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NAMPULA E SOFALA

COWI

Male Engagement and Couples Communication in Reproductive, Maternal and Child Health in Nampula and Sofala Provinces of Mozambique

Findings from the Knowledge, Attitudes, Practices and
Coverage Endline Qualitative Assessment

August 2019



The Maternal and Child Survival Program (MCSP) is a global, \$560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Table of Contents

Table of Contents	iii
Acknowledgments	iv
List of Acronyms	v
Executive Summary	6
Recommendations	7
Background	11
Study Objectives.....	12
Methodology	12
Sampling Strategy	12
Description of Tools	13
Limitations.....	13
Data Collector Trainings.....	14
Data Collection	14
Data Analysis.....	15
Key Findings	15
Male engagement in FP, ANC, and L&D Services	15
Decision-making about having children	24
Decision-making about care-seeking	26
Discussion and conclusions	29
Male engagement in FP, ANC, and L&D Services	29
Decision-making about having children	30
Decision-making about care-seeking	30
Recommendations	31
Annex I. Focus Group Discussion Tool - Women	34
Annex II. Provider IDI Tool	36
Annex III. Health Facility Manager IDI Tool	38

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List of Acronyms

AOR	Adjusted Odds Ratio
ANC	Antenatal Care
BPCR	Birth Preparedness and Complication Readiness
CDA	Community Development Agents
CHC	Community Health Committee
CI	Confidence Interval
DPS	Provincial Health Directorate
EPCMD	Ending Preventable Child and Maternal Deaths
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
IDI	In-depth Interviews
IEC	Information, Education and Communication
IRB	Institutional Review Board
L&D	Labor and Delivery
KAPC	Knowledge, Attitudes, Practices and Coverage
MCSP	Maternal and Child Survival Program
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
RMNCH	Reproductive, Maternal, Newborn and Child Health
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Executive Summary

The United States Agency for International Development's (USAID) Bureau for Global Health's flagship Maternal and Child Survival Program (MCSP) focuses on 25 high-priority countries with the ultimate goal of preventing child and maternal deaths. MCSP introduced and supported high-impact, sustainable reproductive, maternal, newborn and child health (RMNCH) interventions in partnership with ministries of health and other partners. In Mozambique, MCSP implemented activities in two focus provinces – Nampula and Sofala.

In October-November 2016, MCSP conducted a quantitative baseline assessment that included a gender module, whose findings were used to refine gender interventions during two years of project implementation. In November-December 2018, MCSP Mozambique conducted endline studies which included this qualitative male engagement study which had the following objectives:

- Evaluate the feasibility and acceptability of male engagement interventions that encouraged couples' communication aimed at increasing antenatal care (ANC) attendance, joint birth preparedness and complication readiness (BPCR) plans, institutional birth, and use of modern Family Planning (FP)
- Explore how decisions between couples are made and what may influence their decisions about seeking RMNCH services

For the purposes of this study, male engagement and male participation were defined as men taking an active role in protecting and promoting the health and wellbeing of themselves, their partners and children.¹ This engagement can occur within households, communities, or health facilities.

The qualitative male engagement study included 197 participants in two districts, eight communities and two health facilities in Nampula, and two districts, seven communities and two health facilities in Sofala. In both provinces, data were collected only in MCSP-supported areas. The study was approved by the Ministry of Health's (MOH) Health Bioethics Committee and the Johns Hopkins University Bloomberg School of Public Health's Institutional Review Board (IRB).

Key findings included clients' (female and male parents of children under 2 years old), health providers' and facilities managers' perspectives regarding the following:

- Male participation in FP, ANC services, and labor and delivery (L&D) services
- Decision-making about having children
- Decision-making about care-seeking

Focus group discussions (FGDs) and interviews identified the following key findings:

- **Men still make most decisions about fertility and family size:** Respondents reported that deeply patriarchal gender norms limit women's agency and participation in decision-making in both provinces. Women and men reported that women must obtain permission from their male partners before seeking health services. Men still make most decisions regarding how many children to have and when to have them, whether to use FP, and where a woman will deliver. When women expressed a desire to space or limit births, it was usually because of insufficient income to feed, educate and/or clothe children. Men and women both reported, however, that men frequently override women's wishes to limit births by divorcing them and marrying other women until they meet their desired level of fertility. Some said that men see a large number of children as "social recognition" and a way to spread their family name.

¹ Adapted from Plan International and Promundo. Guidance Note on Male Engagement in Maternal, Newborn, and Child Health/Sexual Reproductive Health.

- **Barriers to male participation in health services:** The main barriers to male participation included fears that women only bring their partners for health services when they have TB or HIV and that they will therefore be stigmatized; that men who accompany their partners are bewitched or drugged by them; or men’s fear that the health providers will be male and would see their female partners’ nude bodies.
- **Providers could reduce intimate partner violence (IPV) related to FP utilization through couples counseling:** Women reported a wish to have their male partners participate in FP counseling to reduce the risk of being beaten by them for limiting births. Women reported, however, that men do not usually go to the visits, which could be a potential opportunity for health care providers to understand and shift their male partners’ attitudes and to prevent gender-based violence (GBV) through couples’ FP counseling. Some providers described an increase in women seeking clandestine FP methods when their husbands refuse permission for them to use FP.
- **Community dialogues were effective at increasing male support for healthy RMNCH behaviors:** After MCSP-trained providers counseled couples, men described an increased desire to limit the number of births and to support their pregnant partners beyond just organizing transport for labor and delivery. Men in Nampula in particular reported increased support to pregnant partners after community dialogues, called “palestras,” including fetching firewood and water, allowing women to rest, etc.
- **Provider capacity-building and community dialogues worked together to reduce barriers to male participation:** After palestras and capacity-building of health providers on effective male engagement and couples counseling, community members’ knowledge, attitudes, and practices changed slightly. Men reported they no longer feared being turned away from facilities when accompanying their partners to ANC visits. They were more likely to provide money for transport and medicines, “allow” pregnant women to take vitamins and use mosquito nets, and support their female partners to deliver in a health facility.
- **Beliefs about facility births differ:** Many women deliver at home, unless otherwise instructed by midwives and community health workers. Some women followed the traditional practice of returning to their parents’ home to deliver, and others believed it is now a mandatory policy that all deliveries must take place at a health facility.
- **Men experience barriers to participating in L&D:** In Nampula, there are cultural taboos that prevent men from being present at birth. In both provinces, some facilities still only have one room for multiple women to deliver. Health facility managers and providers described a slight overall increase in the number of men accompanying their female partners and the need for increased privacy in L&D wards to allow more men to participate.
- **Unaccompanied women are often deprioritized for care compared to couples:** Despite MCSP’s capacity-building efforts to ensure single women are not discriminated against in health services, there is a persistent practice of deprioritizing single/unaccompanied women. Couples or men who come alone (e.g., for HIV testing) receive priority over single women in FP, ANC, and child health appointments. Providers justify this discriminatory practice because they believe husbands must go to work and don’t have as much time to wait as women. Some providers in Nampula even refuse to see single women.

Recommendations

The Study Team offers the following recommendations:

- **Continue, improve, and scale up palestras and implement in-depth group education on gender and male engagement:** The MOH should engage implementing partners, other sectors, district officials, community health committees, and community leaders to expand the reach and depth of community social behavior change-focused interventions. Regular and ongoing Palestras on a wide range of health topics in health facilities and in communities should continue. Additional, more comprehensive gender-focused content should be integrated into these, including:

- Examination of gender norms and roles, and debunking of harmful norms or myths around reproductive health (e.g. that it is dangerous for the infant if a father is present at birth);
- Education about the harmful impacts of GBV, awareness raising about rights and the availability of post-GBV services, linkage of GBV survivors to appropriate services, and promotion of non-violent conflict resolution and couple's communication;
- Messaging on the potential benefits of male engagement (e.g., care for men's health needs, increased number of ANC visits; improved nutrition, breastfeeding, and immunization rates,^{2,3} reduced GBV,⁴ improved self-care of women, improved home care practices for women and newborns, reduced maternal workload, increased maternal nutrition and rest during pregnancy, increased caregiving and bonding by fathers, increased value of girl children,⁵ etc.)
- **Address couples' decision-making and women's autonomy:** Palestras and couples counseling should carefully address the balance required between equitable couples' decision-making and women's reproductive autonomy, taking care to ensure that a woman has the right to decide whether she wants her partner involved in her reproductive health, and preventing men from trying to take control of such decision-making. Such efforts should also keep in mind that women experiencing IPV may prefer not to involve their partner because of a risk of violence and may prefer clandestine methods of FP. Palestras and couples counseling remain relatively missed opportunities for providers in both provinces to raise the subject of GBV carefully, including its negative impacts on RMNCH, and to educate communities about the availability of post-GBV services. Palestras and counseling can be offered individually or in groups, either single gender or mixed gender, or a combination of both.
- **Implement evidence-based group education to transform gender norms:** While Palestras are important, one-off interventions are not enough to transform harmful gender norms or encourage long term behavior change. Community health workers should conduct gender transformative group education using evidenced-based curricula, reaching community members repeatedly over time. For example, the MenCare and Promundo Bandebereho Curriculum in Rwanda engaged men and their partners in participatory, small group sessions of critical reflection and dialogue. Group education should be implemented with appropriate expertise, adequate duration and coverage. Men participating in the Bandebereho intervention were invited to 15 sessions (maximum 45 hours) and their partners to 8 (maximum 24 hours). Sessions addressed: gender and power; positive fatherhood; couple communication and decision-making; IPV; caregiving; child development; and male engagement in reproductive and maternal health.⁶

Programs such as Bandebereho have found value in having some sessions for men or women alone during which they can discuss issues they feel are too private or sensitive to discuss in front of participants of the opposite gender. However, for other sessions, it is important for both genders to hear the others' perspectives. Palestras should also take into the account the diversity among men in terms of age, gender identity, sexual orientation, race/ethnicity, marital status, fatherhood, and class.⁷

² Tokhi M, Comrie-Thomson L, Davis J, Portela A, Chersich M, Luchters S. Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. *PLoS One*. 2018;13(1):e0191620.

