who is member of HS in the story] did not do his work as a member of HS because, during the whole story, I have not even heard of prenatal consultation; and [he] lets her [the pregnant woman in the story] give birth at home. Also, there is no spacing between pregnancies. »* -Focus group, husbands who are members of HS, Malgorou. Dosso

What Model husbands' wives say also attests to the degree of their husbands' (direct) exposure to the HS interventions. Indeed, the **direct exposure of the husbands has had a favorable influence on the attitudes and behaviors of their wives vis-à-vis messages conveyed by HS**. We note a positive change in wives own behaviors, mainly early ANC visits, the adoption of FP to space births after delivery, and postnatal follow-up visits.

> *"Through my husband's explanations, I am now aware of many things. For example, I know that women must go to the health center from the start of pregnancy, do all the ANCs, and, after childbirth, it is important to use FP to allow the body to rest. I learned all that from my husband, who is a member of this School. "* -Wife of husband who is member of HS, Matankari

Equipped with information, these women also become change agents in the community who promote good practices in RH.

> *"They [wives of HS husbands] educate us on the use of health services, on assisted deliveries, family planning methods. If you are pregnant, you go to the CSI (health center) for prenatal consultations, and the health worker will know if there is an illness or if all is well. If you don't go to consultations, there is a problem. We learn all that from these women"* -Wife of husband who is non-member of HS, Matankari

The wives' satisfaction with their husbands' involvement in HS is a manifestation of the immediate effects of members of HS (direct exposure) on their wives (indirect exposure). It is clear from these women's comments that before this involvement, they were "ignorant" and did not know much about RH. They mentioned an improvement in their knowledge after discussions with their Model husbands.

> *"Of course, I have noticed improvements in my knowledge of these services since my husband became a member because he shares information with us [...] on family planning services. I know all contraceptive methods, their importance and their use. Before, we were ignorant "* -Wife of husband who is member of HS, Mogheur

In addition to the improvement in husbands' and wives' knowledge of family planning, antenatal care, assisted delivery, and postnatal consultation, some women reported that their husbands' exposure to these messages through HS had increased their spouse's sense of responsibility in helping to monitor the wife's pregnancy. Husbands' monitoring actions are mainly by checking the wife's health record (carnet de santé) and her prescriptions (for husbands who can read) to make sure she follows the doctor's recommendations.

"Our husbands learn that a woman, from 3 months [of pregnancy], needs to be monitored by checking the pregnancy booklet to see if she follows or not the appointments given by the health worker" -Focus group, wives of husbands who are members of HS, Mirrah

In summary, the direct exposure of HS members is very strong, and this is reflected in their attitudes as well as their communications and behavioral support vis-à-vis RH services. These could be indicative of the beginning of the creation of an enabling environment for the adoption of positive behaviors in the use of RH services, which is the end purpose of the HS intervention.

Indirect exposure to interventions

Indirect exposure to interventions mainly concerns male non-members of HS and women. For men who do not participate directly in HS activities, the results show a fairly high exposure to the awareness of messaging conveyed by their peers.

"I have only one wife, and she never missed a consultation, whether it is antenatal or for the children … In addition, any time there is a meeting, I tell her what the members of HS said … There is a difference because I am with members of HS. So everything I hear from them, I tell my wife immediately (the information that I learn) so that she can use it " - Interview, husband who is non-member of HS, Matankari, Dosso

Indeed, in the community, Model husbands are seen as resources by other men. Therefore, the behaviors advocated by these husbands and their daily behaviors, especially in RH, are imitated by male non-members of HS.

"I am new to this village. But after hearing information from my female neighbors, it is about 2 and 3 years ago, and I discovered it thanks to my neighbors because their husbands are members of HS; it is a School that helps a lot of women and gives them a perfect awareness on the use of health services. » -Interview of the wife of a husband who is non-member of HS, Malgorou. Dosso

Testimonies illustrating this « ripple effect » are numerous and are indicative of a significant increase in RH attendance by all categories of men and their wives.

"Before, barely 2 or 3 out of 10 people used health services; now, we have over seven out of ten, and some even give their wives money for care or consultations. For those who have not yet understood, we do not rush them; over time, they will end up joining " - Interview, husband who is non-member of HS, Baban Tapki. Zinder

"It was useful to me in the sense that before, when I gave birth, just after forty days (the traditional period of post-partum abstention from sexual relations), I got pregnant again. And once at the center, I was told the usefulness of practicing family planning and taking these drugs. After this (latest) delivery, it took over a year for me to get pregnant again." - Interview, wife of husband who is non-member of HS

Beyond the men and women in the immediate entourage of HS members, exposure to messages has extended to villages and communities not covered by the intervention. Data are not available to measure the level of exposure of these non-covered communities. However, from the respondents' answers, there are references and indications which show that even if HS do not exist in all villages, messages are still being conveyed in new villages, especially because these communities go to the same health centers.

"I have known of the HS since its establishment here, because it is of special significance. And we also did this work (of HS) at least once in our villages by sensitizing women on health services and centers. We discovered this School through the (NGO) Coach who came here to raise awareness, so we continued to do this work, even though it was not paid work." - Interview, husband who is non-member of HS, Mantankari. Dosso

COMMUNITY ACCEPTABILITY OF HS

At the community level, there is recognition of the importance of *Model husbands* in improving health in general. The involvement of HS members in community activities beyond health eased the community's acceptance of reproductive health promotion activities of the HS. More specifically, HS are perceived by the community as a real school where participants learn and share their experiences, especially on reproductive health. In addition to the personal satisfaction and pride expressed by HS members, non-HS members also mentioned admiration and satisfaction for Model husbands and their activities. There are no negative attitudes or rejection of HS in the respondents' answers. Attitudes towards HS have changed over time, and today, misunderstandings and mockery have given way to admiration.

> *"Before, when people saw a group meeting [organized by an HS], they laughed, saying it is a waste of time, but today, they understand the importance of the thing" -Focus group, wives of husbands who are members of HS, Baban Tapki. Zinder*

Respondents who are non-members mentioned various aspects they appreciate about HS, generally reinforcing how interviewed Model husbands perceive their contribution to the health and social development of their community. Husbands who are not members of HS also seem to value the role Model husbands as men in society, and many consider themselves Model husbands.

> *"It's a school that helps the household work better, meaning it improves relationships between spouses and within the family ... We, too, have become a model couple now."* -Individual interview, husband who is non-member of HS, Kalfou

In other words, the perception that some people in the general population had of HS initially was negative. By persistently undertaking useful actions and convincing others of RH services' usefulness, the HS ended up gaining social recognition and a positive image, even by health workers who may have treated Model husbands as rivals in the past. They also have the support of community leaders, convincing the most skeptical. We can see that all categories of respondents in all visited regions positively appreciate the activities of the HS. So, they have a social base and are well-positioned to act as agents of change. We note that their overall usefulness to the communities is also reaffirmed beyond RH issues.

WOMEN'S PERCEPTION OF MEN REGARDING USE OF RH SERVICES BEFORE AND AFTER THE INTERVENTION

Many men were skeptical and suspicious of RH services; before the HS intervention, they had gender biases and lacked knowledge. Also, there were false rumors about family planning methods that linked method use to limiting births and Western intentions to limit population growth in the community. These perceptions came out during interviews and focus group discussions of wives of husbands who are not members of HS, husbands who are members of HS, and wives of husbands who are members of HS.

"In the beginning, my husband saw [family planning use] as a lack of respect [for her husband] on my part. " -Wife of husband who is non-member of HS, Mogheur

"Many bad stories were told about family planning. Some said it was a way to reduce the population, and others said if you use FP, you can no longer have children. It scared even women, and we can understand that husbands also refused this method […]. Currently, with HS messages, and also with the help of health services, these bad stories have gradually disappeared. " -Wife of husband who is member of HS, Mirriah

Responses of women who claim that they no longer need to use as much effort as before to convince their husbands provide evidence that there is a change in the perception of male non-members of HS towards the use of RH and FP, in particular. HS members initially faced many prejudices and taboos about RH and, especially, about FP methods, which helps to explain the generalized opposition and reluctance of men. It is in such challenging contexts that Model husbands sensitize other husbands and change their attitudes and behaviors, thanks to their social influence that has grown over time.

"We are discussing [now] about the importance and use of family planning because before any use, I have to ask his opinion and make my convincing arguments, but also [talk] about the consequences of giving birth at home. "-Interview, wife of husband who is non-member of HS, Mirriah. Zinder

"Before, people (including husbands) did not understand and thought family planning was about limiting births. " – Focus Group, wives of husbands who are members of HS, Malgorou. Dosso

To summarize, after the HS began to operate, HS members' actions to promote and use RH services are now seen and accepted, as HS are viewed as credible resources. Importantly, their messages reach beyond the immediate HS members to the broader community, supporting the program theory of change. The "diffusion effect" on non-member husbands appears in respondent answers of a positive change (in terms of promoting and supporting access and use of RH services by women) in the behavior of husbands who are non-member of HS and who are around Model husbands.

"They [non-model husbands] ask their wives to go to health center/CSI because, even if they are not members of HS, they are with them [husbands who are members of HS] and they hear what they say." – Focus Group, wives of husbands who are members of HS, Kalfou. Tahoua

"Non-members of Husbands Schools act like members because they attend meetings, including the wives." - Focus Group, wives of husbands who are members of HS, Mogheur. Tahoua'

EQUALIZING MEN AND WOMEN'S ACCESS TO RH INFORMATION

The quotations shared in earlier sections show that more people are accessing RH information and through more diverse channels. Before HS, there was a lack of information on RH health services and a lack of communication between couples. Men did not feel antenatal care, delivery, or family planning had anything to do with them. Thanks to HS awareness-raising activities, men (Model husbands and non-members), are very interested, often even more informed than their wives, and have increasingly positive attitudes towards the use of RH services by women. However, this broadened commitment is mainly to share information and to indicate acceptance that wives choose and use RH services.

Whereas in the past wives had already received some information at the health center during pregnancy and delivery consultations, now, informed husbands also act as agents of sensitization and promoters of RH

services use to women. Even more, women report having more access to information on how to stay healthy and how to use RH services such as antenatal care, assisted delivery, and family planning. Model husbands share this information with their wives and with other men in their communities. Model husbands' *wives,* then, share the information obtained through their husbands with other wives. So, we can say that couples and the whole community now have greater access to RH information, compared to the time before the arrival of HS when people knew very little about RH or had rumor-based rather than fact-based information.

In other words, while Model husbands were engaged to be the main change agents of HS, results show that their wives play a similar trusted, change-agent role in sharing information with their women peers. Thus, wives play an essential role in transmitting information, especially in female circles, inaccessible to Model husbands. The theory of change of the HS program, in which disseminating new ideas takes place through networks of men and women, is confirmed and better understood. In addition, the community's recognition of and trust in wives of Model husbands, contributes to creating a new perception of women as actors of their own well-being and in contributing to the well-being of the community.

Based on these observations, we conclude that these women and men have equalized their access to RH information (information being a domain of power). Equipped with information, women and men can play new health promotion roles in transmitting RH information in the communities covered by this study.

GENDER DYNAMICS AND DISTRIBUTION OF DECISION-MAKING POWER IN RH

Gender defines the roles and responsibilities of men, women, and young people (girls and boys) in a given context. It defines roles in the home as well as in society. As societies vary, so do gender roles and responsibilities. In many societies, including the site of this study, women are responsible for taking care of children. In contrast, men are responsible to provide for the needs of the family and assure that the family is managed correctly. This latter responsibility of the husband also confers on him the duty to make the critical decisions in the family. The results of the gender analysis in this section highlight the difference in gender roles and responsibilities, and helps to understand how interactions occur and how decisions are made in the couple regarding access to and use of RH services. The analysis mainly covers communication in the couple, power relations between men and women, and is focused on the dynamics of decision-making power of women and men regarding assisted delivery and the use of FP methods.

In general, respondents noted greater openness in the communication between husband and wife in the couple. This observation was made by women and men in both model couples and non-model couples. Regarding decisions and decision-making power, husbands continue to be main decision-makers in several RH-related areas. However, women have acquired more decision-making power, especially in the choice of FP methods, although these decisions are always validated and approved by the husband. In some cases, it is the couple who makes the decision, especially for assisted delivery in the health center. Fundamentally, the data show a definite change in men's perceptions and a greater engagement of men in promoting and using FP services. But women are not yet at the first level of decision-making in any of the major categories of RH-related decisions studied.

> *"[…] My husband also thinks that the woman must have a time for her health after delivery and breastfeeding"* –Interview, wife of husband who is member of HS, Kalfou

"My husband thinks that [...] it is beneficial for a woman to use reproductive health services ... personally, my husband encourages and supports me in this initiative. He even gave me permission to go to the reproductive health service even in his absence ... " -Interview, wife of husband who is non-member of HS, Mirriah. Zinder

Change in communication within couples on RH services

Since HS began operating, there has been a positive change in the *style* of RH discussions within couples. This type of incremental change is predicted in the HS program theory of change. The data highlight three key aspects that point to this change: a) reproductive health issues that were previously taboo, especially family planning, are increasingly addressed by couples; b) the emergence of men's positive attitudes about getting involved in the process of seeking care during pregnancy; and c) the dissipation of women's fears to address RH issues with their husbands. Women also mention their ability to express themselves and speak with their husbands about their reproductive health and, above all, they compare the situation to the situation before HS. Most wives, those married to Model husbands as well as those married to non- Model husbands, find that this ability to communicate with their husbands and express themselves within the couple has improved. That is, the style if communication is more equalized and what is discussed has changed. When a wife can talk to her husband about her health problems, this can help put the woman's health at the center of discussions between the couple.

"My way of speaking about [reproductive] health issues has changed [...] I communicate with my husband on all issues [...] since my husband became a member, everything is going well in the household. " -Interview, Wife of husband who is member of HS, Mogheur. Tahoua

The improvement of communication within couples is undoubtedly a positive step in balancing decision-making power within the couple. However, husbands' involvement in the search for RH care remains present. According to wives, their husbands' involvement appears as the beginning of a commitment to their wives' RH, which began from this new communication between husband and wife. This commitment, however, appears as "authorizing" the services-seeking behavior, or by permitting wives to take action.