³ Levto R, van der Gaag N, Greene M, Kaufman M, Barker G. *State of the World's Fathers: A MenCare Advocacy Publication*. Washington, DC, USA: Promundo, Rutgers University, Save the Children, Sonke Gender Justice, and the MenEngage Alliance; 2015.

⁴ Doyle K, Levto R, Barker G, Bastian GG, Bingenheimer JB, Kazimbaya S, et al. Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial. *PLoS One*. 2018;13(4):e0192756.

⁵ Adapted from Plan International and Promundo. *Guidance Note on Male Engagement in Maternal, Newborn, and Child Health/ Sexual Reproductive Health*.

⁶ Doyle K, Levto R, Barker G, Bastian GG, Bingenheimer JB, Kazimbaya S, et al. (2018) Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial. *PLoS ONE* 13(4): e0192756.

⁷ Interagency Gender Working Group, Male Engagement Task Force. "Dos and Don'ts for engaging men and boys." 2019 (In Press).

- **Engage men as allies and champions:** Efforts to engage men should acknowledge and meet their unique needs as clients, partners and agents of change, treating them as allies rather than assuming they are bad actors. Facilitators can amplify the voices of men who support gender equity and those who are positively changing their behaviors.⁸ The MOH recently created guidance with norms for male engagement in health programming,⁹ which can be a useful foundation to improve men’s involvement in health seeking and utilization.

These efforts should be offered in physical spaces and at times that are accessible to women and men, taking into account work hours, harvest seasons, and distance to facilities. Providers should be prepared to receive men in a welcoming manner. They should also consider offering services in other locations where men congregate in the community, and mobile services.¹⁰

When new health facilities are built or existing ones are upgraded, the MOH should ensure that private consultation and examination rooms are available in key service delivery points including FP, ANC, L&D, post-partum wards, post-GBV services, and HIV testing, treatment and care services. Privacy can include a space with a door, curtain, wall, or screen. This can ensure that patients have privacy during sensitive conversations and physical examinations, and also that, when appropriate and desired by the female patient, that men can participate in services.

- **Clarify policies around male participation in health services and address discrimination against unaccompanied women:** The MOH should clarify its policies in writing and through refresher trainings around male accompaniment to services to all providers and facilities across districts. Efforts to engage men should not come at the expense of women’s agency, for example, the de-prioritization in health facilities of women who seek health services without a male partner. Women who seek services alone should receive care of equal quality, timeliness, and prioritization. Couples should not be allowed to skip to the front of the line or receive better quality of care than unaccompanied women. Care should be provided on the facility’s triage system and urgency of need.

Efforts should also avoid encouraging men to take control of reproductive health decision-making. The MOH and partners should continue to encourage male participation in RMNCH services when women desire it, particularly HIV testing in ANC visits, while still respecting women’s reproductive autonomy and agency. This can be accomplished by only asking women when they are alone whether or not they want their partner to participate, explaining to women, and respecting their wishes. Providers and facilities should also seek to engage men further (when women desire it) in couples counseling concerning FP, L&D, postnatal care, and child health visits. This can increase the likelihood that women will actually access services, since respondents in this study described that men’s permission and monetary support are often necessary determinants of health seeking. It can also encourage men to participate in care-seeking for themselves and their families, and to share the burden of caregiving with their female partners.

- **Invest in increasing privacy:** The MOH and implementing partners should continue to support health facilities to increase privacy for both consultation rooms and in labor wards through private consultation rooms, doors, screens, and curtains. This can help overcome physical barriers that prevent men from participating in services and L&D.
- **Invest in programs that empower women economically and increase their employment:** Efforts to address gender power dynamics should also include interventions to empower women economically, such as village savings and loans programs, microlending, or vocational training. Evidence from other countries suggests that women who earn their own income are more capable of seeking health services,

⁸ Interagency Gender Working Group, Male Engagement Task Force. “Dos and Don’ts for engaging men and boys.” 2019 (In Press).

⁹ MISAU. Directrizes Para Engajamento do Homem Nos Cuidados de Saude.” 2018. Accessed 29 Aug, 2019.

<http://www.misau.gov.mz/index.php/directrizes-nacionais?download=169:directriz-para-o-engajamento-do-homem-nos-cuidados-de-saude-2018-v1-0>

¹⁰ Interagency Gender Working Group, Male Engagement Task Force. “Dos and Don’ts for engaging men and boys.” 2019 (In Press).

and that women's employment can be an important factor for changing gender norms regarding women's status in society.

- **Support multisector gender efforts:** The MOH should work closely with other ministries, sectors and implementing partners to ensure that changing gender norms is a priority across all sectors, not only the health sector.

Community members who participated in the study also offered the following further recommendations:

- Health providers and CHCs should organize community debates, following a similar model to the FGDs, to enlighten and clarify women and men's questions regarding RMNCH services;
- They should provide further information about health and diseases in schools and communities on an ongoing basis;
- They should work with local partners to disseminate health information using local radio in local languages, once a day, on diseases, nutrition with a focus on local food products available, and RMNCH services, using practical examples, within popular and accessible programs;
- Health providers and district officials should meet with religious leaders to raise awareness about the importance of male engagement and couples' communication;
- The districts should improve the transportation network to local health facilities to improve access to timely care.

Background

Mozambique's maternal mortality ratio stands at 489/100,000 live births, one of the 20 highest in the world.¹¹ With one in 37 Mozambican women at a lifetime risk of maternal death, 30 newborn deaths, and 97 under-5 child deaths for every 1,000 live births, the MOH is advocating for the increased use of delivery services in health facilities, where women can receive lifesaving care to reduce maternal and neonatal mortality. Despite these efforts, access to health care in Mozambique is limited, with only three physicians for every 100,000 people,¹² compared with the global recommendation of a minimum of 230 physicians per 100,000 people.¹³ Only one-third (36%) of Mozambicans has access to health services within 30 minutes of their home.¹⁴

In 2016, MCSP conducted a KAPC household survey to collect baseline information on the key reproductive, maternal, newborn and child health (RMNCH) knowledge, attitudes, practices and coverage indicators of interest for MCSP. Findings were used to inform the design and implementation of interventions in Nampula and Sofala Provinces. Among the baseline findings was the following:

- Women who discussed reproductive health with partners, measured by communication about FP, were 46% more likely to deliver in a facility (adjusted odds ratio [aOR]=1.46, 95% confidence interval [CI]=1.02-2.10, p=0.04). Approximately half of this effect was mediated through BPCR. When a woman arranged transport on her own, there was no significant increase in institutional delivery, but with partner involvement, there was a larger and significant association (aOR=4.0, p<0.01). Similarly, when a woman chose a delivery site on her own, there was no significant association with institutional delivery (aOR 1.7, p=0.12), but when she did so with her partner, there was a larger and significant association (aOR 2.3, p<0.01). Neither saving money nor choosing a birth companion showed a significant association with institutional delivery—with or without partner involvement. Seventy two percent (95% CI=66-79%) of women in the lowest wealth quintile who did not arrange transport as part of their birth plan delivered at a facility, while among those who were helped by their male partners to arrange transport, 94% (95% CI=92-97%) delivered at facility, nearly eliminating the gap with women in the highest wealth quintile, all of whom delivered in a facility.¹⁵

Taking account of these findings, MCSP's gender interventions at the community level included messaging on couples jointly making a birth preparedness plan, couples discussing FP together, male participation in RMNCH services, and prevention of GBV. These messages were delivered through participatory group dialogues called “palestras,” using song, role play, dance and discussion. They were led by Community Health Committees (CHCs) and overseen periodically by Community Development Agents (CDAs) who were MCSP staff.

At the health facility level, MCSP provided training and mentorship for health workers to conduct couples counseling to facilitate dialogue and education about RMNCH, while also encouraging women to bring their male partners to services if they chose to. Providers were encouraged to address inequitable decision-making power between couples that limit women's ability to seek care in a timely fashion and put their and their children's health and lives at risk.

¹¹ WHO, UNICEF, UNFPA and United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. Geneva, Switzerland, 2015. In World Bank Data Catalog. Accessed 20 June, 2019. World Bank Data Catalogue (Accessed 20 June 2019):

<https://data.worldbank.org/indicator/SH.STA.MMRT?locations=MZ>

¹² World Health Organization. Global Health Observatory Country Views: Mozambique statistics summary (2002-present). Retrieved from <http://apps.who.int/gho/data/node.country.country-MOZ?lang=en>.

¹³ Global Health Workforce Alliance and World Health Organization. A Universal Truth: No Health Without a Workforce. 2013 <https://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/>

¹⁴ World Health Organization. Mozambique's health system. Retrieved from http://www.who.int/countries/moz/areas/health_system/en/index1.html

¹⁵ Sitifane GG, et al. Do Male Engagement and Couples' Communication Influence Maternal Health Care-Seeking? Findings from a Household Survey in Mozambique. BMC Pregnancy and Childbirth. 2019. (In Press).

Study Objectives

In November–December 2018, MCSP Mozambique conducted a set of endline studies that included a qualitative assessment to provide more in-depth information about the nature of male engagement. The study’s specific objectives were to:

1. Evaluate the feasibility and acceptability of male engagement interventions that encouraged couples’ communication aimed at increasing ANC attendance, joint BPCR plans, institutional birth, and use of modern FP;
2. Explore how decisions between couples are made and what may influence their decisions about seeking RMNCH services.¹⁶

Methodology

To obtain data on male engagement and couples’ communication, data were collected in two districts, eight communities and two health facilities in Nampula, and two districts, seven communities and two health facilities in Sofala. In both Provinces, data were collected in MCSP-supported areas. The study was approved by the Ministry of Health (MOH) Health Bioethics Committee and the Johns Hopkins University Bloomberg School of Public Health’s Institutional Review Board (IRB). Interviewers obtained informed consent from all participants.