"Before, when I got pregnant, he didn't want us to go to the health center at all... But now, he is the one who tells me to take the [FP] drugs and do the consultations. Yes, now we are always talking about the method of taking contraceptive drugs. " -Wife of husband who is non-member of HS, Mogheur.

At the same time, increased women's self-confidence is also a result of improved communication within couples. Indeed, interviewees mentioned that the fear of addressing RH questions with husbands has disappeared. Thus, this newfound freedom of expression helps women build their self-confidence.

"It has changed us a lot because, now, women are no longer afraid to talk to their husbands about using contraceptive products. " -Focus group, Wives of husbands who are members of HS Malgorou, Dosso

Power relations between men and women in RH decision-making

Since the implementation of HS, most Model husbands and, by interaction, their peers who emulate them, have acquired knowledge in RH and new ways of partner communication, which have resulted in changes in attitudes, behaviors and gender relations favorable to women. The study results show it is possible to adjust

power relations in the home without creating a contentious environment between husbands and wives in decision-making. Before the HS intervention, it appears that power relations between men and women regarding the decision to seek care or use contraception or assisted delivery belonged to husbands, who could accept or refuse to permit this search for care. A husbands' frequent refusal to grant authorization was related to the lack of information on RH issues and how this search for care could impact the well-being of the couple. Men and women's responses alluded to a relative change from the period before the creation of HS. As noted by a health worker below:

> *"Before [the creation of HS] some women did not show up at the [health] center to collect medicines without their husbands' consent..."* -Health worker, Mogheur. Tahoua

From an epistemological perspective, the word "authorization" from the husband, which appears in discussions with many respondents, deserves to be better defined. Husbands authorize their wives to take some RH actions; at the same time, women say that they feel freer now than before regarding their ability to use RH services. In other terms, as a result of HS activities, men have a clearer commitment to RH, and this commitment does not merely define their attitude towards seeking care, but also their behavior. Both women and health worker respondents reported that men take their wives to RH services more often than before HS activities. However, the real share of decision-making power that women hold in this process remains to be determined. Also, other variables influencing decision-making (not part of this study) need to be taken into account, such as services availability and fees and use of the [financial] resources of the household.

If, in reality, men's authority remains obvious, the findings concurrently show that women can now express their opinions, propose and discuss their preferences with their husbands, and then take specific actions, even if their husbands must still authorize them. This represents a positive change in men's attitudes and their receptiveness to a new style of communication between husband and wife. Men, who were initially reluctant, are now almost systematically consenting to women's requests for RH/FP services.

> *"With the agreement and support of my husband, I decided to go to delivery services and use family planning after my delivery. "* -Interview, Wife of husband who is member of HS Mogheur, Tahoua

Normative perceptions and roles of men and women regarding RH issues

The change in what is considered appropriate men's roles is noticeable in several aspects. Before the implementation of HS, maternity issues were considered to be women's issues. Men's roles were limited to the management of medical emergencies, such as transporting women in labor to the nearest health center and paying for drugs and other medical expenses. Currently, men's attitudes are more favorable to their expanded involvement in RH-related actions. Men get involved in care issues during pregnancy and also during and after delivery, for postnatal care. These men are increasingly appreciated by their peers and the community.

> *"I am 100% happy because by practicing family planning I am resting well [...] My husband's attitude towards the use of reproductive health services has changed."* -Interview, wife of husband who is non-member of HS, Baban Tapki. Zinder

Conversely, those men who don't want their wives to use RH services are criticized and not valued. A change in injunctive social norms is occurring when sanctions that hold norms is place begin to shift. Before women and men were sanctioned if wives use services, now they are being sanctioned if wives do not use services. It

should be noted that the research did not identify any case of men refusing the use of RH services. So before, while it was only women who accompanied women in labor, now husbands are proud to be part of the accompanying companions and to be in front. In several localities covered by this study, testimonies from health workers, wives, and husbands suggest that husbands are also increasingly participating in domestic work. For example, health workers note changes in the distribution of gender roles in households through their communications with women (patients). This change in men's attitudes and household behaviors is more pronounced during pregnancy when women have difficulty performing certain physical efforts. It should also be noted that these attitudes and behaviors are found in nuclear households where couples live by themselves, or without any other family members. It is unlikely that husbands do this work in larger families where there are other people (men, women, children) who can help.

> Men's involvement in women's health *"... has even increased women's decision-making power. In the beginning, the woman had no right to make household decisions, every time it is the man who decided [...if] there are household tasks, for example sweeping the compound, managing the dirt left by animals, and also supplying firewood; all that in the beginning it was only women who did it. But now men have understood, they reduce these tasks for women by sharing them with them, and sometimes it is the man who does them alone. "*-Interview, health worker from Mantakari, Dosso

Men themselves recognize this change in their attitudes, and this also reflects a change in community attitudes (that is, descriptive norms on beliefs about how men engage in household activities), especially participation in domestic work.

> *"The change is that we now know how to manage household tasks ourselves without leaving everything to women. "* -Focus Group, husbands who are members of HS, Kalfou. Tahoua

> *"Even concerning the most difficult household tasks, they manage to help us and reduce our work. "* –Focus Group, wife of husband who is member of HS, Mogheur. *Tahoua*

The above shows that men are not only aware, they are also motivated to play a role to ensure their wives have good reproductive health. This is beneficial to the couple, the family and the community. Respondents also mentioned new behaviors and actions were the results of husbands' commitment to reproductive health. Model husbands get involved in reaching out to men reluctant to adopt new attitudes or use reproductive health services and consequently foster changes in their behavior.

Women's decision-making power regarding RH services

In an effort to quantify power-sharing trends, we looked at two RH service areas - assisted delivery and family planning - in which couples need to make a set of decisions. Those who participated in individual interviews (12 women and 12 men) were asked questions about who the main decider on specific sub-tasks and respondents' three decision-making options is (husband, wife, couple). The questions asked and frequency of responses were analyzed (see Graph 4 at the end of 2.6.7) to understand tendencies on decision-making related to giving birth at the health center or using a family planning method. Data were analyzed by region and by respondent types. With a particular look at women's power, we explored whether women had sole decision-making power or exercised her power as part of the couple, with the assumption that prior to HS, joint couple decisions were rare. We also use qualitative data to help interpret quantitative findings.

Our top-level findings – confirmed by the majority of husbands and wives who participated in individual interviews in the three regions of study - is that women have decision-making power 54% of the time either as part of a couple or individually as a wife. There are also differences in decision-making power by RH area. The "husband" has more decision-making power in assisted delivery (AD) issues than in family planning (FP) issues. (Differences also exist by region, and by type of respondent, and are discussed in the next sections.)

Of 192 responses to all questions, "the husband" is mentioned 46% of the time, followed by "the couple" (32%) and "the wife" (22%). Thus, regarding assisted delivery and family planning, women have decision-making power 54% of the time, but the decision is made more as a couple than as an individual. Women's qualitative responses support this finding, where it generally appears that decisions always involve both husband and wife. *In all the transcripts, no testimony describes a unilateral decision by a husband that the wife has just to accept*. Testimonies show agreement within the couple, although in the case of indecision the husband's opinion prevails. Therefore, reading the quantitative results presented above should be done from this perspective.