Sampling Strategy

The estimated sample size was 168 participants, but 197 participants participated as a result of oversampling. Approaches included FGDs and in-depth interviews (IDIs).

FGD inclusion criteria were as follows:

- Women 18 years or older who had a live birth in the 2 years preceding the survey/study and the child is living at the time of the interview, in MCSP-supported areas;
- Men 18 years and older whose wife had a live birth in the 2 years preceding the survey/study and the child is living at the time of the interview, in MCSP-supported areas.

The participants were identified with support of community leaders, CHCs, and CDAs.

IDI inclusion criteria were as follows:

- Facility managers working in selected MCSP-supported primary health care centers; and
- Providers working in maternity wards, FP services, sick child services, and/or well-child health services in MCSP-supported facilities.

Facility managers were identified by the Provincial Health Directorate (DPS) in each province. Health providers were identified by the facility managers at the primary health facilities that were selected for the qualitative study.

Study sites included selected communities, health facilities, and districts in Nampula and Sofala Provinces, identified using a three-step purposive selection process. First, within each province, two districts included in the KAPC survey were selected. Second, within each selected district, three to four communities were selected and were included in the KAPC survey that received the MCSP gender interventions (palestras and provider capacity-building), as well as two corresponding primary health facilities.

¹⁶ Only Nampula Province systematically rolled out the referral networks

Table 1. Geographic Distribution of FGDs and Interviews

Nampula Province		
District	Communities	Health Facilities
Ribaué	<ul style="list-style-type: none"> • Mucopote • Mucocola • Napasso • Mecuasse 	<ul style="list-style-type: none"> • Ribaué-Sede • Iapala-Sede
Nacala-Porto	<ul style="list-style-type: none"> • Mandama • Conambia • Ribaué • Lili 	<ul style="list-style-type: none"> • Ontupaia • Quissimanjulo
Sofala Province		
District	Communities	Health Facilities
Buzi	<ul style="list-style-type: none"> • Ampara/Hambanhe • Bandua/Bairro 2000 • Bandua/Pavo 	<ul style="list-style-type: none"> • Ampara • Banduo
Nhamatanda	<ul style="list-style-type: none"> • Metuchira/6° Bairro • Metuchira/Bairro Acordos de Lusaka • Nhamatanda/Lamego • Nhamatanda/Nharughonga 	<ul style="list-style-type: none"> • Metuchira • Nhamatanda

Description of Tools

The qualitative tools for FGDs and IDIs (see Annexes I, II, and III) were developed by MCSP and adapted to the Mozambican context jointly by MCSP and the research firm COWI. The tools were translated from English into Portuguese, Emakhuwa, and Sena. Some technical health terms and concepts did not exist in the local languages, and the Study Team attempted to find accessible terms in the local languages to describe these.

FGDs and IDIs explored the following themes:

- Decision-making process on how decisions are made in the family about seeking health care at a facility;
- Who decides on the number of children to have and how is the decision made;
- Opinions on male engagement in services (i.e., FP counseling, ANC, or L&D);
- Barriers to men’s participation in health services;
- Acceptability and feasibility of male participation in services;
- Treatment of women accompanied by male partners versus women without;
- Recommendations for improving male engagement efforts.

Limitations

It was not possible to conduct observations of counseling sessions or the delivery of health services within facilities because of resource constraints and privacy considerations. Direct observation might have contributed to a more in-depth understanding of the feasibility and acceptability of male participation.

The study tools were developed in English and translated into Portuguese, and then into local languages. This may have diluted the meaning or breadth of the study questions.

There were some challenges encountered during fieldwork that are worth noting. In some cases, women did not want to participate in FGDs because of fear about their husbands' perceptions or reactions to their participation. This resulted in some FGDs being small (e.g., five) in number. The field team conducted additional FGDs to account for this. In some referred communities, participants were not available because data collection coincided with the harvest season or because the community leader was absent and could not give permission. Data collection was conducted in different MCSP-supported communities to account for this. Team mobility also was impacted by poor road conditions and underestimation of their impact on travel times between data collection sites.

Data Collector Trainings

MCSP conducted a training of Provincial Coordinators in Maputo and, with COWI, the field teams in Nampula and Sofala between October 15 and 19, 2018. The training covered the entire KAPC study including the quantitative survey, qualitative male engagement study, and qualitative referral narratives study. The objectives of the trainings were to:

1. Become familiar with the endline interview and focus groups discussion guide and topics to be addressed;
2. Assess and improve the interview guide;
3. Understand the data collection strategy;
4. Practice role plays of FGDs and IDIs using the study tools (Annexes I, II, and III).

MCSP and COWI held debrief meetings at the end of each training day to address questions, finalize study instruments, and discuss key considerations for data collection.

Because of delays receiving approval of the study protocol from the Bioethics National Committee, the team could not commence data collection immediately as planned. Therefore, a refresher training and pre-test were conducted between November 20 and 21, 2018 before data collection to ensure no information or momentum were lost. The refresher training was followed by a group discussion by the coordinators to clarify remaining questions.

Data Collection

Qualitative data collection began in November 2018 and ended in January 2019 by the following team members:

- A Qualitative Study Manager who was responsible for ensuring the fieldwork implementation by providing technical assistance on methodological issues during data collection;
- Two Field Coordinators—one for each province—who were responsible for conducting interviews in the survey districts;
- Two Note Takers who were responsible for taking notes from the FGDs;
- Two Translators who were responsible for providing translation during FGDs.

Data Analysis

Thematic content analysis was used.¹⁷ Consultants and MCSP developed a codebook using a priori and emergent codes¹⁸ based on the interview guides, which exemplified specific themes around program implementation, community engagement, and household care-seeking practices and behaviors.

Key Findings

The key findings from the FGDs and IDIs are organized according to the following key themes:

1. Male engagement in FP, ANC, and L&D;
2. Decision-making about having children;
3. Decision-making about care-seeking.

Findings are organized by Province,¹⁹ according to:

- The perspectives of male and female FGD respondents; and
- The perspectives of health facility managers and health providers.

Male Engagement in FP, ANC, and L&D Services

How are men engaged in RMNCH services?

Sofala Province

Within Buzi District, health providers and health facility managers reported that male participation in FP, ANC, and L&D services has increased in the past two years, but that most of the increase was specifically for attending ANC appointments. They mentioned a common mistaken belief in both provinces that it is mandatory for men to accompany female partners for the first ANC visit to open a medical record for the child and to be tested for HIV.

“Male participation is increasing in our statistical data. We always register the partner’s presence in the book.”²⁰

- Facility manager, Buzi District, Sofala Province

“Before, [male participation at the health facilities] almost didn’t exist, but now, at least, they show up, rarely, but they show up. That means that out of every 10 or 15 women, at least 5 [male partners] show up.”

- Facility manager, Buzi District, Sofala Province

Men from Buzi District said they accompany their wives to FP appointments if they are not working in order to witness “everything that is said at the hospital” or to learn about child spacing. They reported that they learned that benefits of child spacing included “to have healthy sons” or “for a woman’s health.” Most men agreed that they do not usually go with their wives to FP appointments. Within the same community, women stated that they would prefer men to accompany them so that they could decide if the woman could use FP,

¹⁷ Ibid, p. 10.

¹⁸ “Codes refer to substantive things (e.g. particular behaviors, incidents or structures), values (e.g. those that inform or underpin certain statements, such as a belief in evidence-based medicine or in patient choice), emotions (e.g. sorrow, frustration, love) and more impressionistic/methodological elements (e.g. interviewee found something difficult to explain, interviewee became emotional, interviewer felt uncomfortable)” - in Gale, N. et al. (2013), «Using the framework method for the analysis of qualitative data in multi-disciplinary health research», in BMC Medical Research Methodology, 13: 117. doi: <https://doi.org/10.1186/1471-2288-13-117>, p. 4).

¹⁹ Findings are presented separately for each province and not aggregated because of cultural differences between provinces that may impact gender norms. For example, Nampula has a traditional matrilineal culture, and we found that decision-making around care-seeking was more egalitarian there than in Sofala Province.

²⁰ Quotations have been edited for clarity.

which some women said was a decision that could not be made by the woman alone. They also said that if men participated in the FP visit, it might prevent violence within the home as a result of women's FP choices. Men stated that they did not often accompany their wives to ANC appointments as they were far away or were working:

“We didn't go together to the health appointments [or] delivery. I was away, working.”

- Male FGD participant, Buzi District, Sofala Province

When men do accompany women, they said it was usually to open a medical record for the child, conduct medical tests, and/or attend the delivery. They considered it important to be present, in case the health facility told their wives to bring their husbands.

“I went there and spoke with the nurse, explaining that we were there to open a medical record. The nurse asked us ‘how many months’ [is she pregnant] and I explained that [she is] ‘X months’ ... I helped provide our information to open the record.”

- Male FGD participant, Buzi District, Sofala Province

“The first time, she went to the health facility alone. They told her to bring her partner. When we went together, they gave us the medical record, weighed and examined the baby, and we returned home. And ... that record was used also for the delivery.”

- Male FGD participant, Nhamatanda District, Sofala Province

Women in Buzi District also stated that men accompany their wives to ANC to open a medical record and on the day of delivery. In Nhamatanda District, some women discussed how their male partners were not present with them for their ANC appointments, as they were not told to bring their husbands. Instead their mothers-in-laws accompanied them:

“When I realized my period was two months late, I informed my husband. And in the fourth month [of pregnancy] I went alone to open the medical record. And they didn't tell me I needed to bring my husband. ... On the day of delivery, I went with my mother and had the baby in Beira, in the Chingussura Hospital.”