> *"Here [in Niger], the husband is the head of the family, so it's normal for him to make the decisions in the family. There are decisions women cannot make, regardless of their position. However, here in Kalfou, there is a significant commitment of men [to support] the health of women. In many families, even if the man ultimately decides, the woman's point of view is always considered. At home, for example, after my husband attended two meetings at the HS, we decided together to use FP after our third child. My husband wanted the use of FP pills, but I said I might forget some days, and that could lead to an unintended pregnancy. So, I decided to use injection, and my husband did not make an issue of it. "* -Interview, wife of husband who is member of HS Magheur

Another limit to women's decision-making power is when men are involved and informed of the benefits of RH/FP, they may tend to compel their spouse to take an action. For a very small number of respondents, HS activities lead to reinforcing men's power, manifested in a husband's strong encouragement or even demand that his wife's actions or decisions be made with the husband's consent.

> *"Since the establishment of HS, men were positioned as leaders because they are the heads of households, and all decisions must be made with their agreement. This is why it was decided that no woman should take birth spacing pills without her husband's consent. Since this work started, we have always worked with men in order for them to explain to their wives to ask for their consent before taking these contraceptives. "* Interview, husband who is member of HS, Matankari

This tendency is also confirmed by comments from health workers who affirm that, following their discussions with husbands on FP, there are men who seem very convinced of the importance of FP use and insist that their wives come to the health center to use an FP method. According to a health worker from Mirriah, some women coming for FP methods are obliged by their husbands to get FP, and they are often directly supervised by their husbands.

Among women surveyed, some favor this imposition of RH services by their husbands. They see this action as a way for husbands to exercise their authority and express their adherence, support, and involvement in the search for RH care for the wife and the couple.

> *"We tend to have men who want to know the benefits and disadvantages of using family planning and, after having been informed by the health worker, may even force their wives to come and take*

it. Sometimes, men even go to the health center to be sure their wives come for consultations. That means there has been a lot of change. " Interview, health worker from Mirriah

"The woman will always remain a woman; it takes a man to straighten her out […]". Interview, wife of husband who is member of HS, Matankari,

To summarize: In all regions, results show husbands as increasingly favorable to RH. This has opened spaces to discussion within couples on RH issues and actions as women are accessing services. In a few cases, where the husband thinks the wife or the couple need RH services, he may compel (*"imposer"*) his wife to use services. In the vast majority of transcripts, though, the term 'imposer' appears not as a coercive action (e.g., if you don't do this, you will be punished). Rather it is an appropriation or adoption of RH issues by the person who is still considered as head of the family and who authorizes what is right for his family in general and his wife in particular. Couple discussions that are more equal in style and substance between husband and wife than prior to HS activities, lead to decisions and actions that lead to improved RH.

Returning to the quantitative analysis, the following sections describe who is the main decision-maker in preparing for deliveries and using family planning. The analysis extends to comparing differences/similarities across region.

Decision-makers based on region: Who generally decides on the use of assisted delivery and family planning

While husbands generally hold more decision-making power than wives and couples in all regions, regional variations do exist. Reviewing data by region in Graph 4, Zinder and Tahoua seem to be the two regions where husbands' decision-making power is more pronounced compared to the Dosso region. In Tahoua region, the proportion of responses indicating wives have decision-making power is more pronounced. In Zinder, couples are more often mentioned as decision-makers than wives, unlike in Dosso and Tahoua.

In the Dosso region, women have more power individually than in the couple. Accordingly, after an initial discussion or in the husband's absence, the wife can decide on the place of delivery and the FP method to use.

"It must be recognized that in the household, it is normal for the husband's voice to prevail over that of the wife. This is cultural here. But since the implementation of HS, husbands have been discussing with and consulting women more, especially on reproductive health issues. We do not coerce our wives; we listen to them before making our decision." -Focus group husbands who are members of HS, Tapki

In terms of power dynamics, qualitative results show that Dosso women have acquired a greater ability to communicate their needs and make certain decisions, such as going to the health center for RH services and deciding which FP method they want to use. While respondents indicate that there are reasonably clear limits regarding women's decision-making, we did encounter rare cases where women say they can decide by themselves.

"... Today, I am the only one to decide, whether it is for antenatal or post-natal care... For family planning also, the choice is mine in the use of contraceptive methods and how to space my births. " - Wife of husband who is non-member of HS, Baban Tapki.

This ability appears among both Model husbands' wives and non-model husbands' wives. The community, including men, accept this new decision-making power dynamic. Nevertheless, we should keep in mind the relativity of women's decision-making power. To turn these decisions into actions, the husband's authorization remains essential. In addition, a woman's ability to seek RH services also depends on her ability to access and use household (financial) resources. This also limits women's decision-making.

Decision-makers for FP based on the nature of the couple: model couples versus non-model couples

Regarding the respondents' perspective on FP use decisions, in general, model and non-model husbands and wives all mentioned the husband first as the person who monitors the wife's use of FP. According to the majority of respondents, husbands' commitment to and support for FP use by their wives has increased over time.

> *"It's not like before, where if you went to family planning services, your husband scolded you. Today, he is the one who tells you after the delivery to go get the family planning drugs ... »* -Wife of husband who is member of HS, Mogheur.

There is no distinction between Model husbands' answers and non-model husbands' answers. Both types of respondents mentioned "husband" three times more than "wife". Similarly, model and non-model wives have rarely mentioned "the wife" as the first decision-maker. They cited more the "couple" as the decision-maker. However, "couple" was more often identified by non-model wives for decision-making. Thus, according to non-model wives' perspective, "wives" are increasingly associated in decision-making by their husbands. Model wives think couples and wives have equal importance in decision-making. In other words, decisions can be made by the couple as well as by the wife. In both cases, the husband agrees with the decision. This shows that for model wives, there has been significant progress in women's ability to decide on the couple, especially when it comes to FP.

> *"FP is recognized as very important to the health of women and the well-being of the household. Currently, decisions about FP use in the household are made by the couple because everyone has a role to play. In the couple, even if one member wants to make a decision, they will necessarily involve the other as recommended by the Model husbands in the community "* -Wife of husband who is member of HS, Tapki.

Regarding the decision-maker on FP, there is no difference between model wives' answers and non-model wives' answers. The decision by the couple (mentioned 10 out of 24 times) slightly exceeds the husband's decision individually (mentioned 9 out of 24 times). For all respondents, "the wife" makes few decisions by herself. Also, model and non-model husbands mention the "husband" as the decision-maker. However, non-model husbands mentioned decision-making by couples more than Model husbands. The latter gives very slightly more decision-making power to the "wife" individually.

The "husband" is more often mentioned as the decision-maker, especially for paying for a FP method and for getting a method. All respondents mentioned the "husband" more, especially Model husbands who were unanimous (in 18 out of 24 answers) in identifying the husband as the person who pays for and obtains FP. However, only model and non-model wives mentioned "the wife" for this decision (in 3 out of 6 answers), giving the woman more decision-making power on this subject. Also, non-model husbands and their wives mentioned the couple, although the number is minimal. However, regarding obtaining an FP method, model wives mentioned "the wife" more.

The timing for having their next baby is an essential question within couples. This question is more accentuated in couples who use a family planning method. Although "husband" is more often mentioned as the decision-maker for FP issues in general, there are decision points where it is the "couple" who is mentioned more often. For example, on decisions when to have the next baby, the majority of respondents (14 out of 24) mentioned 'the couple.'. The "wife" is also mentioned as the person who decides when to have the next baby; only non-model wives did not mention the "wife" as the person who makes this decision.

Of note, some regional differences exist. In the regions of Dosso and Zinder FP decisions are either consensual (couples), or depends on the wife, according to the respondents. In Dosso, the husband unilaterally decides when to have the next baby only in two out of eight cases. In Zinder, the couple decides in 7 of 8 cases, and by the wife in 1 of 8 cases. In no case does the husband unilaterally decide when to have the next baby, according to our sample in Zinder. In Tahoua, though, the man chooses the time for the next baby in six out of eight cases, with the couple choosing in two out of eight cases.

> *"It takes two people to have a baby. Therefore, in a couple, the two must agree on when to have a baby to avoid unintended pregnancies in the couple. Husbands who are members of HS sensitized a lot on FP and they advised couples to agree on all the questions in order to make it work"* -Wife of husband who is non-member of HS, Tahoua

Although procreation is an essential element in a Nigerien couple's life, before the promotion of FP, a newborn's arrival often was unexpected for the wife and the husband, who were frequently surprised by the pregnancy. The generalized understanding that reproductive decision-making was possible, whether made together or unilaterally, could only come about with the availability of contraceptive methods as well as the FP promotion by the HS.

Once the decision on when to have the next baby is made, whether it is imminent or not, the next question for the couple is whether or not to use FP, and particularly the specific method to be used. The choice of the FP *method* is made mainly by the couple, with a certain predominance of the woman's opinion in some cases. This means that the husband and wife discuss and agree on a method to use following this dialogue. According to qualitative data, the choice of the FP method is one of the rare decisions where the wife's opinion comes first or prevails over the husband's. The choice is made first by the couple; if necessary, the wife can choose the method she wants, and lastly, the husband can make a choice. Note that all this can vary depending on couples and circumstances. Here, it is clear that the improvement of communication within couples through HS played a significant role in this situation. Indeed, the availability and the easy access to information through awareness-raising activities allows couples to make an informed choice.

> *"We know FP methods through the health center, so it is up to my wife to say which one she prefers"* –Interview, husband who is member of HS Malgorou

> *"Men do not use these products. It's the woman who uses them and knows what is possible and easy for her. The man must not impose a method on her, otherwise things may not work […] for that, the choice [of the method] it is me who decides."* Interview, wife of member of HS, Kalfou

In summary, there is a visible commitment and adherence of men to RH in general and FP in particular in the visited communities. This commitment by men gives women even more freedom of choice and decision regarding the choice of a method and involvement in deciding when to have children. This is a significant change in the role of women in RH decision-making. According to the results, in most cases, FP decisions are made by consensus (couple) or by the wife. None of the sites had respondents mentioning any refusal by a husband (whether HS husband or non-HS husband) for a wife to use FP. Among Model husbands, there is a

strong tendency towards the wives' greater freedom of decision (on what to use and when to use it), and this can be an effect of the impact of HS on attitudes and behaviors.

Overall, regardless of respondent type, husbands remain the decision-makers in most RH actions in all localities and regions. However, decisions made as a couple are the most frequent in Zinder, and in Tahoua, where women have more decision-making power individually than in the Kalfoua region. In Tahoua, a more matriarchal local culture also helps explain the decision-making power of women, even if HS fostered this behavior. Compared to before the arrival of HS, it is now easier for women to make decisions, and men are more understanding and committed to their wives' involvement and at times greater independence in decision-making by women regarding the use of RH services. Such a shift is already a big step towards the empowerment of women in procreation, in the strong patriarchal environment that exists in the country.

There still exists much room to further the creation of gender dynamics that will be more favorable to decision-making power for women in the use of services. The trend towards more cooperation between men and women, and the fact that men systematically accept their wives' access to FP and assisted delivery, are significant steps towards freedom in decision-making in use of RH services in the patriarchal context of Niger.

To deepen shifts in gender-equitable RH decision-making there is need to intensify HS in existing communities (possibly bringing in new, 'deeper' gender reflection efforts to members in existing schools). There is need to scale up HS activities in new communities, which creates new cross-village intersections for HS, as they work in community-acceptable ways to achieve an initial level of gender-equity.

Decision-makers for assisted delivery based on the type of the couple: model couples versus non-model couples

By comparing the responses of wives of Model husbands and Model husbands to responses of wives of non-model husbands and non-model husbands, it appears that those closest to HS activities think that women's decision-making power is higher when it concerns assisted delivery.

The quantitative analysis also shows that the "Husband" response does not dominate any of the 4 decision points, with the exception of financing delivery services. Husbands are also frequently cited for being the main decision-maker about where to deliver. "Wife" is mentioned in the majority of answers on the decision related to the preparation of the baby's room, and "Wife' and Couple' are equally cited for making decisions about who will deliver the baby. While husbands (Model and non-model) mention "Husband" more often as the decision-maker on issues related to who will deliver the baby, wives of Model husbands more often mention the "Wife", and wives of non-model husbands more often mention the "Couple." Obviously, model wives and non-model wives do not have the same views on the issue. This may be a result of the direct influence of Model husbands, who are the first to assimilate HS messaging, and the directly share the information with their wives.

> *"Delivery is a time when women need support and, above all, understanding. Before the moment arrives for [delivery], it happens that we already know where the delivery will take place. So, the decision is not made on the day of delivery. The woman is first of all the one who decides. Typically, the delivery takes place where the wife did her ANC visits, and in any case, the health center is the only choice because nobody wants to give birth at home since we [HS] started. It is the husband's duty to take the wife to the health center at the time of delivery and stay with her to give her support. Also, there is need for a person who can help the wife before she is released from the health center*

[…] this person is known in advance. It is generally a woman from the house and the person can vary from one household to another. " - Focus group, Model husbands, Malgourou.

Concerning delivery, we were interested in the following points related to delivery: the preparation of the baby's room; the choice of the place of delivery, the choice of the person who accompanies the woman to the health center, and the funding source for the delivery-related expenses.

Traditionally, mothers and mothers-in-law care for newborn babies and the quantitative data reflect this: 15 of 24 respondents indicated this was the wife's job, six indicated couples, and only three said this was the husbands' decision. To welcome the newborn, a preparation is essential, namely a place where the newborn will sleep. Usually, this space is not far from the mother to make breastfeeding and routine baby care easy. In this context, the preparation of this space is the mother's responsibility. Given such preparation is done before the delivery and takes place when the pregnancy is very advanced or almost at full term, it requires a special effort on the part of the pregnant wife. This wifely responsibility can be seen as a privilege, which allows a wife to add her own touch of maternal love and decide how she wants to welcome her baby.

On the other hand, because of the state of her pregnancy, this work can appear like a chore because every small movement of the pregnant wife requires a tremendous effort on her part. (The word "chore" is used here with caution because the data do not indicate that the woman is forced to do this task. Rather the idea of "chore" relates to physical challenges of carrying out the task during the later months of pregnancy.)

Regarding deciding where to deliver, Model husbands and their wives mentioned 'wives' whereas non-model husbands and their wives did not mention "wife" as the decision-maker. Interestingly, only the wives mentioned "couples" as the decision-maker, but this was not a large-frequency response relative to other responses. It is also interesting to note that during focus group discussions, couples (consensual decision) are regularly mentioned for deciding where to deliver.