- Female FGD participant, Nhamatanda District, Sofala Province

Nampula Province

Within Nampula Province, perceptions of whether male engagement has increased during the past two years differed within and across districts. Health providers in Ribaué-Sede District stated that male participation in FP, ANC, and L&D services has increased during the past two years, particularly in relation to ANC appointments:

“Yes, I noted that in the last two years, [male] participation was very small, but now out of every 10 women, 8 are coming with their partners. For the two who are coming alone, it is because [they] are divorced or widowed or something like that.”

- Health provider, Ribaué-Sede District, Nampula Province

“Yes, I noted [an increase], especially for antenatal appointments. I believe that in the last two years there were more men coming with their pregnant partners to open the medical antenatal record. Even here, in the maternity ward, they show up. But our maternity doesn't have the conditions or structure for men to be with their wives during delivery.”

- Health provider, Ribaué-Sede District, Nampula Province

At the same time, some health providers and facility managers within Ribaué-Sede said that male engagement has decreased during the past two years, and then men only accompany their partners for delivery:

“[The] man goes with his wife looking for health services, for example, when the woman is pregnant. [He] only goes with her when she is going to have the baby. In the middle it doesn’t exist.”

- Facility manager, Ribaué-Sede, Nampula Province

In Nacala-Porto District, some facility managers felt that level of male engagement remained constant over the last two years.

“Male engagement is not very high concerning men coming with their wives and children; I have been here for one and a half years ... and [male participation] is at the same level as before ... there wasn’t any change.”

- Facility manager, Nacala-Porto District, Nampula Province

They explained that this was despite public presentations conducted by health facilities to increase male engagement. The lack of change was attributed to men traveling or working.

According to health providers in Nacala-Porto, male participation in RMNCH services is mainly characterized by men going with their wives to open the antenatal medical record because they believe it is mandatory:

“[Men] come often because of the mandatory issue [to open the medical record when women are pregnant].”

- Health provider, Nacala-Porto District, Nampula Province

“Men only came to open the medical record.”

- Health provider, Nacala-Porto District, Nampula Province

In Nacala-Porto District, Nampula Province, health providers also discussed how men usually help women in terms of prevention of anemia during pregnancy, bringing fish (home) and other nutritious foods.

Men in Nacala-Porto community stated that male participation in RMNCH services is only during the first ANC appointment unless there is something out of the ordinary.

In the Ribaué-Sede District, women described how some men go with them to the health facility to open a medical record when they are pregnant, and while there they attend a public presentation and receive tests for HIV or malaria. They said that men, however, are not present during the ANC visit:

“When you arrive, [they] send the husband in [the health providers] and do a palestra. And after that, [he] is stung on the finger to do a test to see if he has AIDS or malaria. If [he] doesn’t have [either], they send the husband outside and the woman stay there getting treatment Woman stays alone, and they tell her to climb into the bed and measure her belly, and give her pills, and return home.”

- Female FGD participant, Ribaué-Sede District, Nampula Province

Barriers to male engagement

Barriers to male engagement in both provinces mainly included beliefs, norms, and practices related to whether or not men went to health facilities.

Sofala Province

Some men identified the information, education and communication (IEC) materials at hospitals that make it look like those who are given priority have a serious illness as a barrier to their participation.

“[The posters] say that priority is given to people with tuberculosis and people with a serious illness. So, when healthy people arrive at the hospital and the couple has priority, I don’t feel good, I feel that [people] are looking at us in an awkward way.”

- Male FGD participant, Nhamatanda District, Sofala Province

Some men described a perception of men who accompany their wives as having been drugged or bewitched by them:

“That one, he has ‘macumba’ (was bewitched) to leave his work and go with his wife [to the hospital].”

- Male FGD participant, Nhamatanda District, Sofala Province

Similarly, women identified community beliefs that equated going to the hospital with being sick as a barrier toward male engagement:

“Other people from the community has a wrong thought and they thought that men have a disease of some kind to seek care at the hospital.” ... Another woman added that, “They thought that the couple that was going to the hospital maybe had HIV and that they took pills.”

- Female FGD participant, Buzi District, Sofala Province

Some health providers in Buzi District described cultural beliefs as a barrier to male engagement in L&D services:

“[One barrier is related to] the region’s culture ... men cannot be part of woman’s delivery.”

- Facility manager, Buzi District, Sofala Province

Some health providers and facility managers in Nhamatanda District identified HIV couples testing in ANC as a barrier to male participation. Some reported that women fear notifying their partners of an HIV positive status.

“[Women] are afraid of sharing their diagnostics with their husband, because it brings suspicion ... and divorce ... especially with HIV/AIDS. If the woman is positive and the man is not positive, questions begin: ‘how did you catch that infection? With whom did you go, because I am negative?’ So, sometimes women don’t want their husbands to go to the health appointments with them. Others are happy because their husband is there.”

- Facility manager, Nhamatanda District, Sofala Province

“She cannot explain [her HIV status] to her husband ... and is afraid there are aggressive husbands and she ends up being quiet.”

- Health provider, Nhamatanda District, Sofala Province

Health providers also discussed men’s employment and the inability to take time off to accompany their partners for RMNCH services as a barrier to their participation:

“For those who have a job, [they] need permission to come to the hospital. To the others, self-employed, these are hours doing biscates²¹ they are losing ... when they come with their wives.”

- Facility Manager, Nhamatanda District, Sofala Province

A facility manager in Nhamatanda District said that “men have a lot of prejudices with hospital,” adding that, “Nowadays people think that infections are more present in women, not because they are in reality. What happens is that men don’t look for health care. So, there are more women cases than men, because they are not there to be tested.”

- Facility Manager, Nhamatanda District, Sofala Province

²¹ Biscates are small informal businesses

Nampula Province

Men in Nampula Province stated that barriers to male engagement included taboos or beliefs regarding men's involvement in "women's issues":

"We heard that if you go in to see [the delivery], it will be the last time that you will see your wife. On the next time, don't go in, because it is very dangerous, the things that come out from inside [her]. So, it is because of that that our ancestors always put that as a secret that can be revealed only to women and health providers."

- Male FGD participant, Ribaué-Sede District, Nampula Province

"We don't know what happens inside," and "it is taboo [for men to be at the delivery room]."

- Male FGD participant, Nacala-Porto District, Nampula Province

"It is something men cannot see, it is sensitive, because in the place where a child is born, someone dies."

- Male FGD participant, Ribaué-Sede District, Nampula Province

Barriers to male participation also included lack of money and opportunity costs of not working.

"[If you go to the hospital you] lose a lot of time, wasting opportunities to do something that is not useful."

- Male FGD participant, Nacala-Porto District, Nampula Province

"If I go to the hospital, I only go there to malaria test or when I am sick, if I don't feel well. But I never go with my wife, because at that time, when she's going to open the medical record, it is when I am doing my biscuits."²²

- Male FGD participant, Nacala-Porto District, Nampula Province

These views were also echoed by women in the community:

"[A man] can go to the hospital, but he doesn't go into the labor room; he stays outside, because inside, in our tradition, men don't go in, because inside dangerous things happen. So, men cannot be present, only women can be, that is why she will go with her mother if she is around or her sister-in-law if she is there. If not, she will stay with the midwife."

- Female FGD participant, Ribaué-Sede District, Nampula Province

"[Men] don't go in because it is taboo."

- Female FGD participant, Ribaué-Sede District, Nampula Province

Some women said they were concerned that if they spoke about FP with their husbands, they "would look for other women."

- Female FGD participant, Nacala-Porto District, Nampula Province

Health providers discussed the lack of privacy as a barrier to male engagement during L&D. In Iapala-Sede, while men are allowed in the maternity, because of the lack of privacy (i.e., a single room for every woman's delivery), they have to go outside when there are other women giving birth. Within Nacala-Porto District, the lack of privacy was also a barrier to male engagement:

"Here we are in the outskirts, [man] cannot go in ... even there, where you have a folding screen [separating women] in the maternity, not even a male colleague can go in."

- Health provider, Nacala-Porto District, Nampula Province

²² Biscates are small informal business

According to health providers and facility managers in Nacala-Porto District, barriers to male engagement included cultural norms, where male presence at health facilities during RMNCH is seen as out of the ordinary, and men are not allowed to support women during delivery. In relation to L&D, health providers also stated that some men prefer women to do a “traditional delivery process” and give birth at home, because of the presence of men at health facilities:

“[As] men arrive at the health facility, they will find a man there, so there are still things that we are fighting to solve.”

- Facility manager Nacala-Porto District, Nampula Province

Other barriers included the distance and the opening and closing hours of health facilities.

As in Sofala Province, health providers in Nampula Province also discussed women’s fear of being left by their partners if their partners find out they tested positive for HIV:

“If the woman’s HIV test comes out positive, the woman will most of the time end up divorced. And in the next health appointment, when the woman arrives here, she says that ‘that man abandoned me and called me names.’ ... They say, ‘if I am alone, why should I continue to come to the hospital, if it was you who made him leave me?’”

- Health provider, Ribaué-Sede District, Nampula Province

Facilitators of male engagement

Facilitators of male engagement in both provinces related mainly to increased knowledge of men’s roles beyond the health facility, for example supporting usage of FP, or supporting pregnant women by increased sharing of household labor or providing nutritious food.

Sofala Province

Men in Buzi District described how public palestras about RMNCH at health facilities encouraged men’s engagement and their support for FP:

“...So, the wife says that three or four children are enough. But we insist for her to have more, seven, sometimes 10 children. Then, what happens at the health facility at the follow up visit, the health providers say: ‘Papa, if your wife already has five children, you should know she is losing blood.’ So, we start to think about it, that it’s worth stopping for a while or that my wife should do FP. ... We can understand the palestras at the health facility; they sometimes help us a lot.”