"Couples talk about the use and attendance of delivery and family planning services; we discuss together the use of maternity services " –Focus group, wives of husbands who are members of HS, Magheur

"Yes, in our community, couples discuss the visit to the health center/ CSI to use the delivery services". Focus group, husbands who are members of HS, Mantankari

Therefore, it appears that couples are discussing the issue of assisted delivery, which is a positive change. Even if the final decision rests primarily with the husband, this decision takes into account the wife's opinion, according to almost all interviewees. Thus, the patriarchal tradition that wives cannot/must not go somewhere without husbands' approval would explain why the choice of the place of delivery must always suit the husband. Also, for more practical reasons, the place of delivery is also subject to the husband's financial possibilities as the main provider for the family. In most cases, delivery requires a trip to the health center and payment for prescriptions during the delivery, although, currently, free consultations have reduced these expenses. The health center can be located in the home village, or kilometers from the village. In all cases, given the pregnant wife's' condition, it is almost impossible for her to go there without help. A means of transportation is therefore essential, with the ability to cover transportation fees or fuel costs. This help comes from the husband (when he is present) who is, theoretically, the person closest to the wife. Therefore, whether they are Model husbands or other husbands sensitized by them, the men tend to take pregnant wives to a place of delivery that seems to them the closest, or the least expensive, or that inspires the most confidence. This can appear as husbands imposing the place of delivery on wives because it is the husbands' opinion or

perception which prevails over those of the wives when putting this decision into action. But the decision point itself has many nuances including who has authority over household finances.

There are regional variations: More gender-equitable decisions are taken in Tahoua, where in one in eight cases, the wife or the couple decide, and in Zinder, where couples decide in 1 in 8 cases. Only Dosso remains one hundred percent patriarchal, where the decision rests exclusively with the husband.

On the subject of paying for delivery services, model and non-model wives unanimously mentioned "husband", as did model and non-model husbands. However, Model husbands mentioned "wife" and non-model husbands mentioned "couple" only once. It is observed that household expenses in general and delivery-related expenses, in particular, are the man's responsibility, and the results of this survey confirm that except again for Tahoua where one in four wives contribute to these expenses. In Baban Tapki (Zinder), the couple shares these types of expenses in one in four cases. In Dosso, the man is exclusively responsible for mobilizing resources to meet the costs of the delivery.

In summary, although delivery is traditionally a woman's matter, husbands in the cases we have studied are more at the front in terms of the decisions, when decision-points are subdivided for delivery. Even if men's power seems to have increased in this area, it can be said that an expected change has taken place: that is, men's involvement and interest in delivery, once perceived as taboo or a forbidden area for them. We should note that the man's involvement in RH, so much sought after by the HS strategy, implies his increased financial participation in the process of seeking RH services.

Ultimately, after a general analysis (by region, by respondents and by decision category), very few decisions are exclusively reserved for women, whether they are wives of Model husbands or wives of non-model husbands.

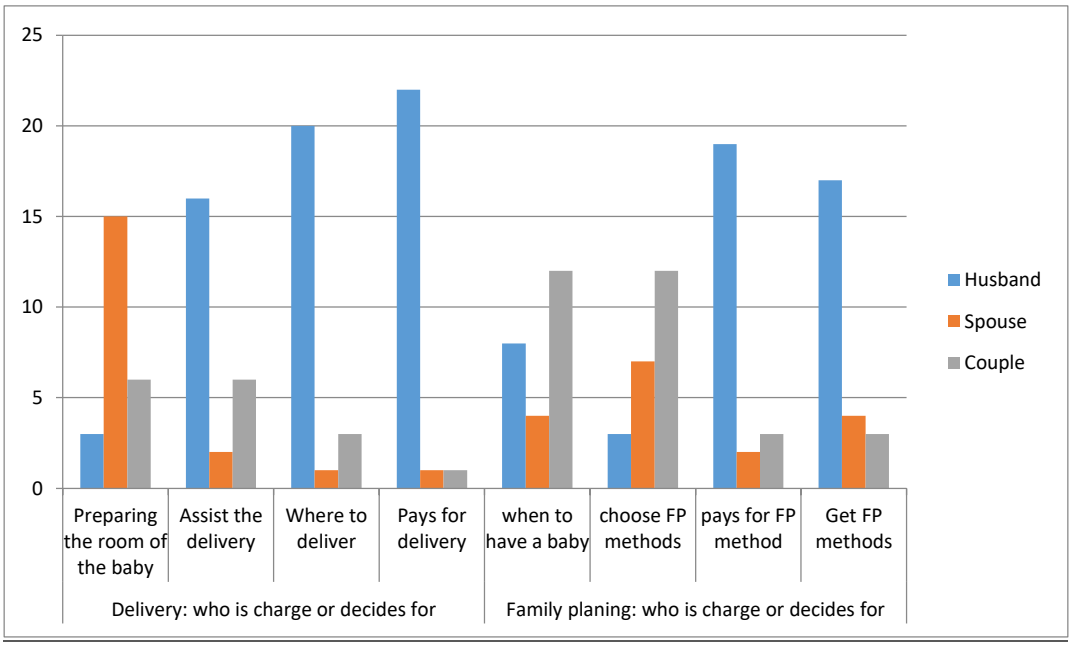


Figure 8 | Barometer of decision-making in the couple among all respondents (Model husbands and wives and non-model husbands and wives combined). *Note: These data are not representative of the study sample; the power-sharing questions were asked only in interviews (and do not include respondents in focus group discussions).*

MEN'S PERCEPTION OF WOMEN'S DECISION-MAKING POWER

Both men and women (Model husbands and their wives, non-model husbands and their wives) say that women have acquired a specific decision-making power in the household. This decision-making power is more accentuated in FP, reflecting a change in husbands' attitudes, and above all, in their behavior. There are few references on what men think of the decision-making power that women have acquired and the question was not explicitly asked. Because of this it is not possible to say with certainty that men positively view women now having greater decision-making power. We can only say that the data show that men are not opposed to women making certain RH services-related decisions in the couple.

> *"This change we noticed is about ourselves, the population of the village, because before, we had used an old logic, and that really set us back. Hausa people often say: "in kid Ya sake, rama ma saka si ka yi" which means (if the rhythm changes, the dance also must change). So, we too must change our behavior [towards the women's freedom of decision-making], we must not keep the same behavior as people from the past. "* Interview, husband who is non-member of HS Mogheur

In many answers, it appears that men in general show great support for their wives when it comes to relaying HS messages and encouraging their peers to adopt the promoted behaviors.

MAGNITUDE OF THE CHANGE

According to respondents, changes introduced by HS are not limited to the communities covered by the intervention. Indeed, according to many respondents, the messages and behaviors advocated by HS are visible in neighboring villages and health areas. HS ideas are also referred to during discussions in villages where HS do not operate during impromptu meetings (e.g., at ceremonies, in the market). In addition to these interpersonal contacts between communities, we must also mention comments by health workers in villages not covered by HS. The "ripple effect" on neighboring communities, as mentioned by the health workers, suggests potential changes in gender relations concerning the use of RH services by women and couples.

> *"These changes impact everyone in the community. When I arrived here, we recorded one birth per month at the health center. People did not go to health centers. Women gave birth at home. But thanks to HS, all this has changed. Messages also arrive in villages and non-covered communities and there is an increase in the visits to RH services*" –Interview, health worker Baban Tapki

> *"The changes we've talked about are not just about HS, it's about the whole community because those who are members and non-members all benefit from this progress. "* –Interview, health worker, Malgorou

Regarding the unevenness of social change efforts in general: As noted earlier, HS's obvious success in promoting RH services should not hide that gender and power gains are not universal. The study identified some (a few) respondents' reluctance to change, and some unintended effects, particularly around the strengthening of men's power over women's use of RH services. These respondents' comments reveal that some men are compelling their wives to use FP. Having now mastered RH mechanisms, these men position themselves as main actors in promoting and supporting the use of RH services. It is an illusion that a positive social behavior change in RH affects the whole community in the same way and at the same time.

Regarding sustainability of HS as a social force in villages: Members in visited HS are ready to commit for the long haul. Testimonies of other respondents, see three below, show that men are now interested in RH issues and will continue their work.

"Our detractors say we work without pay and try to discourage us. But we always answer that this is not a problem because we work for our village. In addition, we have to set a good example in the neighborhood, because there are people who tell others not to even listen to us. They think we are preventing births. " –Interview, husband who is member of HS, Mirriah.

Regarding the sustainability of the gender and other effects that have resulted from HS: We believe the sensitization work is not yet complete, despite the very significant positive results recorded in RH and gender areas. If enough community members are convinced of the benefits of using RH services, a new normative environment will eventually emerge, as predicted in the program theory of change. The study findings showed that most respondents say they will not abandon the gains in reproductive health and gender equity, even after the end of the HS intervention.

"There will be no abandonment of my current practice since it is beneficial." -Interview, husband who is member of HS, Matankari.

"Nothing can stop her from continuing to use FP, because it is for her own good and that of our children. " –Interview, husband who is non-member of HS, Mogheur.

Based on compiled answers from all husbands and wives that indicate community willingness to not go backwards vis-à-vis RH-related behavior change, and that visited sites were in regions having schools that have been functioning in the last five and ten years, we predict that the changes brought about by the HS intervention should last even if HS disappear. However, the sustainability of this social and behavior change will be judged over time. We note a significant reduction in HS's activities over the last year, with the suspension of the NGO SongES' support due to a lapse in funding by UNFPA, the primary funder of the HS initiative.

DISCUSSION

The results of this study show the beginning of community-level gender-equitable changes in attitudes and behaviors concerning the use of RH services by couples, especially husbands' commitments to promoting RH services use within their households and communities, while also acknowledging the existence of a range of gendered effects. It seems difficult for respondents to describe and precisely situate the position of decision-making power within the household, in particular between the husband and the wife. This difficulty is accentuated when analyzing transcripts and interpreting the husbands' position on RH issues as a result of the HS intervention. The transcripts/responses present husbands as the final RH decision-makers. Yet this characterization of husbands leads to confusion about men's social position (as head of the family) versus their role as the provider or person responsible for the well-being of their family. This former role is more linked to patriarchy, while the latter usually leads the husband to make decisions for the good of the family. There is a possibility that respondents interpret husbands' agreement or even their suggestions, as decisions, and accordingly see husbands as decision-makers. Within a single transcript, there may be several answers indicating that the husband decides or the husband is the ultimate decision-maker. And yet, the same respondent continues by mentioning others as final decision-makers, such as the wife or the couple as having more decision-making power on the same subject. Thus, answers that put men first as 'ultimate' decision-makers, especially in FP and when to have a baby, must be read and interpreted, taking into account the difficulty of determining respondents' actual positions.

Women's level of decision-making varies with the type of decision. This observation appears in other studies conducted in sub-Saharan Africa (Gnoumou Thiombiano, B. 2014). In Ghana, a similar gender study found that less than a third of women participate in decisions about their health care (Ghana GSS and ICF International, 2009). The same study indicates that factors such as education level and, consequently, an improvement in knowledge and understanding, can increase women's decision-making power. Similarly, our study also shows that improving the knowledge of Model husbands and by extension their wives through HS activities helps improve the decision-making power of women, especially in FP.

Many factors can lead to changes in gender norms, including exposure to new ideas and practices discussed through formal and informal channels such as conversations, observing role models and exposure to media. The same forces that contribute to changing norms can also reinforce discriminatory norms. Although rarely mentioned by this sample of respondents, our research has shown that some men exposed to HS ideas have interpreted their RH commitment as an opportunity to strengthen their decision-making power by imposing some decisions on their wives. Thus, our study has shown that gender norms change was mixed; that change was not linear, especially in transforming decision-making power relations in RH areas. The nonlinear nature of norms-shifting is expected from gender and social norms theory and practice; there is always cohabitation between new and old norms, and changes can have unintended, undesired effects (UK AID, 2015).

Role models and community resource people can be real catalysts for change, especially for gender norms. The HS theory of change highlights HS members' positive role modeling as an important factor to catalyze change. In social norms parlance, Model husbands have become important reference groups for other men. It is important to note again that in RH, community changes are not quite linear vis-a-vis gender and power. Indeed, decision-making power always is influenced by cultural and patriarchal norms that exist in the study areas.

Recognizing that both individual and community factors are essential in changing social norms (UK AID, 2015), the integration of individual and community efforts in the implementation of HS significantly contributed to the beginning of a normative change expected in the theory of change. At an individual level, Model husbands received individualized coaching from trained NGO staff that enabled them to be resources in their communities. Through their knowledge and outreach actions, Model husbands became a reference group for other men. At the community level, the approach had a multiplier effect (feedback loops). Many schools, each with HS members implementing community activities in the same period, each with a link that strengthened collaboration and trust between husbands and health centers, have led to an environment where ideas and messages on RH are positively received. The normative environment has shifted both in perceptions about what others are doing (descriptive norms) and what others should be doing (injunctive norms): Community beliefs and perceptions are strong vis-à-vis the importance of RH services and women's use of services (descriptive norms). Some sanctions (a byproduct of injunctive norms) have flipped for male engagement in RH and moving away from prescribed gender norms. For example, prior to HS, men were viewed with suspicion and disbelief if they dared to move into 'women's issues' and promote RH services and use. Prior to HS, social sanctions existed for men who dared to help their wives with household chores during pregnancy and post-delivery. These sanctions are greatly diminished in the study sites, that represent a range of ethnic groups residing in Niger.

The study results confirm the hypotheses of the HS theory of change in the sense that the changes described by the respondents correspond to those described and predicted in the theory of change. These include changes in husbands' attitudes towards RH, community trust in Model husbands, improvement in men's knowledge about RH, and their acceptance of these services are some elements of the theory of change that appear in the results. With these study results, the 2016 program theory of change can be fine-tuned and results made more explicit. Based on these findings, and given the answers from respondents (husbands, wives, health workers) on the increase in the frequentation of RH services, which is the ultimate goal sought by HS, the theory of change of HS is validated.

As with any study, there are limitations. This study's main limitation was in defining the concept "decision-making power," which could have been better defined in the beginning to facilitate the interpretation of data referring to the continuum of power in decision-making. This limitation often led to difficulty to designate the various household members' decision-making powers, including the husband. Future studies should do formative research to develop operational understanding of such concepts to facilitate later analysis.