- Male FGD participant, Buzi District, Sofala Province

“Something has changed. ... Before the palestras, we were afraid of going with our wives to the health facility, because we thought they would send us away.”

- Male FGD participant, Buzi District, Sofala Province

They also discussed how the palestras changed what they perceived as their role in RMNCH. For example, men stated that before the palestras, they thought that their only role was to “help my wife to look for transportation to go to the hospital.”

- Male FGD Participant, Buzi District, Sofala Province

Women in Nhamatanda District discussed how the palestras changed men's behavior:

“It [men's behavior] has changed since we started going to the palestras. The partner who was violent at home is now on a good path.” Another woman said, “He has reduced the number of mistresses because he knows about the severity of diseases he can catch outside the home. And there is understanding in the home.”

- Female FGD participant, Nhamatanda District, Sofala Province

“Before counseling, when I asked him for money he wouldn't give, but now he gives me money.”

- Female FGD participant, Nhamatanda District, Sofala Province

“When I ask him to buy vitamin pills, now he buys it.”

- Female FGD participant, Nhamatanda District, Sofala Province

Some respondents in Buzi District reported a belief that it was mandatory for babies to be delivered in a health facility:

“It has changed, yes, because now we have knowledge that it is forbidden to have the baby at home and now, we do it in the hospital. So, every couple knows, men also know it, that it is not allowed to have the baby at home. ... So, there are some changes in the decision-making process.”

- Female FGD participant, Buzi District, Sofala Province

“In the old times our parents said to have the baby in our homes, but now when it is near the time of delivery, my husband makes me go to the hospital to deliver. He says that it's forbidden to deliver at home, and that we should deliver at the hospital. So, it is changing, because we all have knowledge that delivery is at the hospital.”

- Female FGD participant, Buzi District, Sofala Province

Palestras also encouraged men to permit their wives to deliver in a health facility:

“They [health providers] advise to have the delivery at the health facility, they know why it is good, and when [the baby] is born at home, children don't stay healthy, they don't stay well.”

- Male FGD participant, Buzi District, Sofala Province

“First we talk at home and the final decision is made by the hospital. They are the ones who can see delivery complications, where it is best to be born.”

- Male FGD participant, Buzi District, Sofala Province

Health facility managers within Sofala Province explained that male engagement was increasing because of community engagement, the close proximity of the health facilities, and more humanized services:

“[The increase] probably has to do with more community engagement, with the creation of the Community Health Committees, and the benefits of having more information.”

- Facility manager, Buzi District, Sofala Province

“Men are coming more to the health facility because the majority don't live far away from the health facility.”

- Facility manager, Buzi District, Sofala Province

“We are involving male partners because we use humanized services. ... They don't come often, but sometimes female patients are able to take the information with them, and then [their] male partners show up.”

- Facility manager, Buzi District, Sofala Province

In Nhamatanda, a facility manager mentioned that “something has changed. ... Nowadays, the ladies are not coming alone to the health appointments. They are with their husbands ... who want to know what is going on with their partner’s health.” He explained that this change is linked with health education: “I think barriers are being overcome due to the [community health activists’] participation in women’s and men’s lives who attend our services. It has been a very strong tool for the hospital to reach remote areas or even families that have health prejudices.”

- Facility manager, Nhamatanda District, Sofala Province

Health providers also said that the involvement of community leaders and the CHCs helped to increase male engagement.

Nampula Province

Men in Nampula Province discussed how their behavior changed after attending palestras at health facilities. The palestras showed the importance of taking sick children to the hospital and delivering in a facility:

“Before the palestras we didn’t know anything, because it was before knowing the hospital’s importance. With the projects that are appearing more and more, we get to know everything.”

- Male FGD participant, Buzi District, Sofala Province

Within Nampula Province, some men reported they were motivated to participate to prevent negative experiences their partners had previously faced when seeking services alone.

“[She said] I am pregnant, and I took her to the health facility because I have a son who had many complications because I didn’t take him to the hospital. But in this last pregnancy, I said right away, ‘let’s go to the hospital.’ And I took her, and stayed until the child was born, and there were no complications. We got good care and we didn’t pay anything. After the baby was born, they gave us a card. I went to all my wife’s health appointments ... I took her by bike to the hospital when my son was born. But I was not allowed in the labor room.”

- Male FGD participant, Buzi District, Sofala Province

Men also reported that health providers gave them information that encouraged them to participate:

“When my wife was with two months [along in pregnancy] she was very weak, and I took her to the hospital. They told me that I should give her vitamins. And I didn’t have anything to give. I looked for nantata and she drank it, and my son was born, and he is not weak, he’s fat. Nantata is a traditional plant from which you get juice and it is used to increase vitamins and blood.”

- Male FGD participant, Nacala-Porto District, Sofala Province

“We can bring diseases to our wife and baby that is still in her belly, so we open a medical record and we do tests.”

- Male FGD participant, Nhamatanda District, Sofala Province

Health Facility Policies and Practice around Prioritizing Couples

Providers, facility members, and community respondents reported that the practice of prioritizing women who are accompanied by male partners over women who come alone often had negative repercussions for unaccompanied women, such as being turned away from care, facing increased waiting times, or disrespectful treatment.

Sofala Province

In Buzi District, some health facility managers believed it was mandatory for women to bring their partners and reported this as a reason for increased male engagement:

“When it is the ANC appointment, every woman that brings her partner has priority.”
- Facility manager, Buzi District, Sofala Province

One respondent explained that women who go with their partners speak with other women in the community, advising that “next time bring your partners to be the first to be taken care at ANC appointments.”

- Health provider, Buzi District, Sofala Province

Other health providers, however, said that they “give priority to whom arrives first, and who has a more serious health condition.”

- Health provider, Buzi District, Sofala Province

In Nhamatanda District, health providers also prioritized couples for care, and some even refused unaccompanied women services.

“Couples have priority because the husband [has] to go to work.”
- Health provider, Nhamatanda District, Sofala Province

“When I am here, I say to mothers that they have to bring their husband. If not, I won’t take care of them.”
- Health provider, Nhamatanda District, Sofala Province

“If there are nine [women], but four brought their husband, we take care of those ones”
- Health provider, Nhamatanda District, Sofala Province

Nampula Province

Women and men believed there was a mandatory rule that prioritized couples over unaccompanied women. It is unclear where this belief came from, but it was echoed by providers in many areas. Women in the Nacala-Porto District said that women going with their partners to the health facility have priority over single mothers and widows, who needed a written statement made by the secretary of the neighborhood (“secretário de bairro”) to justify why they were going alone, including justifying who made them pregnant.

“No, here in this region, we all [women] start to go with three months, when it arrives that hour we go to the hospital with our husbands. And if you don’t go with your husband, they send you back to the community leader to justify if the husband is dead or if he is not around. Because if you don’t take that paper, the woman is not seen by the health providers.”
- Female FGD participant, Ribaué-Sede District, Nampula Province

“Each woman should go with her husband to the health facility. And when his wife goes alone, they tell her to sit down, and call the one who arrived with her husband. And if you arrived alone even when you are the first one to arrive, you are called last. You start to say that that person gave money or she knows someone—without knowing that it is because she is going with her husband.”
- Male FGD participant, Nacala-Porto District, Nampula Province

“There are others who don’t know the advantages of going with your wife. They don’t go to ANC appointments.”
- Male FGD participant, Nacala-Porto District, Nampula Province

Men in the Mandama community stated that they saw women who had come alone but arrived earlier, before women who brought their partners, and they felt that it was not fair. They stated that they would feel badly if they arrived first at the health facility and were the last to be seen by the health providers, and hospital’s rules about giving priority to women going with their husband when compared with women going alone makes them feel obligated to be there.

According to health providers within Ribaué-Sede, reasons for an increase in male engagement include health facilities' practice of giving priority to women with their partners and asking for a written statement by the secretário de bairro justifying why women were going alone:

“If the woman came alone, we threatened that ‘if you don’t come with your husband, we won’t take care of you’, and she is afraid of getting out of her home, far away, and arriving here and not being taken care of. When women arrived at home, they informed their female neighbors ... ‘if you are going without your husband, you will not be taken care of’ ... and they end up coming with their partners.”

- Health provider, Ribaué-Sede District, Nampula Province

“If a woman is coming alone, she brings the secretário de bairro’s document justifying why, and all women that come here have that. If they are widows, he puts there that she lost her husband in X year, X reason. It’s only to open the antenatal medical record ... justifying if she was abandoned or if the husband lives far away, if she is divorced or widowed, all information is there.”

- Facility manager, Ribaué-Sede District, Nampula Province

“They are forced to come, if they are denied services, women have to go to the secretário de bairro to bring the declaration, in which it says that the husband is absent or that he declined to go. This way, men feel obligated to come to the hospital”

- Health provider, Ribaué-Sede District, Nampula Province

Decision-making about having children

Joint decision-making and couples’ communication

Sofala Province

In Buzi District, the majority of male participants stated that decision-making about having children is done by the couple together, and cited concerns about expenses, employment, and their partners as reasons to decide to limit births:

“Couples in this community, yes, they argue, because, for example, nowadays if too many children are born, it is difficult because of the expenses and send to school ... I already have eight children.”

- Male FGD participant, Buzi District, Sofala Province

“We argue, talk, and reach a consensus with my wife. Because of expenses it is hard to have many children, because a long time ago we had a lot of things to survive, we could go and take sweet potato. Now it doesn’t exist anymore.”

- Male FGD participant, Buzi District, Sofala Province

“When I saw she couldn’t take any more, we stopped having children. And also I don’t have a job anymore.”

- Male FGD participant, Buzi District, Sofala Province

In Nhamatanda District, women described that couples often debate the number of children to have:

“In this community we talk, yes, about the number of children to have. ... Some have children every five years and other couples every four years.”