CONCLUSIONS

HS in Niger intervene in a society having strong patriarchal tendencies and we would not expect to see a drastic change in social and gender norms in the short term. Yet, the HS intervention has brought notable attitudinal and behavioral changes in gender relations, especially within couples whose husbands are members of HS, but also visible in the community at large, where non-member husbands and wives begin to replicate the promoted attitudes and behaviors and spread the messages conveyed by HS. To show the level of actual spread, we note that the study protocol aimed to interview women and men who do not use RH services, but none could be found. According to community members, there are no longer women who don't use RH services.

The positive changes that were generated, especially in gender dynamics, through joint decision-making and a greater ability for women to make choices and make certain decisions, cover several essential elements. The greatest progress in women's empowerment in decision-making concerns family planning and the couple's choice of when to have the next child. Beyond this, the emergence of new behaviors such as men's involvement in domestic work during women's pregnancies, is also a significant positive change in gender relations in general, particularly in men's behavior. Changes observed in gender roles stem from the establishment of couple communication on RH services and their use. This communication itself originates from the messages and behaviors conveyed by HS. These positive findings represent a step toward changing gender norms within a predominantly patriarchal society.

The HS approach helped to highlight the importance and relevance of RH services for couples. Both women and men (members of HS and non-members alike) demonstrate awareness of the benefits of using reproductive health services., the results show the changes in perceptions, attitudes, and behaviors in men and women involved in HS. Without threatening men's status of the "head of household," or ignoring the barriers and observed reluctance to change, women, especially those whose husbands participate in HS, and although not as pronounced, women whose husbands do not participate directly, have acquired greater decision-making power. This power is accepted by husbands in the use of RH services in general and FP in particular.

The HS programmatic theory of change is now clearer, thanks to this study. Before, many of the pathways to change were hypothesized but never tested using systematic inquiry. The study sheds light on how the dissemination of new ideas, attitudes, and promoted behaviors, spread (diffuse) and reach people beyond the areas where HS operate. It also shows ways in which gender-related power dynamics are changing, albeit slowly. Gender effects are reaching not only those directly involved in HS but also the whole community. The approach works across different social contexts. Similar effects were observed in all regions visited, meaning the HS intervention seems to generate the same results, regardless of socio-cultural differences from one region in Niger to another. Finally, it is noted that some Model husbands' actions go beyond the intervention's RH objectives, contributing to health and overall well-being of their communities.

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ANNEX 1: MAIN DECISION-MAKERS IN ASSISTED DELIVERY AND FAMILY PLANNING, BY REGION, AND BY CATEGORY OF RESPONDENTS (N=24)

Regions	Sites	Participant types	Assisted delivery: Who is in charge of, or decides for:				Family planning: Who is in charge of, or decides for:			
			Preparing the baby's room	Who will attend the delivery	the place of delivery	Paying for delivery services	When to have the next baby	Choosing the FP method	Paying for the FP method	Obtaining the FP method
DOSSO	Malgouou	Non-model husbands	Husband	Couple	Husband	Husband	Wife	Couple	Husband	Husband
		Wives of Non-model husbands	Wife	Couple	Husband	Husband	Wife	Husband	Husband	Husband
		Model husbands	Husband	Husband	Husband	Husband	Husband	Couple	Husband	Husband
		Wives of Model husbands	Wife	Husband	Husband	Husband	Husband	Wife	Husband	Husband
	Matankari	Non-model husbands	Wife	Husband	Husband	Husband	Couple	Husband	Couple	Couple
		Wives of Non-model husbands	Wife	Couple	Couple	Husband	Wife	Wife	Wife	Wife
		Model husbands	Wife	Husband	Husband	Husband	Couple	Couple	Husband	Husband
		Wives of Model husbands	Wife	Couple	Husband	Husband	Couple	Couple	Wife	Wife
TAHOUA	Kalfou	Non-model husbands	Husband	Wife	Husband	Husband	Couple	Couple	Husband	Husband
		Wives of Non-model husbands	Wife	Couple	Couple	Husband	Husband	Couple	Wife	Husband
		Model husbands	Wife	Husband	Wife	Husband	Couple	Wife	Husband	Husband
		Wives of Model husbands	Wife	Wife	Husband	Husband	Husband	Couple	Husband	Wife
	Mogheur	Non-model husbands	Husband	Wife	Husband	Husband	Husband	Husband	Husband	Husband
		Wives of Non-model husbands	Couple	Husband	Husband	Husband	Couple	Couple	Couple	Husband
		Model husbands	Husband	Husband	Husband	Husband	Husband	Husband	Husband	Husband
		Wives of Model husbands	Wife	Wife	Wife	Husband	Couple	Husband	Husband	Husband
ZINDER	Baban Tapki	Non-model husbands	Wife	Husband	Husband	Couple	Couple	Couple	Husband	Husband
		Wives of Non-model husbands	Couple	Couple	Husband	Husband	Couple	Husband	Husband	Husband
		Model husbands	Wife	Husband	Husband	Husband	Wife	Wife	Husband	Husband
		Wives of Model husbands	Couple	Husband	Couple	Husband	Couple	Couple	Wife	Wife
	Mirriah	Non-model husbands	Wife	Husband	Husband	Husband	Couple	Wife	Husband	Husband
		Wives of Non-model husbands	Couple	Husband	Husband	Husband	Couple	Couple	Husband	Husband
		Model husbands	Couple	Husband	Husband	Husband	Couple	Couple	Husband	Husband
		Wives of Model husbands	Wife	Wife	Husband	Husband	Couple	Couple	Husband	Couple

SUMMARY ASSISTED DELIVERY	Preparing the baby's room			Who will attend the delivery			Of the place of delivery			Paying for delivery service		
	Husband	Wife	Couple	Husband	Wife	Couple	Husband	Wife	Couple	Husband	Wife	Couple
Model Husbands	2	3	1	6	0	0	5	1	0	5	1	0
Non-Model Husbands	3	3	0	3	2	1	6	0	0	5	0	1
TOTAL AMONG HUSBANDS (n=12)	5	6	1	9	2	1	11	1	0	10	1	1
Wife of Model husbands	0	5	1	2	3	1	4	1	1	6	0	0
Wife of Non-Model Husbands	0	3	3	2	0	4	4	0	2	6	0	0
TOTAL AMONG WIVES (n=12)	0	8	4	4	3	5	8	1	3	12	0	0
SUMMARY FAMILY PLANNING	When to have the next baby			Choosing the FP method			Paying for the FP method			Getting the FP method		
	Husband	Wife	Couple	Husband	Wife	Couple	Husband	Wife	Couple	Husband	Wife	Couple
Model Husbands	2	1	3	1	2	3	6	0	0	6	0	0
Non Model Husbands	1	1	4	2	1	3	5	0	1	5	0	1
TOTAL AMONG HUSBANDS (n=12)	3	2	7	3	3	6	11	0	1	11	0	1
Wife of Model husbands	2	0	4	1	1	4	4	2	0	2	3	1
Wife of Non-Model Husbands	1	2	3	2	1	3	3	2	1	5	1	0
TOTAL AMONG WIVES (n=12)	3	2	7	3	2	7	7	4	1	7	4	1