- Female FGD participant, Nhamatanda District, Sofala Province

Some said that the decision is made by the couple and is tied to family income, and they gave the example that lower income families can’t buy clothes for 10 children, but for five they can. They reported that when

they realize that they don't have adequate income to have more children, women seek FP at the health facilities.

Some FGD respondents discussed how if women do not agree with men regarding the number of children to have or fail to produce them, men will find alternative means to have their desired number of children:

“If there is no consensus with the wife, for example, the woman wants fewer children and the man wants more, what happens is that the man ends up deciding to marry another woman [laughs], to be able to reach the number of children he wants.”

- Male FGD participant, Buzi District, Sofala Province

“The husband looks for another [woman] and says that ‘if you are denying having the number of children I want, I will go marry with another to have the number of children I want.’ If the woman doesn't accept, he abandons home.”

- Female FGD participant, Buzi District, Sofala Province

Health providers echoed the sentiments expressed by some community members in Sofala that if women want to limit births but their male partners do not agree, they sometimes find a new partner.

“[Men say,] ‘I want this number of children; if you don't have the ability of giving me those children, I will find another place to have them.’ If she cannot give him children, [he] will look for another partner with the ability of having them.”

- Health provider, Nhamatanda District, Sofala Province

“Men will threaten [them] with a katana [blade]. He goes and marries another one.”

- Health provider, Nhamatanda District, Sofala Province

Nampula Province

In the Ribaué-Sede District in Nampula Province men discussed how FP was a joint decision:

“For me, the way I did family planning, I went together with my wife the first time, but on the second, I told her that she could go alone, because it is something agreed between us”

- Male FGD participant, Ribaué-Sede District, Sofala Province

Other men in Nacala-Porto District threaten to leave women who want to limit births:

“I speak with my wife and say I want 4 [children]. If she denies, I will leave you [his wife].”

- Male FGD participant, Nacala-Porto District, Nampula Province

Some cited religion as a reason for not using FP.

“I, in my home, will never ask my wife to do planning [FP], because that you don't do that in our religion. So, if she wants, she can go, but I will never accept that”.

- Male FGD participant, Ribaué-Sede District, Sofala Province

Men typically hold decision-making power

Sofala Province

Health providers and facility managers in Sofala Province discussed how many couples are starting to debate how many children to have, or the length of time to wait before having another child. However, they said this is still not common practice. The majority of facility managers discussed how the decision about how many and when to have children ultimately remains with men:

“When it is the man who wants to have more children, the woman, even if she doesn’t want more, she must have them, because her husband wants them. But when it’s [the] man that doesn’t want more, the woman doesn’t need to have more. So, in this case, what I think is that the man is still the one who is in charge”

- Facility manager, Buzi District, Sofala Province

“If we don’t reach an agreement, my word as a man prevails as the head of the family. So, you do what I am saying, because I am taking care of the house, children, the food, it is I who brings it and so on.”

- Facility manager, Nhamatanda District, Sofala Province

“Women are very submissive; men decide if she should have [babies] or not because of socioeconomic reasons, and also cultural ones. And women are like a machine for making babies.”

- Facility manager, Nhamatanda District, Sofala Province

“We have just done mobile outreach brigades for FP. So, when we arrive there, that woman who didn’t yet inform the husband, even if he is far away, was not able to speak with him on that day, she cannot go to FP. ... She has to wait for her husband’s answer before she can go to the facility for services. ... This is something that shows us that [women] are totally dependent on the husband.”

- Facility manager, Buzi District, Sofala Province

Nampula Province

Some health facility managers in Nampula Province held similar views to those in Sofala in relation to men’s decision-making power, and emphasized that couples’ communication about number of children remains limited or does not exist. For example, in Nacala-Porto District, Nampula Province, health providers stated that the decision of how many children the couple should have is made by men.

“[Women show] resistance [to FP], not because she doesn’t want it, but because her husband didn’t decide. She has to go home and talk with her husband, and the husband decides; unilateral decision, it seems that there is no talk [between them] about the number of children they should have.”

- Facility manager, Nacala-Porto District, Nampula Province

Decision-making about Care-seeking

Joint decision-making and couples’ communication

Sofala Province

In Buzi District, some men and women described that they were involved in the decision-making process about care-seeking. Respondents also reported that other family members were also sometimes involved.

“Sometimes it is I who makes the decision; sometimes it is my wife who makes the decision; and other times we talk about it and reach a consensus to go to the hospital.”

- Male FGD participant, Buzi District, Sofala Province

“Any family member that is at home can make the decision to go to the health facility; they don’t need neither the [spouse’s] permission. Any family member who sees someone get sick can take them to the hospital. There is no need for asking for permission.”

- Male FGD participant, Buzi District, Sofala Province

Other men in Buzi District said that they were the main decision-makers about care-seeking:

“In my family, it is the man who takes the decision to get care-seeking at the health facility.”

- Male FGD participant, Buzi District, Sofala Province

“I say when to take to the hospital and give money for the health appointment; the decision is mine.”

- Male FGD participant, Buzi District, Sofala Province

In the Buzi District, some cited work as a reason for women making a decision independently to seek care. Men stated that women take their children to the hospital when men are working, and at the end of the day, they inform them in person or by mobile phone.

“I am far away, how can she wait for my permission?”

- Male FGD participant, Buzi District, Sofala Province

In Nhamatanda District, men discussed how decision-making when women are pregnant is influenced by what the health facility requires, and that because men are busy, it is the women’s responsibility to go to the hospital:

“When my wife is pregnant, in that moment the decision is not taken by the men anymore (...) [at the hospital women have] those medical records every week or every month saying she should go to the hospital and the date is with her and not with me anymore (...) she should take care of the dates to know that today she needs to go to the hospital, because men are always busy.”

- Male FGD participant, Nhamatanda District, Sofala Province

Women in the Nhamatanda District also described how decision-making about care-seeking is done by men. They explained that first the women inform their husbands if they need to go to the health facility, and then if they agree to seek care, men usually take their wives to the hospital by bike, motorbike, or women go alone.

Women underlined that they need to obtain their husband’s permission to go to the health facility, saying that

“It is the husband who decides, so he can be sure that his wife is pregnant.”

- Female FGD participant, Nhamatanda District, Sofala Province

In addition, women argued that if they disobey their husbands, the men call the woman’s family and complain about her behavior:

“The husband decides everything because he is the owner of the house, he is in charge at home, he has to know everything we do.”

- Female FGD participant, Nhamatanda District, Sofala Province

Women in Buzi District added that it is a couples’ decision about other RMNCH services, but when it is time to deliver, it is men who say, “go to the hospital.”

Health providers and health facility managers in Sofala Province also believed that men held decision-making power about care-seeking. As one facility manager stated:

“Taking in account that, in here, we are at the countryside, it always the husband [laugh], he is the strongest in the household. So, most of the times, they [women] wait to have really his opinion, some say that they were expecting his permission to come or not to the hospital. ... At a certain point, we can see that weakness.”

- Facility manager, Nhamatanda District, Sofala Province

Nampula Province

In Nampula Province, some men described how the decision was made by both women and men, especially when transportation was needed to go to the health facilities:

“Usually we make the decision together, when the woman says our son is sick or has fever pains. As fathers, we are obligated to give money for them to go to the health appointment. So, the decision is ours together.”

- Male FGD participant, Nacala-Porto District, Nampula Province

“We decide together with our wives and take our sons to the hospital with our wives. If we are far away, our wife takes him to the hospital. When we return, our wife says that our son is sick, but ‘I already took him to the hospital.’”

- Male FGD participant, Nacala-Porto District, Nampula Province

Men in Ribaué-Sede District also said that the decision is made by the couple, adding that men provide money. Others in Ribaué-Sede District stated that they are the ones who decided where women deliver their babies because of their control over financial resources:

“It is man who have money to give to woman; because we live far away from the hospital and it is not possible to go by foot. So, it is because of that that man decide.”

- Male FGD participant, Ribaué-Sede District, Nampula Province

In Nacala-Porto District, men also stated that women make the decision, because men are working or are looking for work:

“[Women] don’t need permission, because I go do my ‘biscates’ [small informal income] fish and return very late. So, it is not possible for her to wait for me, because I return around 5 p.m. So, it is necessary that man leaves money for the woman go to the health facility if something happens during man’s absence, she cannot wait.”

- Male FGD participant, Nacala-Porto District, Nampula Province

Some women in Nacala-Porto District said that though they need men’s permission to go to the health facility, the decision of care-seeking is taken together. Others stated that men usually decide if women and children should go to the health facility:

“If we are married, we speak with our husbands if our child is sick and if he has the time, he goes with us or give us money to the issue of buying medication, and in the case of transportation.”

- Female FGD participant, Ribaué-Sede District, Nampula Province

“But we need to ask for permission [to men] to go to the hospital. Yes, if you are married, you need to ask him, as well as for him to give money or to go with you to the hospital, because to ask your husband is to respect him here in our community.”

- Female FGD participant, Ribaué-Sede District, Nampula Province

Women also underlined that they decide if they should go to the health facilities, as men do not have a fixed income. They described that men need to go every day to look for work to provide for the sustainability of their families.

Health providers and facility managers in Nampula Province held similar beliefs, stating:

“Men [are the ones] who make the decision.”

- Facility manager, Ribaué-Sede District, Nampula Province

“This is a community in which woman doesn’t have the power of decision, men reign in everything, no one can take a decision without asking him.”

- Health provider, Ribaué-Sede District, Nampula Province

Discussion and Conclusions

Male Engagement in FP, ANC, and L&D Services

According to health facility managers and health providers within Sofala Province, during the past two years male engagement in RMNCH has increased slightly, but mainly in ANC services. Within Nampula Province, there was less agreement across the districts as to whether male engagement has increased, with some respondents stating there was an increase, others stating it has stayed the same, and some stating that it has decreased. Male engagement was not precisely quantified, and could have meant male attendance at appointments, or active participation. The slight increase in male engagement in some areas was predominately for ANC visits, and may have been a result of men accompanying their partners to open a medical record, as well as facilities' policy or practices of prioritizing women who are accompanied by their male partners.

One common finding across the provinces was facilities' practice or policy of prioritizing women who brought their male partners to an RMNCH appointment over women who came unaccompanied. Providers sometimes practiced gender discrimination against unaccompanied women by turning them away from services, increase their waiting times, or treating them disrespectfully. In some Districts, discrimination against unaccompanied women went beyond the facility. Single mothers and widows were required to obtain a written statement made by the secretary of the neighborhood justifying why they were going to the health facility alone. These unnecessary and bureaucratic obstacles could prevent or delay unaccompanied women from seeking care.

Anecdotal evidence suggests that the facility policies of prioritizing couples over unaccompanied women may be a legacy of HIV programs in the area, which routinely encourage couples' HIV testing during the first ANC appointment. MCSP was unable to find any such written policy, but respondents in both provinces in both communities and facilities cited its existence. The implementation of such a policy could have negative repercussions for women who do not want their partners involved, unmarried women— especially adolescents and/or women who have become pregnant as a result of rape, women experiencing intimate partner violence from their partners, widows, women whose partners live or work far from home, and sexual and gender minorities. Anecdotal evidence related to MCSP during program implementation suggests that some women who do not want to bring their partner are bringing in friends or taxi drivers to pose as their partner to ensure they receive priority service. This could have implications for HIV prevention efforts that rely upon index case testing, and thwart efforts to engage male partners during couples ANC or FP counseling. MCSP was aware of this issue and attempted to address it in capacity-building efforts for providers. These findings, however, reveal that further work is required.

Within Sofala Province, there were barriers to male engagement at the health facility and community levels. These included beliefs that those who go to a health facility may have a serious, stigmatized illness such as HIV or TB; cultural beliefs that men should not be a part of RMNCH—that they may have been drugged or bewitched by women if they accompany their female partners, or their participation in L&D might cause the death of the newborn, women being afraid of sharing their HIV positive status with their partners; men's employment coinciding with facility hours; men's desire to have many children, and their dominance around decision-making about family size. Within Nampula Province, barriers included taboos around men's involvement in women's health, particularly in regard to L&D; a lack of money; and opportunity costs related to finding employment. Health providers also discussed the lack of privacy in maternity wards as a barrier to male engagement during L&D, as well as women's fear that they will be left by their partners if they test positive for HIV or express a desire to limit family size.

Facilitators to male engagement within Sofala Province included public presentations at health facilities about FP or RMNCH, knowledge imparted through counseling by health providers, palestras, and the close proximity of health facilities. Within Nampula Province, facilitators to male engagement included previous negative experiences because of a lack of men's engagement encouraging women to bring their partners,

obtaining knowledge from health providers, and men obtaining knowledge and accessing services for their own health.

These findings suggest that MCSP's palestras and capacity-building efforts for providers did not go far enough to address inequitable gender norms and beliefs that reduced women's decision-making power to seek services. Interventions to transform gender norms and behaviors require participatory approaches that occur consistently over time, reinforcing key messaging. Unfortunately the lack of significant change may be a result of program constraints including the short duration of the activity (1.5-2 years) the small number of messages focused on gender, the short duration of gender-focused palestras and provider capacity-building sessions, and a potential lack of consistent quality between palestras held by CHCs and CDAs or counseling sessions given by providers.

Decision-making about having children

The majority of community participants discussed how decision-making about having children was done jointly by the couple. Health providers in both provinces, however, felt that decision-making was primarily done by men. Within Sofala Province, respondents discussed how men will often find alternative means (such as threatening divorce or finding another partner) to have their desired number of children if their partners do not agree, while only men discussed such mechanisms within Nampula Province. These findings point to the entrenched gender norms at play that encourage men to want a large number of children and to limit women's decision-making power over reproduction.

Decision-making about Care-seeking

Perceptions of who made decisions regarding women's RMNCH care-seeking differed across provinces. Overall, the majority of participants discussed how decision-making was primarily done by men. In both Sofala and Nampula Provinces, however, there were examples of joint decision-making within couples. Health providers in both provinces said that men made decisions regarding women's RMNCH care-seeking. In some instances, women made the decision because men were away from home because of work commitments.

Recommendations

The Study Team offers the following recommendations:

- **Continue and scale up palestras on gender and male engagement:** The MOH and implementing partners should continue to support Community Health Committees and health facilities to conduct regular and ongoing palestras on a wide range of health topics in health facilities and in communities. Additional, comprehensive gender-focused content should be integrated into these, including messaging on the potential benefits of male engagement (e.g., care for men's health needs, increased number of ANC visits; improved nutrition, breastfeeding, and immunization rates,^{23,24} reduced GBV,²⁵ improved self-care of women, improved home care practices for women and newborns, reduced maternal workload, increased maternal nutrition and rest during pregnancy, increased caregiving by fathers, increased value of girl children,²⁶ etc.)
- **Address couples' decision-making and women's autonomy:** Palestras and couples counseling should carefully address the balance required between equitable couples' decision-making and women's reproductive autonomy, taking care to ensure that a woman has the right to decide whether she wants her partner involved in her reproductive health, and preventing men from trying to take control of such decision-making. Such efforts should also keep in mind that women experiencing IPV may prefer not to involve their partner because of a risk of violence and may prefer clandestine methods of FP. Palestras and couples counseling remain relatively missed opportunities for providers in both provinces to raise the subject of GBV carefully, including its negative impacts on RMNCH, and to educate communities about the availability of post-GBV services.
- **Implement evidence-based group education to transform gender norms:** Palestras should go beyond speaking about the benefits of male engagement and seek to transform gender relations and norms. Community health workers should conduct gender transformative group dialogues and education using evidenced-based curricula, reaching community members repeatedly over time. For example, the MenCare and Promundo Bandebereho Curriculum in Rwanda engaged men and their partners in participatory, small group sessions of critical reflection and dialogue. Men participating in the Bandebereho intervention were invited to 15 sessions (maximum 45 hours) and their partners to 8 (maximum 24 hours). Sessions addressed: gender and power; positive fatherhood; couple communication and decision-making; IPV; caregiving; child development; and male engagement in reproductive and maternal health.²⁷

Palestras and counseling can be offered individually or in groups, either single gender or mixed gender. Programs such as Bandebereho have found value in having some sessions for men or women alone during which they can discuss issues they feel are too private or sensitive to discuss in front of participants of the opposite gender. However, for other sessions, it is important for both genders to hear the others' perspectives. Palestras should also take into the account the diversity among men in terms of age, gender identity, sexual orientation, race/ethnicity, marital status, fatherhood, and class.²⁸

²³ Tokhi M, Comrie-Thomson L, Davis J, Portela A, Chersich M, Luchters S. Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. *PLoS One*. 2018;13(1):e0191620.

²⁴ Levto R, van der Gaag N, Greene M, Kaufman M, Barker G. State of the World's Fathers: A MenCare Advocacy Publication. Washington, DC, USA: Promundo, Rutgers University, Save the Children, Sonke Gender Justice, and the MenEngage Alliance; 2015.

²⁵ Doyle K, Levto R, Barker G, Bastian GG, Bingenheimer JB, Kazimbaya S, et al. Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial. *PLoS One*. 2018;13(4):e0192756.

²⁶ Adapted from Plan International and Promundo. Guidance Note on Male Engagement in Maternal, Newborn, and Child Health/ Sexual Reproductive Health.

²⁷ Doyle K, Levto R, Barker G, Bastian GG, Bingenheimer JB, Kazimbaya S, et al. (2018) Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial. *PLoS ONE* 13(4): e0192756.

²⁸ Interagency Gender Working Group, Male Engagement Task Force. "Dos and Don'ts for engaging men and boys." 2019 (In Press).

- **Engage men as allies and champions:** Efforts to engage men should acknowledge and meet their unique needs as clients, partners and agents of change, treating them as allies rather than assuming they are bad actors. Facilitators can amplify the voices of men who support gender equity and those who are positively changing their behaviors.²⁹ The MOH recently created guidance with norms for male engagement in health programming,³⁰ which can be a useful foundation to improve men’s involvement in health seeking and utilization.

These efforts should be offered in physical spaces and at times that are accessible to women and men, taking into account work hours, harvest seasons, and distance to facilities. Providers should be prepared to receive men in a welcoming manner. They should also consider offering services in other locations where men congregate in the community, and mobile services.³¹

- **Clarify policies around male participation in health services and address discrimination against unaccompanied women:** The MOH should clarify its policies in writing and through refresher trainings around male accompaniment to services to all providers and facilities across districts. Providers and facilities should prioritize clients based on the urgency of care required, not based on whether a patient is accompanied or not. The MOH and partners should continue to encourage male participation in RMNCH services when women desire it, particularly HIV testing in ANC visits, while still respecting women’s reproductive autonomy and agency. This can be accomplished by only asking women when they are alone whether or not they want their partner to participate, explaining to women, and respecting their wishes. Providers and facilities should also seek to engage men further (when women desire it) in couples counseling concerning FP, L&D, postnatal care, and child health visits. This can increase the likelihood that women will actually access services, since respondents in this study described that men’s permission and monetary support are often necessary determinants of health seeking. It can also encourage men to participate in care-seeking for themselves and their families, and to share the burden of caregiving with their female partners.
- **Invest in increasing privacy:** The MOH should continue to support health facilities to increase privacy for both consultation rooms and in labor wards through private consultation rooms, doors, screens, and curtains. This can help overcome physical barriers that prevent men from participating in services and L&D.
- **Invest in programs that empower women economically and increase their employment:** Efforts to address gender power dynamics should also include interventions to empower women economically, such as village savings and loans programs, microlending, or vocational training. Evidence from other countries suggests that women who earn their own income are more capable of seeking health services, and that women’s employment can be an important factor for changing gender norms regarding women’s status in society.
- **Support multisector gender efforts:** The MOH should work closely with other ministries, sectors and implementing partners to ensure that changing gender norms is a priority across all sectors, not only the health sector.

Community members who participated in the study also offered the following further recommendations:

- Health providers and CHCs should organize community debates, following a similar model to the FGDs, to enlighten and clarify women and men’s questions regarding RMNCH services;
- They should provide further information about health and diseases in schools and communities on an ongoing basis;

²⁹ Interagency Gender Working Group, Male Engagement Task Force. “Dos and Don’ts for engaging men and boys.” 2019 (In Press).

³⁰ MISAU. Diretrizes Para Engajamento do Homem Nos Cuidados de Saude.” 2018. Accessed 29 Aug. 2019. <http://www.misau.gov.mz/index.php/diretrizes-nacionais?download=169:directriz-para-o-engajamento-do-homem-nos-cuidados-de-saude-2018-v1-0>

³¹ Interagency Gender Working Group, Male Engagement Task Force. “Dos and Don’ts for engaging men and boys.” 2019 (In Press).

- They should work with local partners to disseminate health information using local radio in local languages, once a day, on diseases, nutrition with a focus on local food products available, and RMNCH services, using practical examples, within popular and accessible programs;
- Health providers and district officials should meet with religious leaders to raise awareness about the importance of male engagement and couples' communication;
- The districts should improve the transportation network to local health facilities to improve access to timely care.

Annex I. Focus Group Discussion Tool - Women³²

Introduction

- Introduce yourself (name, affiliation).
- Ensure the respondents are comfortable, have time, and are able to participate in the FGD.
- Provide consent document by reading it and giving the respondents a copy.
- Describe why the respondents were selected for the FGD.
- Explain that the respondents' answers will be put together with the answers of other people to help get a wide understanding of what people think about this topic. Their names/communities will not be included with their responses.
- Ask if the respondents have any questions.

Before beginning the interview, read the consent form and obtain the participants' consent to proceed with the interview. DO NOT proceed without informed consent. Inform the participants that you would like to start recording the interview & taking notes, and start the audio recorder.

1. I am interested in hearing about the experiences of people in this community who participated in community dialogues. I would like to ask you about any changes you may have noticed in your community, between other couples, or with your own husband or partner about discussions and practices around pregnancy and birth.
2. How do you make decisions in your family about seeking health care at a facility? Do you make the decision, does your partner, or both of you together?
Probe: Did you rely upon your partner for money for transport or fees?
3. Did you need his permission to go to the health facility?
4. How did you and your partner decide where to give birth? Do you discuss and decide together? Or is it a decision primarily made by one of you?
5. Has anything about decision-making changed since participating in a community dialogue?
6. Has anything about decision-making changed since being counseled by a provider in a health facility?
7. Do couples in this community decide if and when to have a child? If yes, how is that decision made?
8. Probe: Does the woman decide, the man, or the couple together?
9. Has anything recently changed about the way this decision is made?
10. If yes, what do you think made this change? Was it because of something from the community dialogues, the health provider at the facility, or something else?
11. What do you think about the idea of bringing a male partner with you for FP counseling, ANC, or labor and delivery?
Probe: Has your attitude about bringing your partner with you for health services changed after participating in a community dialogue? If yes, how so?
12. Has your attitude about your partner participating in health services changed after your partner accompanied you to a health facility and you were both counseled by a health provider? If yes, how? If not, why?
13. What did you find to be the benefits of joint counseling, if any? The drawbacks? Has your partner's attitude about this changed? If yes, what was the change, and what caused it?

³² The FGD tool for men is almost identical, but with revised language to correspond to the male gender.

14. What is the attitude of others in your family or community about men accompanying their partners to the health center?
Probe: Did this affect your decision to bring your partner to the health center or not?
15. Have these attitudes changed after participating in a community dialogue? If yes, how so?
16. Are there barriers to men in your community participating in health services for themselves or their families?
17. Do women and men in this community typically agree or disagree on the number of children they would like to have? If they disagree, what happens?
Probe: Would you prefer to have your partner come with you to a FP counseling session, or would you prefer to go alone? Why?
18. If a man goes for a FP session with his partner, what might have caused him to go?
19. If your partner accompanied you for labor and delivery, what inspired him to do so? If he did not, why not?
Probe: Did you find any benefit from his accompaniment? Any negative consequence?
20. Have you ever heard of or seen a woman with a male partner getting to skip the line, or receiving better treatment, than women who came alone for health services?
Probe: How would you feel if that happened?
21. Overall, what have been the contributions, negative or positive, of the efforts to include men in maternal, newborn and reproductive health, and FP?
22. What have been the positive or negative contributions of community dialogues on gender, power and male roles in maternal, newborn and reproductive health?
23. What have been positive or negative contributions of efforts to engage men in maternal, newborn and reproductive health at health facilities?
24. Is there anything you would change or add?

Annex II. Provider IDI Tool

Introduction

- Introduce yourself (name, affiliation).
- Ensure the respondent is comfortable, has time, and is able to participate in the interview.
- Provide consent document by reading it and giving the respondent a copy.
- Describe why the respondent was selected for the interview.
- Explain that the respondent's answers will be put together with the answers of other people to help get a wide understanding of what people think about this topic. Their names/communities will not be included with their responses.
- Ask if the respondent has any questions.

Before beginning the interview, read the consent form and obtain the participants' consent to proceed with the interview. DO NOT proceed without informed consent. Inform the participants that you would like to start recording the interview & taking notes, and start the audio recorder.

1. In this community, who usually makes household decisions regarding seeking health care in a facility?
2. Do you think that women and men in this community agree on the number of children they would like to have? What happens if they disagree?
3. Who decides how many children a couple will have?
4. Have you seen any changes in the number of men who come to health facilities in this district in the past year?
5. Are they coming for their own health needs or to support their families?
6. Do you believe women want or do not want their male partner to participate in FP, ANC, and/or L&D? Why or why not?
7. Do you believe men want to participate in these health services? Why or why not?
8. Are there any barriers in this health facility to men participating in health services, on their own or with their families?
9. During couples counseling sessions for FP, ANC and L&D, do men usually ask questions and give responses, or do they usually stay silent and just listen?
10. Who usually participates more—the woman or man?
11. What do you think motivated men to participate in couples counseling?
12. What was men's role in the counseling visit?
13. Were there any benefits from men's participation? Were there any challenges in having them participate?
14. How did discussions about FP, ANC, and L&D go between men and women when you counseled them?
15. Did you notice any trends in who made decisions about FP, ANC, and L&D?
16. Do you find male participation in FP or ANC visits has any impact on the counseling session? On the woman's health behavior?
17. How easy is it for you to counsel men? Couples? What could make it easier?
18. What key messages or approaches do you use to counsel men and couples that you find are effective?
19. Have you seen any changes in attitudes among other health providers in this district about men participating in health services in the past year? What?

20. Have you ever heard of or seen a woman whose male partner comes with them for services getting to skip the line, or receiving better treatment, than women who came alone?
21. Overall, what have been the contributions, negative or positive, of the efforts to include men in maternal, newborn and reproductive health, and FP?
22. What have been the positive or negative contributions of community dialogues on gender, power, and male roles in maternal, newborn and reproductive health?
23. What have been positive or negative contributions of efforts to engage men in maternal, newborn and reproductive health at health facilities?
24. Is there anything you would change or add?

Annex III. Health Facility Manager IDI Tool

Introduction

- Introduce yourself (name, affiliation).
- Ensure the respondent is comfortable, has time, and is able to participate in the interview.
- Provide consent document by reading it and giving the respondent a copy.
- Describe why the respondent was selected for the interview.
- Explain that the respondent's answers will be put together with the answers of other people to help get a wide understanding of what people think about this topic. Their names/communities will not be included with their responses.
- Ask if the respondent has any questions.

Before beginning the interview, read the consent form and obtain the participants' consent to proceed with the interview. DO NOT proceed without informed consent. Inform the participants that you would like to start recording the interview & taking notes, and start the audio recorder.

1. In this community, who usually makes household decisions regarding seeking health care in a facility?
2. Do you think that women and men in this community agree on the number of children they would like to have? What happens if they disagree?
3. Have you seen any changes in the number of men who come to health facilities in this district in the past year?
4. Are they coming for their own health needs or to support their families?
5. Do you believe women want or do not want their male partner to participate in FP, ANC, and/or L&D? Why or why not?
6. Do you believe men want to participate in these health services? Why or why not?
7. Are there any barriers in this health facility to men participating in health services, on their own or with their families?
8. On average, do men rarely, sometimes or frequently accompany their female partner for health services in this facility?
9. Does your facility have any policies or norms regarding the participation of men or other family members in health services?
10. In this health facility, is a man allowed to accompany his female partner for FP? ANC? L&D?
11. Do men attend the births of their children in this health facility? Why or why not?
12. Is there privacy in the delivery room? (For example, walls, screens, or curtains separating each client?)
13. Have you ever heard of or seen a woman whose male partner comes with her for services getting to skip the line, or receiving better treatment, than women who came alone? What happens to women who do not bring their husband?
14. Overall, what have been the contributions, negative or positive, of the efforts to include men in maternal, newborn and reproductive health, and FP?
15. What have been the positive or negative contributions of community dialogues on gender, power, and male roles in maternal, newborn and reproductive health?
16. What have been positive or negative contributions of efforts to engage men in maternal, newborn and reproductive health at health facilities?
17. Is there anything you would change or add?